HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1796.70] *(Division 2 enacted by Stats. 1939, Ch. 60.)*

CHAPTER 2. Health Facilities [1250 - 1339.59] *(Chapter 2 repealed and added by Stats. 1973, Ch. 1202.)*

ARTICLE 1. General [1250 - 1264] *(Article 1 added by Stats. 1973, Ch. 1202.)*

1250. As used in this chapter, “health facility” means a facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer, and includes the following types:

(a) “General acute care hospital” means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. A general acute care hospital may include more than one physical plant maintained and operated on separate premises as provided in Section 1250.8. A general acute care hospital that exclusively provides acute medical rehabilitation center services, including at least physical therapy, occupational therapy, and speech therapy, may provide for the required surgical and anesthesia services through a contract with another acute care hospital. In addition, a general acute care hospital that, on July 1, 1983, provided required surgical and anesthesia services through a contract or agreement with another acute care hospital may continue to provide these surgical and anesthesia services through a contract or agreement with an acute care hospital. The general acute care hospital operated by the State Department of Developmental Services at Agnews Developmental Center may, until June 30, 2007, provide surgery and anesthesia services through a contract or agreement with another acute care hospital. Notwithstanding the requirements of this subdivision, a general acute care hospital operated by the Department of Corrections and Rehabilitation or the Department of Veterans Affairs may provide surgery and anesthesia services during normal weekday working hours, and not provide these services during other hours of the weekday or on weekends or holidays, if the general acute care hospital otherwise meets the requirements of this section.

A “general acute care hospital” includes a “rural general acute care hospital.” However, a “rural general acute care hospital” shall not be required by the department to provide surgery and anesthesia services. A “rural general acute care hospital” shall meet either of the following conditions:

(1) The hospital meets criteria for designation within peer group six or eight, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982.

(2) The hospital meets the criteria for designation within peer group five or seven, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982, and has no more than 76 acute care beds and is located in a census dwelling place of 15,000 or less population according to the 1980 federal census.

(b) “Acute psychiatric hospital” means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services.

(c) (1) “Skilled nursing facility” means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

(2) “Skilled nursing facility” includes a “small house skilled nursing facility (SHSNF),” as defined in Section 1323.5.

(d) “Intermediate care facility” means a health facility that provides inpatient care to ambulatory or nonambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

(e) “Intermediate care facility/developmentally disabled habilitative” means a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer persons with developmental disabilities who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.

(f) “Special hospital” means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical or dental staff that provides inpatient or outpatient care in dentistry or maternity.

(g) “Intermediate care facility/developmentally disabled” means a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to persons with developmental disabilities whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.

(h) “Intermediate care facility/developmentally disabled-nursing” means a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons with developmental disabilities or who demonstrate significant developmental delay that may lead to a developmental disability if not treated.

(i) (1) “Congregate living health facility” means a residential home with a capacity, except as provided in paragraph (4), of no more than 18 beds, that provides inpatient care, including the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social, recreational, and at least one type of service specified in paragraph (2). The primary need of congregate living health facility residents shall be for availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis. This care is generally less intense than that provided in general acute care hospitals but more intense than that provided in skilled nursing facilities.

(2) Congregate living health facilities shall provide one or more of the following services:

(A) Services for persons who are mentally alert, persons with physical disabilities, who may be ventilator dependent.

(B) Services for persons who have a diagnosis of terminal illness, a diagnosis of a life-threatening illness, or both. Terminal illness means the individual has a life expectancy of six months or less as stated in writing by his or her attending physician and surgeon. A “life-threatening illness” means the individual has an illness that can lead to a possibility of a termination of life within five years or less as stated in writing by his or her attending physician and surgeon.

(C) Services for persons who are catastrophically and severely disabled. A person who is catastrophically and severely disabled means a person whose origin of disability was acquired through trauma or nondegenerative neurologic illness, for whom it has been determined that active rehabilitation would be beneficial and to whom these services are being provided. Services offered by a congregate living health facility to a person who is catastrophically disabled shall include, but not be limited to, speech, physical, and occupational therapy.

(3) A congregate living health facility license shall specify which of the types of persons described in paragraph (2) to whom a facility is licensed to provide services.

(4) (A) A facility operated by a city and county for the purposes of delivering services under this section may have a capacity of 59 beds.

(B) A congregate living health facility not operated by a city and county servicing persons who are terminally ill, persons who have been diagnosed with a life-threatening illness, or both, that is located in a county with a population of 500,000 or more persons, or located in a county of the 16th class pursuant to Section 28020 of the Government Code, may have not more than 25 beds for the purpose of serving persons who are terminally ill.

(5) A congregate living health facility shall have a noninstitutional, homelike environment.

(j) (1) “Correctional treatment center” means a health facility operated by the Department of Corrections and Rehabilitation, the Department of Corrections and Rehabilitation, Division of Juvenile Facilities, or a county, city, or city and county law enforcement agency that, as determined by the department, provides inpatient health services to that portion of the inmate population who do not require a general acute care level of basic services. This definition shall not apply to those areas of a law enforcement facility that houses inmates or wards who may be receiving outpatient services and are housed separately for reasons of improved access to health care, security, and protection. The health services provided by a correctional treatment center shall include, but are not limited to, all of the following basic services: physician and surgeon, psychiatrist, psychologist, nursing, pharmacy, and dietary. A correctional treatment center may provide the following services: laboratory, radiology, perinatal, and any other services approved by the department.

(2) Outpatient surgical care with anesthesia may be provided, if the correctional treatment center meets the same requirements as a surgical clinic licensed pursuant to Section 1204, with the exception of the requirement that patients remain less than 24 hours.

(3) Correctional treatment centers shall maintain written service agreements with general acute care hospitals to provide for those inmate physical health needs that cannot be met by the correctional treatment center.

(4) Physician and surgeon services shall be readily available in a correctional treatment center on a 24-hour basis.

(5) It is not the intent of the Legislature to have a correctional treatment center supplant the general acute care hospitals at the California Medical Facility, the California Men's Colony, and the California Institution for Men. This subdivision shall not be construed to prohibit the Department of Corrections and Rehabilitation from obtaining a correctional treatment center license at these sites.

(k) "Nursing facility" means a health facility licensed pursuant to this chapter that is certified to participate as a provider of care either as a skilled nursing facility in the federal Medicare Program under Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) or as a nursing facility in the federal Medicaid Program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), or as both.

(l) Regulations defining a correctional treatment center described in subdivision (j) that is operated by a county, city, or city and county, the Department of Corrections and Rehabilitation, or the Department of Corrections and Rehabilitation, Division of Juvenile Facilities, shall not become effective prior to, or, if effective, shall be inoperative until January 1, 1996, and until that time these correctional facilities are exempt from any licensing requirements.

(m) "Intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN)" means a homelike facility with a capacity of four to eight, inclusive, beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have continuous needs for skilled nursing care and have been certified by a physician and surgeon as warranting continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated. ICF/DD-CN facilities shall be subject to licensure under this chapter upon adoption of licensing regulations in accordance with Section 1275.3. A facility providing continuous skilled nursing services to persons with developmental disabilities pursuant to Section 14132.20 or 14495.10 of the Welfare and Institutions Code shall apply for licensure under this subdivision within 90 days after the regulations become effective, and may continue to operate pursuant to those sections until its licensure application is either approved or denied.

(n) "Hospice facility" means a health facility licensed pursuant to this chapter with a capacity of no more than 24 beds that provides hospice services. Hospice services include, but are not limited to, routine care, continuous care, inpatient respite care, and inpatient hospice care as defined in subdivision (d) of Section 1339.40, and is operated by a provider of hospice services that is licensed pursuant to Section 1751 and certified as a hospice pursuant to Part 418 of Title 42 of the Code of Federal Regulations.

(Amended by Stats. 2015, Ch. 483, Sec. 1. (AB 1211) Effective October 4, 2015.)

1250.02. Article 9 (commencing with Section 70901) of Chapter 1 of Division 5 of Title 22 of the California Code of Regulations, as adopted to implement the requirements of Section 2 of Chapter 67 of the Statutes of 1988, shall apply to a rural general acute care hospital as defined in Section 1250. Any reference in those provisions to the Office of Statewide Health Planning and Development shall instead refer to the department. Any reference in those provisions to a small and rural hospital shall instead refer to a rural general acute care hospital. The department may adopt regulations to implement or administer this action.

(Added by Stats. 1993, Ch. 931, Sec. 3. Effective January 1, 1994.)

1250.03. A rural general acute care hospital that does not provide surgical and anesthesia services shall maintain written transfer agreements with one or more general acute care hospitals that provide surgical and anesthesia services.

(Added by renumbering Section 1250.1 (as added by Stats. 1993, Ch. 931) by Stats. 1994, Ch. 146, Sec. 94. Effective January 1, 1995.)

1250.05. (a) All general acute care hospitals licensed under this chapter shall maintain a medical records system, based upon current standards for medical record retrieval and storage, that organizes all medical records for each patient under a unique identifier.

(b) This section shall not require electronic records or require that all portions of patients' records be stored in a single location.

(c) In addition, all general acute care hospitals shall have the ability to identify the location of all portions of a patient's medical record that are maintained under the general acute care hospital's license.

(d) All general acute care hospitals, including those holding a consolidated general acute care license pursuant to Section 1250.8, shall develop and implement policies and procedures to ensure that relevant portions of patients' medical records can be made available within a reasonable period of time to respond to the request of a treating physician, other authorized medical professionals, authorized representatives of the department, or any other person authorized by law to make such a request, taking into consideration the physical location of the records and hours of operation of the facility where those records are located, as well as the best interests of the patients.

(Added by Stats. 1998, Ch. 310, Sec. 12. Effective August 19, 1998.)

1250.06. A licensed general acute care hospital, as defined pursuant to subdivision (a) of Section 1250, or an acute psychiatric hospital, as defined pursuant to subdivision (b) of Section 1250, shall adopt policies and procedures regarding the responsibility for ensuring proper methods of repackaging and labeling of bulk cleaning agents, solvents, chemicals, and nondrug hazardous substances used throughout the hospital. The hospital is not required to consult a pharmacist regarding the repackaging and labeling of these substances, except for areas where sterile compounding is performed.

(Added by Stats. 2014, Ch. 319, Sec. 4. (SB 1039) Effective January 1, 2015.)

1250.1. (a) The department shall adopt regulations that define all of the following bed classifications for health facilities:

(1) General acute care.

(2) Skilled nursing.

(3) Intermediate care-developmental disabilities.

(4) Intermediate care—other.

(5) Acute psychiatric.

(6) Specialized care, with respect to special hospitals only.

(7) Chemical dependency recovery.

(8) Intermediate care facility/developmentally disabled habilitative.

(9) Intermediate care facility/developmentally disabled nursing.

(10) Congregate living health facility.

(11) Pediatric day health and respite care facility, as defined in Section 1760.2.

(12) Correctional treatment center. For correctional treatment centers that provide psychiatric and psychological services provided by county mental health agencies in local detention facilities, the State Department of State Hospitals shall adopt regulations specifying acute and nonacute levels of 24-hour care. Licensed inpatient beds in a correctional treatment center shall be used only for the purpose of providing health services.

(13) Hospice facility.

(b) Except as provided in Section 1253.1, beds classified as intermediate care beds, on September 27, 1978, shall be reclassified by the department as intermediate care—other. This reclassification shall not constitute a “project” within the meaning of Section 127170 and shall not be subject to any requirement for a certificate of need under Chapter 1 (commencing with Section 127125) of Part 2 of Division 107, and regulations of the department governing intermediate care prior to the effective date shall continue to be applicable to the intermediate care—other classification unless and until amended or repealed by the department.

(Amended by Stats. 2012, Ch. 673, Sec. 3. (SB 135) Effective January 1, 2013.)

1250.2. (a) (1) As defined in Section 1250, “health facility” includes a “psychiatric health facility,” defined to mean a health facility, licensed by the State Department of Health Care Services, that provides 24-hour inpatient care for people with mental health disorders, severe substance use disorders, as defined in subdivision (o) of Section 5008 of the Welfare and Institutions Code, or cooccurring mental health and severe substance use disorders, or other persons described in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code. This care shall include, but not be limited to, the following basic services: psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, food services, and substance use disorder services, as medically necessary and appropriate. Psychiatric health facilities shall only admit persons whose physical health needs can be met in an affiliated hospital or in outpatient settings and shall only admit people with stand-alone severe substance use disorders involuntarily pursuant to Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code.

(2) It is the intent of the Legislature that the psychiatric health facility shall provide a distinct type of service to persons with mental health disorders, severe substance use disorders, or cooccurring mental health and substance use disorders in a 24-hour acute inpatient setting. The State Department of Health Care Services shall require regular utilization reviews of admission and

discharge criteria and lengths of stay in order to ensure that these patients are moved to less restrictive levels of care as soon as appropriate.

(b) (1) The State Department of Health Care Services may issue a special permit to a psychiatric health facility for it to provide structured outpatient services (commonly referred to as SOPS) consisting of morning, afternoon, or full daytime organized programs, not exceeding 10 hours, for acute daytime care for patients admitted to the facility. This subdivision shall not be construed as requiring a psychiatric health facility to apply for a special permit to provide these alternative levels of care.

(2) The Legislature recognizes that, with access to structured outpatient services, as an alternative to 24-hour inpatient care, certain patients would be provided with effective intervention and less restrictive levels of care. The Legislature further recognizes that, for certain patients, the less restrictive levels of care eliminate the need for inpatient care, enable earlier discharge from inpatient care by providing a continuum of care with effective aftercare services, or reduce or prevent the need for a subsequent readmission to inpatient care.

(c) Any reference in any statute to Section 1250 of the Health and Safety Code shall be deemed and construed to also be a reference to this section.

(d) Notwithstanding any other law, and to the extent consistent with federal law, a psychiatric health facility shall be eligible to participate in the Medicare program under Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), and the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), if all of the following conditions are met:

(1) The facility is a licensed facility.

(2) The facility is in compliance with all related statutes and regulations enforced by the State Department of Health Care Services, including regulations contained in Chapter 9 (commencing with Section 77001) of Division 5 of Title 22 of the California Code of Regulations.

(3) The facility meets the definitions and requirements contained in subdivisions (e) and (f) of Section 1861 of the federal Social Security Act (42 U.S.C. Sec. 1395x(e) and (f)), including the approval process specified in Section 1861(e)(7)(B) of the federal Social Security Act (42 U.S.C. Sec. 1395x(e)(7)(B)), which requires that the state agency responsible for licensing hospitals has ensured that the facility meets licensing requirements.

(4) The facility meets the conditions of participation for hospitals pursuant to Part 482 of Title 42 of the Code of Federal Regulations.

(Amended by Stats. 2024, Ch. 644, Sec. 1. (SB 1238) Effective January 1, 2025.)

1250.3. (a) (1) “Chemical dependency recovery hospital” means a health facility that provides 24-hour inpatient chemical dependency recovery services for persons who have a dependency on alcohol or other drugs, or both alcohol and other drugs. Each facility shall have a medical director who is a physician and surgeon licensed to practice in this state.

(2) “Chemical dependency recovery services” shall include, but not be limited to, the following basic services: medications for addiction treatment, medically supervised voluntary inpatient detoxification, patient counseling, group therapy, physical conditioning, family therapy, outpatient services, and dietetic services, but does not include emergency department services or medical inpatient admission for treatment of severe, potentially life-threatening, intoxication and withdrawal syndromes.

(b) The Legislature finds and declares that problems related to the inappropriate use of alcohol or other drugs, or both alcohol and other drugs, are widespread and adversely affect the general welfare of the people of the State of California. It is the intent of the Legislature to expand access to chemical dependency recovery services, and to support persons receiving those services, while ensuring the safety and quality of care for all patients in a health facility. It is also the intent of the Legislature that the chemical dependency recovery hospital will provide an innovative inpatient treatment with medications, as well as a program for persons who have a dependency on alcohol or drugs, or both alcohol and other drugs. The Legislature further finds and declares that significant cost reductions can be achieved by chemical dependency recovery hospitals when both of the following conditions exist:

(1) Architectural requirements established by the department encourage a flexible and open construction approach that significantly reduces capital construction costs and allows for the use of nonfreestanding facilities.

(2) Programs are designed to provide comprehensive inpatient treatment while permitting substantial flexibility in the use of qualified personnel to meet the specific needs of the patients of the facility.

(c) A separately licensed chemical dependency recovery hospital that is not a part of a general acute care hospital shall have agreements with one or more general acute care hospitals providing for 24-hour emergency service and pharmacy, laboratory, and any other services that the department may require.

(d) All beds in a separately licensed chemical dependency recovery hospital shall be designated for chemical dependency recovery services. Chemical dependency recovery beds shall be used exclusively for alcohol or other drug dependency treatment, or both alcohol and other drug dependency treatment.

(e) (1) General acute care hospitals and acute psychiatric hospitals may provide chemical dependency recovery services as a supplemental service within the same building, or in a separate building on campus that meets the structural requirements of a freestanding chemical dependency recovery hospital described in the OSHPD 6 requirements of the most recent version of the California Building Code.

(2) Chemical dependency recovery services may be provided in a general acute care hospital or acute psychiatric hospital without a distinct part, or outside the hospital's distinct part, in beds that are licensed for a service other than chemical dependency recovery. A general acute care hospital or acute psychiatric hospital providing chemical dependency recovery services that are not in a distinct part shall do both of the following:

(A) Require all staff treating a patient receiving chemical dependency recovery services to have the appropriate competencies for chemical dependency recovery and for other care they provide in the unit in which the patient has been placed, consistent with their role in patient care.

(B) Meet the nurse-to-patient staffing ratios for the unit in which the patient has been placed.

(3) Chemical dependency recovery services shall comply with the basic services requirements, and optional services requirements if the facility is approved by the department to provide them, for chemical dependency recovery hospitals in Chapter 11 (commencing with Section 79001) of Division 5 of Title 22 of the California Code of Regulations.

(4) Chemical dependency recovery services provided pursuant to this subdivision shall not require a separate license.

(5) When a general acute care hospital, acute psychiatric hospital, or distinct unit thereof providing chemical dependency recovery services under paragraph (1) meets the definition of a part 2 program, as defined in Section 2.11 of Title 42 of the Code of Federal Regulations, the general acute care hospital, acute psychiatric hospital, or distinct unit thereof shall provide the confidentiality protections required by Part 2 (commencing with Section 2.1) of Subchapter A of Chapter I of Title 42 of the Code of Federal Regulations to the hospital's or unit's patients with a substance use disorder.

(f) Chemical dependency recovery services may be provided in a freestanding facility, within a hospital building. Notwithstanding any other law, chemical dependency recovery services may be provided within a hospital building that has been removed from general acute care use.

(g) Chemical dependency recovery services may be colocated with other services of its parent general acute care hospital or acute psychiatric hospital.

(h) A reference in any statute to Section 1250 shall be deemed and construed to also be a reference to this section.

(i) Notwithstanding any other law, the department may, without taking any regulatory actions pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific this section by means of an All Facilities Letter or similar instruction.

(Amended by Stats. 2024, Ch. 637, Sec. 1. (AB 2376) Effective January 1, 2025.)

1250.4. (a) As used in this section:

(1) "Department" means the Department of Corrections or the Department of the Youth Authority.

(2) "Communicable, contagious, or infectious disease" means any disease that is capable of being transmitted from person to person with or without contact and as established by the State Department of Health Services pursuant to Section 120130, and Section 2500 et seq. of Title 17 of the California Code of Regulations.

(3) "Inmate or ward" means any person incarcerated within the jurisdiction of the Department of Corrections or the Department of the Youth Authority, with the exception of a person on parole.

(4) "Institution" means any state prison, camp, center, office, or other facility under the jurisdiction of the Department of Corrections or the Department of the Youth Authority.

(5) "Medical director," "chief of medical services," or "chief medical officer" means the medical officer, acting medical officer, medical director, or the physician designated by the department to act in that capacity, who is responsible for directing the medical treatment programs and medical services for all health services and services supporting the health services provided in the institution.

(b) Each health care facility in the Department of Corrections and in the Department of the Youth Authority shall have a medical director in charge of the health care services of that facility who shall be a physician and surgeon licensed to practice in California and who shall be appointed by the directors of the departments. The medical director shall direct the medical treatment programs for all health services and services supporting the health services provided in the facility.

(c) The medical director, chief of medical services, chief medical officer, or the physician designated by the department to act in that capacity, shall use every available means to ascertain the existence of, and to immediately investigate, all reported or suspected cases of any communicable, contagious, or infectious disease and to ascertain the source or sources of the infections and prevent the spread of the disease. In carrying out these investigations, the medical director, chief of medical services, chief medical officer, or the physician designated by the department to act in that capacity, is hereby invested with full powers of inspection, examination, and quarantine or isolation of all inmates or wards known to be, or reasonably suspected to be, infected with a communicable, contagious, or infectious disease.

(d) The medical director, chief of medical services, chief medical officer, or the physician designated by the department to act in that capacity, shall order an inmate or ward to receive an examination or test, or may order an inmate or ward to receive treatment if the medical director, chief of medical services, chief medical officer, or the physician designated by the department to act in that capacity, has reasonable suspicion that the inmate or ward has, has had, or has been exposed to a communicable, contagious, or infectious disease and the medical director, chief of medical services, chief medical officer, or the physician designated by the department to act in that capacity, has reasonable grounds to believe that it is necessary for the preservation and protection of staff and inmates or wards.

(e) Notwithstanding Section 2600 or 2601 of the Penal Code, or any other provision of law, any inmate or ward who refuses to submit to an examination, test, or treatment for any communicable, contagious, or infectious disease or who refuses treatment for any communicable, contagious, or infectious disease, or who, after notice, violates, or refuses or neglects to conform to any rule, order, guideline, or regulation prescribed by the department with regard to communicable disease control shall be tested involuntarily and may be treated involuntarily. This inmate or ward shall be subject to disciplinary action as described in Title 15 of the California Code of Regulations.

(f) This section shall not apply to HIV or AIDS. Testing, treatment, counseling, prevention, education, or other procedures dealing with HIV and AIDS shall be conducted as prescribed in Title 8 (commencing with Section 7500) of Part 3 of the Penal Code.

(g) This section shall not apply to tuberculosis. Tuberculosis shall be addressed as prescribed in Title 8.7 (commencing with Section 7570) of the Penal Code.

(Amended by Stats. 1996, Ch. 1023, Sec. 152. Effective September 29, 1996.)

1250.5. "Council" means the Advisory Health Council.

(Added by Stats. 1973, Ch. 1202.)

1250.6. Any requirement placed upon, or reference to, a corporation in this chapter, shall also apply to a limited liability company.

(Added by Stats. 2001, Ch. 685, Sec. 2. Effective January 1, 2002.)

1250.7. (a) (1) With respect to each hospital designated by the department as a critical access hospital, and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare Rural Hospital Flexibility Program, the department may develop criteria to waive any requirements of Division 5 (commencing with Section 70001) of Title 22 of the California Code of Regulations that are in conflict with the federal requirements for designation in the federal program, if the department finds that it is in the public interest to do so, and the department determines that the waiver would not negatively affect the quality of patient care.

(2) The criteria established pursuant to this subdivision shall not be considered regulations within the meaning of Section 11342 of the Government Code, and shall not be subject to adoption as regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(b) Nothing in this section shall be construed to mean that a critical access hospital is not a general acute care hospital. Every hospital designated by the department as a critical access hospital and certified as such by the United States Department of Health and Human Services shall be deemed to be a general acute care hospital, as defined in subdivision (a) of Section 1250, even if the department waives regulatory requirements otherwise applicable to general acute care hospitals pursuant to this section.

(Added by Stats. 2002, Ch. 752, Sec. 2. Effective January 1, 2003.)

1250.8. (a) Notwithstanding subdivision (a) of Section 127170, the department, upon application of a general acute care hospital that meets all the criteria of subdivision (b), and other applicable requirements of licensure, shall issue a single consolidated license to a general acute care hospital that includes more than one physical plant maintained and operated on separate premises or that has multiple licenses for a single health facility on the same premises. A single consolidated license shall not be issued where the

separate freestanding physical plant is a skilled nursing facility or an intermediate care facility, whether or not the location of the skilled nursing facility or intermediate care facility is contiguous to the general acute care hospital unless the hospital is exempt from the requirements of subdivision (b) of Section 1254, or the facility is part of the physical structure licensed to provide acute care.

(b) The issuance of a single consolidated license shall be based on the following criteria:

(1) There is a single governing body for all the facilities maintained and operated by the licensee.

(2) There is a single administration for all the facilities maintained and operated by the licensee.

(3) There is a single medical staff for all the facilities maintained and operated by the licensee, with a single set of bylaws, rules, and regulations, which prescribe a single committee structure.

(4) Except as provided otherwise in this paragraph, the physical plants maintained and operated by the licensee which are to be covered by the single consolidated license are located not more than 15 miles apart. If an applicant provides evidence satisfactory to the department that it can comply with all requirements of licensure and provide quality care and adequate administrative and professional supervision, the director may issue a single consolidated license to a general acute care hospital that operates two or more physical plants located more than 15 miles apart under any of the following circumstances:

(A) One or more of the physical plants is located in a rural area, as defined by regulations of the director.

(B) One or more of the physical plants provides only outpatient services, as defined by the department.

(C) If Section 14105.986 of the Welfare and Institutions Code is implemented and the applicant meets all of the following criteria:

(i) The applicant is a nonprofit corporation.

(ii) The applicant is a children's hospital listed in Section 10727 of the Welfare and Institutions Code.

(iii) The applicant is affiliated with a major university medical school and located adjacent thereto.

(iv) The applicant operates a regional tertiary care facility.

(v) One of the physical plants is located in a county that has a consolidated and county government structure.

(vi) One of the physical plants is located in a county having a population between 1,000,000 and 2,000,000.

(vii) The applicant is located in a city with a population between 50,000 and 100,000.

(c) In issuing the single consolidated license, the state department shall specify the location of each supplemental service and the location of the number and category of beds provided by the licensee. The single consolidated license shall be renewed annually.

(d) To the extent required by Chapter 1 (commencing with Section127125) of Part 2 of Division 107, a general acute care hospital that has been issued a single consolidated license:

(1) Shall not transfer from one facility to another a special service described in Section 1255 without first obtaining a certificate of need.

(2) Shall not transfer, in whole or in part, from one facility to another, a supplemental service, as defined in regulations of the director pursuant to this chapter, without first obtaining a certificate of need, unless the licensee, 30 days prior to the relocation, notifies the Office of Statewide Health Planning and Development, the applicable health systems agency, and the state department of the licensee's intent to relocate the supplemental service, and includes with this notice a cost estimate, certified by a person qualified by experience or training to render the estimates, which estimates that the cost of the transfer will not exceed the capital expenditure threshold established by the Office of Statewide Health Planning and Development pursuant to Section 127170.

(3) Shall not transfer beds from one facility to another facility, without first obtaining a certificate of need unless, 30 days prior to the relocation, the licensee notifies the Office of Statewide Health Planning and Development, the applicable health systems agency, and the state department of the licensee's intent to relocate health facility beds, and includes with this notice both of the following:

(A) A cost estimate, certified by a person qualified by experience or training to render the estimates, which estimates that the cost of the relocation will not exceed the capital expenditure threshold established by the Office of Statewide Health Planning and Development pursuant to Section 127170.

(B) The identification of the number, classification, and location of the health facility beds in the transferor facility and the proposed number, classification, and location of the health facility beds in the transferee facility.

Except as otherwise permitted in Chapter 1 (commencing with Section 127125) of Part 2 of Division 107, or as authorized in an approved certificate of need pursuant to that chapter, health facility beds transferred pursuant to this section shall be used in the transferee facility in the same bed classification as defined in Section 1250.1, as the beds were classified in the transferor facility.

Health facility beds transferred pursuant to this section shall not be transferred back to the transferor facility for two years from the date of the transfer, regardless of cost, without first obtaining a certificate of need pursuant to Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.

(e) Transfers pursuant to subdivision (d) shall satisfy all applicable requirements of licensure and shall be subject to the written approval, if required, of the state department. The state department may adopt regulations that are necessary to implement this section. These regulations may include a requirement that each facility of a health facility subject to a single consolidated license have an onsite full-time or part-time administrator.

(f) As used in this section, “facility” means a physical plant operated or maintained by a health facility subject to a single, consolidated license issued pursuant to this section.

(g) For purposes of selective provider contracts negotiated under the Medi-Cal program, the treatment of a health facility with a single consolidated license issued pursuant to this section shall be subject to negotiation between the health facility and the California Medical Assistance Commission. A general acute care hospital that is issued a single consolidated license pursuant to this section may, at its option, be enrolled in the Medi-Cal program as a single business address or as separate business addresses for one or more of the facilities subject to the single consolidated license. Irrespective of whether the general acute care hospital is enrolled at one or more business addresses, the department may require the hospital to file separate cost reports for each facility pursuant to Section 14170 of the Welfare and Institutions Code.

(h) For purposes of the Annual Report of Hospitals required by regulations adopted by the state department pursuant to this part, the state department and the Office of Statewide Health Planning and Development may require reporting of bed and service utilization data separately by each facility of a general acute care hospital issued a single consolidated license pursuant to this section.

(i) The amendments made to this section during the 1985–86 Regular Session of the Legislature pertaining to the issuance of a single consolidated license to a general acute care hospital in the case where the separate physical plant is a skilled nursing facility or intermediate care facility shall not apply to the following facilities:

(1) A facility that obtained a certificate of need after August 1, 1984, and prior to February 14, 1985, as described in this subdivision. The certificate of need shall be for the construction of a skilled nursing facility or intermediate care facility that is the same facility for which the hospital applies for a single consolidated license, pursuant to subdivision (a).

(2) A facility for which a single consolidated license has been issued pursuant to subdivision (a), as described in this subdivision, prior to the effective date of the amendments made to this section during the 1985–86 Regular Session of the Legislature.

A facility that has been issued a single consolidated license pursuant to subdivision (a), as described in this subdivision, shall be granted renewal licenses based upon the same criteria used for the initial consolidated license.

(j) If the state department issues a single consolidated license pursuant to this section, the state department may take any action authorized by this chapter, including, but not limited to, any action specified in Article 5 (commencing with Section 1294), with respect to a facility, or a service provided in a facility, that is included in the consolidated license.

(k) The eligibility for participation in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code) of a facility that is included in a consolidated license issued pursuant to this section, provides outpatient services, and is located more than 15 miles from the health facility issued the consolidated license shall be subject to a determination of eligibility by the state department. This subdivision shall not apply to a facility that is located in a rural area and is included in a consolidated license issued pursuant to subparagraphs (A), (B), and (C) of paragraph (4) of subdivision (b). Regardless of whether a facility has received or not received a determination of eligibility pursuant to this subdivision, this subdivision shall not affect the ability of a licensed professional, providing services covered by the Medi-Cal program to a person eligible for Medi-Cal in a facility subject to a determination of eligibility pursuant to this subdivision, to bill the Medi-Cal program for those services provided in accordance with applicable regulations.

(l) Notwithstanding any other provision of law, the director may issue a single consolidated license for a general acute care hospital to Children’s Hospital Oakland and San Ramon Regional Medical Center.

(m) Notwithstanding any other provision of law, the director may issue a single consolidated license for a general acute care hospital to Children’s Hospital Oakland and the John Muir Medical Center, Concord Campus.

(n) (1) To the extent permitted by federal law, payments made to Children’s Hospital Oakland pursuant to Section 14166.11 of the Welfare and Institutions Code shall be adjusted as follows:

(A) The number of Medi-Cal payment days and net revenues calculated for the John Muir Medical Center, Concord Campus under the consolidated license shall not be used for eligibility purposes for the private hospital disproportionate share hospital replacement funds for Children’s Hospital Oakland.

(B) The number of Medi-Cal payment days calculated for hospital beds located at John Muir Medical Center, Concord Campus that are included in the consolidated license beginning in the 2007–08 fiscal year shall only be used for purposes of calculating disproportionate share hospital payments authorized under Section 14166.11 of the Welfare and Institutions Code at Children's Hospital Oakland to the extent that the inclusion of those days does not exceed the total Medi-Cal payment days used to calculate Children's Hospital Oakland payments for the 2006–07 fiscal year disproportionate share replacement.

(2) This subdivision shall become inoperative in the event that the two facilities covered under the consolidated license described in subdivision (a) are located within a 15-mile radius of each other.

(Amended by Stats. 2008, Ch. 179, Sec. 136. Effective January 1, 2009.)

1250.10. (a) (1) "Psychiatric residential treatment facility" means a health facility licensed by the State Department of Health Care Services, that is operated by a public agency or private nonprofit organization that provides inpatient psychiatric services, as described in Subpart D (commencing with Section 441.150) of Title 42 of the Code of Federal Regulations, to individuals under 21 years of age, in a nonhospital setting.

(2) Psychiatric residential treatment facilities shall obtain and maintain certification to provide Medi-Cal inpatient psychiatric services for individuals under 21 years of age in compliance with the Centers for Medicare and Medicaid Services requirements.

(3) Psychiatric residential treatment facilities shall comply with applicable utilization control requirements in Part 456 of Title 42 of the Code of Federal Regulations, including, but not limited to, Subpart D for Mental Hospitals. Psychiatric residential treatment facilities shall comply with utilization reviews, including, but not limited to, provisions specific to certification and recertification of need for inpatient care at least every 60 days, length of stay, continued stay, and length of stay modifications in order to ensure that patients are transitioned back to the community.

(4) The department shall set a statewide bed limit based on an analysis to ensure that inpatient psychiatric services for individuals under 21 years of age are available and sufficient in amount, duration, and scope to reasonably achieve the purpose for which services are provided. The statewide bed limit shall comply with state and federal Medicaid requirements. The department shall notify the Legislature when the total number of beds in licensed psychiatric residential treatment facilities in the state reaches 250 beds, 500 beds, and 750 beds.

(b) Notwithstanding any other law, and to the extent consistent with federal law, a psychiatric residential treatment facility shall be eligible to participate in the Medicare program under Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), and the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), if all of the following conditions are met:

(1) The facility is licensed as a psychiatric residential treatment facility by the State Department of Health Care Services to provide inpatient psychiatric services to Medicaid-eligible individuals under 21 years of age.

(2) The facility is in compliance with all applicable state and federal Medicaid statutes, regulations, and guidance, including, but not limited to, inpatient initial and continued stay authorization criteria, individual plan of care requirements, documentation, and treatment plan review.

(3) The facility meets the definition of a psychiatric residential treatment facility pursuant to Section 483.352 of Title 42 of the Code of Federal Regulations.

(4) The facility provides inpatient psychiatric services to Medicaid-eligible individuals under 21 years of age in accordance with the requirements and standards developed by the State Department of Health Care Services pursuant to the authority in Section 1905(a)(16) and (h) (42 U.S.C. Sec. 1396d(a)(16) and (h)), Section 1902(a)(9)(A) (42 U.S.C. Sec. 1396a(a)(9)(A)), which authorizes the State Department of Health Care Services to establish and maintain health standards for institutions in which Medicaid beneficiaries may receive services, and Section 1902 (a)(33)(B) (42 U.S.C. Sec. 1396a (a)(33)(B)) of the federal Social Security Act and the Medicaid State Plan.

(5) The facility has a provider agreement with the State Department of Health Care Services or a mental health plan to provide the inpatient psychiatric services benefit to Medicaid-eligible individuals 21 years of age.

(6) The facility obtains a certification for participation in the federal Medicaid program and maintains compliance with the conditions of participation for psychiatric residential treatment facilities pursuant to Subpart D of Part 441 and Subpart G of Part 483 of Title 42 of the Code of Federal Regulations.

(7) For purposes of the requirements specified in Subpart G of Part 483 of Title 42 of the Code of Federal Regulations, facility staff shall have training on engaging in trauma-informed prevention and deescalation interventions with the goal of reducing seclusion and restraint.

(8) The facility maintains accreditation from one of the following organizations identified in Section 441.151 of Title 42 of the Code of Federal Regulations:

(A) Joint Commission on Accreditation of Healthcare Organizations.

(B) The Commission on Accreditation of Rehabilitation Facilities.

(C) The Council on Accreditation of Services for Families and Children.

(D) Any other accrediting organization with comparable standards recognized by the State Department of Health Care Services.

(9) The facility has guidelines for operation that include, at a minimum, each of the following:

(A) Requirements that all services and programs align to the trauma-informed care standards.

(B) Length of stay to be determined by medical necessity for the duration of time needed to stabilize, treat, and transition the patient to a less restrictive setting consistent with the patient individual plan of care.

(C) Requirements that patients are connected to a continuum of care and services to promote healing and step down to community-based care in facility plans of operation, along with the identification of strategies, treatment, services, and supports that the facility will employ to connect the youth and their families to community-based services and to step down the youth to family-based care.

(D) The implementation of an individual plan of care that is all of the following:

(i) Developed and implemented no later than 72 hours after admission.

(ii) Designed to achieve the patient's discharge from inpatient status, step-down service, at the earliest possible time or as a diversion to admittance to a psychiatric hospital.

(iii) The individual plan of care shall be based on a diagnostic evaluation that is developed by a treatment team in consultation with the patient and their parents, legal guardians, or others into whose care they will be released after discharge, and include discharge plans and after-care resources such as community services to ensure continuity of care with the patient's family, school, and community upon discharge.

(c) The facility shall annually, by July 1 of each year, provide the State Department of Health Care Services with all of the following data:

(1) Total number of patients admitted, including the number of Medi-Cal beneficiaries and the number of patients under the jurisdiction of the juvenile court.

(2) Age, race or ethnicity, and gender of patients served, and, if available, sexual orientation and gender identity or expression of patients.

(3) Duration of stay of each patient and the average and median lengths of stay for patients under the jurisdiction of the juvenile court and separately for those not subject to juvenile court jurisdiction.

(4) For each patient, the type of placement the patient was in prior to admission, if any, the services and interventions provided to the patient prior to address the patient's crisis needs, if any, and the number of prior hospitalizations, if any.

(5) Professional classification of staff and contracted staff.

(6) For each patient, the type of placement the client was discharged to.

(7) The types of community-based services provided to patients during their stay to facilitate their transition back into the community, if any, including a breakdown of services provided to patients under the jurisdiction of the juvenile court and separately for those not subject to juvenile court jurisdiction.

(8) Postdischarge plans and after care resources, including the type and intensity of mental health services, provided upon discharge.

(9) The number of patients subjected to restraint, the number of times each patient was subjected to restraint, and the types and duration of restraint.

(10) The facility's policies regarding patient rules of conduct, behavioral incentives and discipline, and procedures for notifying patients of their rights.

(11) A copy of the patient's rights and facility complaint procedures provided to each patient upon admission.

(d) The State Department of Health Care Services and the State Department of Social Services shall, by January 1 of each year, provide to the Senate and Assembly Committees on Health, Human Services, and Judiciary with a report summarizing the information provided under subdivision (c) including, at a minimum:

(1) For each facility, all of the following:

(A) The total number of patients admitted, including the number of Medi-Cal beneficiaries and the number of patients under the jurisdiction of the juvenile court.

(B) The age, race or ethnicity, and gender of patients served, and, if available, sexual orientation and gender identity or expression of patients served.

(C) The average and median lengths of stay at the facility.

(D) Professional classifications of staff and contracted staff.

(E) The types of placements patients were discharged to.

(F) The types of community-based services provided to patients during their stay to facilitate their transition back into the community, if any, including a breakdown of services provided to patients under the jurisdiction of the juvenile court and separately for those not subject to juvenile court jurisdiction.

(G) The number of patients subjected to restraint, the number of times each patient was subjected to restraint, and the types and duration of restraint.

(H) The number of patients who had previously been admitted to the same or a different psychiatric residential facility.

(2) On a statewide basis, all of the following:

(A) (i) The total number of patients admitted to psychiatric residential facilities, including the number of Medi-Cal beneficiaries and the number of patients under the jurisdiction of the juvenile court.

(ii) The total number of patients admitted to psychiatric residential facilities, including the number of Medi-Cal beneficiaries and the number of patients under the jurisdiction of the juvenile court, from each county. For purposes of this clause, "from each county" refers to the county where the patient resided prior to admission to the facility.

(B) (i) The age, race or ethnicity, and gender of patients served, and, if available, the gender expression of patients served.

(ii) The age, race or ethnicity, and gender of patients served, and, if available, sexual orientation and gender identity or expression of patients served from each county. For purposes of this clause, "from each county" refers to the county where the patient resided prior to admission to the facility.

(C) The average and median lengths of stay.

(D) The types of placements patients were discharged to.

(E) The number of patients subjected to restraint, the number of times each patient was subjected to restraint, and the types and duration of restraint.

(F) The number of patients who had previously been admitted to the same or a different psychiatric residential treatment facility.

(G) (i) The number of intensive services foster care homes, enhanced intensive services foster care homes, other family-based treatment settings, and other less-restrictive placement settings available by county.

(ii) For the purposes of this data collection, "family-based treatment setting" means a licensed home-like setting to serve a child's, minor's, or youth's behavioral health needs. These family-based treatment settings may utilize a range of applicable license types, so long as they provide enhanced care and supervision in a home-like setting, meet all requirements

pursuant to their respective license type, and provide an integrated behavioral health treatment as an alternative to, or stepdown from, psychiatric residential facilities and short-term residential therapeutic programs.

(e) (1) The State Department of Health Care Services shall, in consultation with the State Department of Social Services, the County Behavioral Health Directors Association of California, provider representatives, children's rights advocates, disability rights advocates, and other relevant stakeholders, establish regulations for psychiatric residential treatment facilities. At a minimum, the regulations shall include all of the following:

(A) Therapeutic programming shall be provided seven days per week, including weekends and holidays, with sufficient mental health professional and paraprofessional staff to maintain an appropriate treatment setting and services, based on individual client's needs.

(B) The established number of beds in the facility shall be consistent with the individual treatment needs of the clients served at the facility and shall meet the requirements developed pursuant to subdivision (u) of Section 4081 of the Welfare and Institutions Code. At least 50 percent of the beds shall be in single-occupancy rooms.

(C) (i) The length of stay shall be consistent with the individual plan of care developed by the interdisciplinary team.

(ii) In the case of non-Medi-Cal beneficiaries, reauthorizations for admission shall be obtained using the process established by the entity providing coverage.

(D) The length of stay shall be consistent with the individual plan of care developed by the interdisciplinary team. If a determination is made by a health care professional that a psychiatric residential treatment facility is medically necessary and is the appropriate level of care, reauthorization for admission shall be obtained using the process established by the entity providing coverage.

(E) For voluntary admission of any minor patient subject to the jurisdiction of the juvenile court, the facility shall obtain court authorization for the admission pursuant to Section 361.23 or 727.13, as applicable, and Section 6552 of the Welfare and Institutions Code. Whenever consent for admission of a patient who is subject to the jurisdiction of the juvenile court is revoked, the facility shall immediately contact the county child welfare agency or probation department, as applicable, to arrange for the patient's discharge.

(F) Facilities shall include ample physical space for accommodating individuals who provide daily emotional and physical support to each client and for integrating family members into the day-to-day care of the youth. The facility shall provide patients with at least one hour per day of outdoor exercise or other time spent outside, weather permitting.

(G) The facility shall collaborate with each client's existing mental health team, if applicable, child and family team, as defined by paragraph (4) of subdivision (a) of Section 16501 of the Welfare and Institutions Code, if the patient is an Indian child, as defined in subdivisions (a) and (b) of Section 224.1 of the Welfare and Institutions Code, who is under the jurisdiction of the juvenile court, the child's tribe, if applicable, and other support persons or providers identified by the child or parents within three business days of intake and throughout the course of care and treatment, as appropriate.

(H) The facility shall provide information, upon request, to the county child welfare agency or county probation department to assist the county with its implementation of the patient's aftercare plan for transitioning each admitted child from the program.

(I) The patient's rights provisions contained in Sections 5325, 5325.1, 5325.2, and 5326 of the Welfare and Institutions Code shall be available to any patient admitted to, or eligible for admission to, the facility. Every patient shall have a right to a hearing by writ of habeas corpus, within two judicial days of the filing of a petition for the writ of habeas corpus with the superior court of the county in which the facility is located, for their release. Regulations adopted pursuant to this section shall specify the procedures by which this right shall be ensured. These regulations shall generally be consistent with the procedures contained in Article 5 (commencing with Section 5275) of Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code concerning habeas corpus for individuals, including children, subject to various involuntary holds.

(J) The facility shall establish and implement an individual plan of care within 72 hours of the patient's admission that is designed to achieve the patient's discharge from inpatient status, step-down service, at the earliest possible time. The individual plan of care shall be based on a diagnostic evaluation that is developed by a treatment team in consultation with the patient and their parents, legal guardians, or others in whose care they will be released after discharge and include discharge plans and after-care resources such as community services to ensure continuity of care with the patient's family, school, and community upon discharge. The plan of care shall be updated at least every 10 days, or more frequently if warranted by the patient's change in acuity. For patients who are under the jurisdiction of the juvenile court, the patient's social worker or probation officer and, for Indian children, as defined by subdivisions (a) and (b) of Section 224.1 of the Welfare and Institutions Code, the child's tribe shall be included in the consultation by the treatment team.

(K) Guidelines for the use of physical restraints and seclusion providing protections and safeguards in addition to the requirements in Subpart G (commencing with Section 483.350) of Title 42 of the Code of Federal Regulations. If a patient under the jurisdiction of the juvenile court under Section 300 or 602 of the Welfare and Institutions Code has been restrained or secluded, the facility shall notify the patient's counsel, social worker, or probation officer, as applicable, the patient's tribe if the patient is an Indian child, as defined in subdivisions (a) and (b) of Section 224.1 of the Welfare and Institutions Code, and, except in cases in which parental rights or a legal guardianship has been terminated, the patient's parent, legal guardian, or Indian custodian.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific the provisions applicable to psychiatric residential treatment facilities in this chapter, Division 1.5 (commencing with Section 1180) of this code, and Chapter 1 (commencing with Section 11000) of Part 3 of Division 9 of the Welfare and Institutions Code, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, until regulations are adopted no later than December 31, 2027.

(f) On or before June 1, 2027, the secretary or their designee, in consultation with the State Department of Social Services, shall report to the Legislature on the use of psychiatric residential treatment facilities in the state. The report shall include evaluation metrics assessing the efficacy of facilities in treating the mental health of individuals under 21 years of age, including analyses of individuals under 21 years of age within and without the jurisdiction of the juvenile court and by age, race or ethnicity, and sexual orientation and gender identity, and shall be submitted in compliance with Section 9795 of the Government Code.

(g) Information released or published pursuant to this section shall not contain data that may lead to the identification of patients receiving services in a psychiatric residential treatment facility or information that would otherwise allow an individual to link the published information to a specific person. Data published by the department shall be deidentified in compliance with Section 164.514(a) and (b) of Title 45 of the Code of Federal Regulations.

(Added by Stats. 2022, Ch. 589, Sec. 3. (AB 2317) Effective January 1, 2023.)

1250.11. The State Department of Public Health shall develop written guidelines and regulations as necessary to minimize the risk of transmission of blood-borne infectious diseases from health care worker to patient, from patient to patient, and from patient to health care worker. In so doing, the department shall consider the recommendations made by the federal Centers for Disease Control and Prevention for preventing transmission of HIV and Hepatitis B. The department shall also take into account existing regulations of the department as well as standards, guidelines, and regulations pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) regarding infection control to prevent infection or disease as a result of the transmission of blood-borne pathogens. In so doing, the department shall consult with the Medical Board of California, the Dental Board of California, and the Board of Registered Nursing as well as associations representing health care professions, associations of licensed health facilities, organizations that advocate on behalf of those infected with HIV, and organizations representing consumers of health care. The department shall complete its review of the need for guidelines and regulations by January 1, 1993.

(Amended by Stats. 2017, Ch. 561, Sec. 100. (AB 1516) Effective January 1, 2018.)

1251. "License" means a basic permit to operate a health facility with an authorized number and classification of beds. A license shall not be transferable.

(Amended by Stats. 1976, Ch. 854.)

1251.3. A health facility licensed as a general acute care hospital, providing alcohol recovery services, may convert its licensure category to an acute psychiatric hospital and it may reclassify all of its general acute care beds to acute psychiatric without first obtaining a certificate of need pursuant to Section 127170 if all of the following conditions are met:

(a) The health facility notifies, in writing, the State Department and the Office of Statewide Health Planning and Development on or before September 3, 1982.

(b) The project would reclassify all of the facility's general acute care beds to acute psychiatric.

(c) The total licensed capacity of the facility to be converted does not exceed 31 beds.

(Amended by Stats. 1996, Ch. 1023, Sec. 155. Effective September 29, 1996.)

1251.4. (a) Notwithstanding any other law, upon application of the Department of Corrections and Rehabilitation, the department shall change the license category of a general acute care hospital licensed to the Department of Corrections and Rehabilitation to a correctional treatment center license. No licensing inspection is required for this change of license category.

(b) Notwithstanding any other law, upon application of the Department of Corrections and Rehabilitation, the department shall change the license category of a general acute care hospital or any other licensed health facility located on the grounds of a prison

to a correctional treatment center license regardless of the location of the buildings included in those licenses. No licensing inspection is required for this change of license category.

(Added by Stats. 2014, Ch. 26, Sec. 10. (AB 1468) Effective June 20, 2014.)

1251.5. A “special permit” is a permit issued in addition to a license, authorizing a health facility to offer one or more of the special services specified in Section 1255 when the state department has determined that the health facility has met the standards for quality of care established by state department pursuant to Article 3 (commencing with Section 1275).

(Added by Stats. 1973, Ch. 1202.)

1251.6. (a) The Legislature finds and declares all of the following:

(1) The Camp Fire in 2018 resulted in the destruction of most of the towns of the eastern part of the County of Butte, including the towns of Paradise, Magalia, and Concow, as well as Feather River Hospital in Paradise operated by Adventist Health.

(2) Feather River Hospital was, by far, the largest employer in Paradise, and was the only acute care hospital service in the northeastern part of the county, including the communities of Paradise, Stirling City, Lovelock, De Sabla, and Magalia.

(3) The community that lived near Feather River Hospital was made up primarily of individuals with coverage under the federal Medicare Program or the Medicaid program, and many had only limited access to transportation. Access to health care and health resources has been greatly exacerbated since the Camp Fire.

(4) As the community begins to rebuild, it will be necessary for some health care services to be available to address potential injuries at worksites and during construction.

(5) Because the destruction of the town of Paradise was so complete, it has created a unique situation in that it is unclear at this time whether and how long it will take for the community to rebuild, which makes it difficult for Adventist Health to determine whether a rebuild of the hospital makes sense at this point.

(6) Therefore, it is the intent of the Legislature in enacting this section to permit Adventist Health to provide emergency stabilization services at the site of the former Feather River Hospital for a limited period of time, to ensure the community of Paradise has access to emergency stabilization services as it begins the rebuilding process. It is further the intent of the Legislature that the community of Paradise have access to the highest quality of emergency stabilization services and, therefore, the Legislature encourages Adventist Health to staff the site with physicians who are board certified in emergency medicine, with the understanding that due to the devastation and relocation of many residents, this may not be possible. It is further the intent of the Legislature that this is a temporary approach, intended to provide a period of time to assess whether and to what extent the town of Paradise will return and make the construction of a new hospital viable.

(7) It is not the intent of the Legislature to establish a model for a freestanding emergency department, which is currently, and remains, prohibited by state law.

(b) The department shall issue a special permit, as defined in Section 1251.5, to allow a general acute care hospital, as defined in subdivision (a) of Section 1250, to offer emergency stabilization services at a location that is neither inside nor contiguous to the applicant hospital, including serving as an emergency medical services receiving site if authorized to do so by the medical director of the local emergency medical services agency pursuant to Section 1798.101, if the hospital provides satisfactory evidence to the department that the hospital has a written transfer agreement with the hospital closest to the location where emergency stabilization services will be provided pursuant to this section, and any other hospital necessary to ensure the safe and effective transfer of patients needing services outside the capacity of the closest hospital, and if the applicant hospital submits and has received approval for an application pursuant to subdivision (c) and meets all of the following requirements:

(1) The location is in the town of Paradise within the County of Butte and serves the same area previously served by Feather River Hospital.

(2) The location meets the regulatory requirements applicable to emergency departments, as described in subdivisions (a), (b), (d), (e), (f), (g), (h), (i), (k), (l), and (n) of, and paragraph (6) of subdivision (m) of, Section 70413 of, subdivision (a) of Section 70415 of, and Sections 70417, 70419, 70651, 70655, 70657, and 70841 of, Title 22 of the California Code of Regulations.

(3) The location meets the nurse-to-patient staffing requirements of a basic emergency department, as specified in the regulations adopted pursuant to Section 1276.4.

(4) The location complies with the hospital’s existing collective bargaining agreements.

(5) The location is open 24 hours a day, 7 days a week.

(6) The location provides medical, pharmacy, nursing, clinical laboratory, and radiological services onsite in compliance with Article 3 (commencing with Section 70201) of Chapter 1 of Division 5 of Title 22 of the California Code of Regulations.

(7) The location provides nutritional services to patients. The location may comply with this paragraph by providing those services directly or by contracting with an outside entity.

(8) The location complies with the federal Emergency Medical Treatment and Active Labor Act (Section 1395dd of Title 42 of the United States Code) and with Section 1317 of this code.

(9) The location has informed the local emergency medical services agency about the types of medical conditions and injuries that the facility cannot treat and for which the patient needs to be transported directly to a general acute care hospital emergency department.

(10) Notwithstanding subdivision (i) of Section 70651 of Title 22 of the California Code of Regulations, the wording of exterior signs states “EMERGENCY STABILIZATION SERVICES, PHYSICIAN ON DUTY.”

(11) The location stabilizes for transport or release a patient within 24 hours of registration. The location reports to the department any failure to stabilize a patient for transfer or release of the patient within 24 hours.

(12) Upon registration, the location provides a patient with a written notice that the patient should consult with their health care coverage carrier about which services may be covered and for which copayments and charges the patient may be responsible.

(13) The location posts information identifying the three nearest hospitals ranked by estimated driving time from the nearest to the farthest away.

(14) The location posts a sign, at or near any public entrance of the location, stating that patients requiring surgery, trauma care, or an inpatient bed will be transported to the nearest hospital.

(15) The location meets the physical plant requirements and has received clearance from the Office of Statewide Health Planning and Development, as appropriate for the setting and services being provided at the location.

(16) The applicant hospital has submitted and received approval on an application that meets the requirements of subdivision (c).

(c) (1) The application shall be submitted pursuant to Section 1265 and shall include all of the following:

(A) A plan of operation that shall, at a minimum, address the location’s plan for patient care, infection control, waste disposal, and linen services.

(B) The policy and procedure that the location will implement for the emergency transportation of patients that cannot be served by the facility. The policy and procedure shall comply with the standards of practice and shall include all of the following:

(i) How the patient will be transported to the nearest general acute care hospital emergency department.

(ii) The timeframe for transfer to the nearest general acute care hospital with an emergency department.

(iii) How the location will ensure patient safety during the transfer.

(C) A written transfer agreement with the nearest hospital with an emergency department.

(D) A community outreach and education plan to ensure the community is informed of the types of services that the facility is capable of providing. The plan shall include instructions identifying the care that the facility is capable of providing and indicating the types of injuries or conditions for which a patient should be transported directly to the nearest general acute care hospital emergency department.

(E) A triage algorithm that the location developed and will implement in collaboration with the local emergency medical services agency to determine appropriate patients for transport to the location.

(2) The special permit application fee shall be fifteen thousand dollars ($15,000).

(3) Notwithstanding Section 1267, a special permit issued pursuant to this section shall expire two years from the date of its issuance, and may be renewed every two years, for a combined period not to exceed six years from the initial date of issuance.

(4) Prior to a first renewal of the special permit, the hospital that is issued a special permit pursuant to this section shall perform a community needs assessment, which shall be submitted to the department at least 90 calendar days prior to the renewal date.

Prior to a second and final renewal of the special permit, the hospital shall have submitted plans for construction of a new hospital for review with the Office of Statewide Health Planning and Development.

(5) The department may deny a request for approval or renewal of a special permit if the location fails to meet the requirements of this chapter pursuant to Section 1269. The department may suspend or revoke a special permit pursuant to Article 5 (commencing with Section 1294).

(d) A hospital issued a special permit pursuant to this section shall report all of the following:

(1) For purposes of the Annual Report of Hospitals required by regulations adopted pursuant to Section 1250.8, report bed and service utilization data separately by each facility issued a single consolidated license pursuant to this section.

(2) Hospital reporting requirements specified in Section 1279.1 regarding adverse events and the reporting requirements specified in Section 70737 of Title 22 of the California Code of Regulations.

(3) By March 1 of each year, a detailed report on the types of services, number of patients served, and any adverse patient outcomes during the prior calendar year.

(e) Notwithstanding any other law, the department may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific this section by means of an All Facilities Letter or similar instruction.

(f) This section shall remain in effect only until January 1, 2028, and as of that date is repealed.

(Added by Stats. 2019, Ch. 839, Sec. 1. (SB 156) Effective January 1, 2020. Repealed as of January 1, 2028, by its own provisions.)

1252. (a) “Special service” means a functional division, department, or unit of a health facility that is organized, staffed, and equipped to provide a specific type or types of patient care and that has been identified by regulations of the state department and for which the state department has established special standards for quality of care. “Special service” does not include a functional division, department, or unit of a nursing facility, as defined in subdivision (k) of Section 1250, that is organized, staffed, and equipped to provide inpatient physical therapy services, occupational therapy services, or speech pathology and audiology services to residents of the facility if these services are provided solely to meet the federal Centers for Medicare and Medicaid Services certification requirements. “Special service” includes physical therapy services, occupational therapy services, or speech pathology and audiology services provided by a nursing facility, as defined in subdivision (k) of Section 1250, to outpatients.

(b) This section does not limit the department’s ability to evaluate compliance with the therapy requirements for nursing facilities and skilled nursing facilities established in Title 22 of the California Code of Regulations during investigations or inspections, including, but not limited to, inspections conducted pursuant to Section 1422, or to limit the department’s ability to enforce the therapy requirements.

(Amended by Stats. 2014, Ch. 288, Sec. 1. (AB 1974) Effective January 1, 2015.)

1253. (a) No person, firm, partnership, association, corporation, or political subdivision of the state, or other governmental agency within the state shall operate, establish, manage, conduct, or maintain a health facility in this state, without first obtaining a license therefor as provided in this chapter, nor provide, after July 1, 1974, special services without approval of the state department. However, any health facility offering any special service on the effective date of this section shall be approved by the state department to continue those services until the state department evaluates the quality of those services and takes permitted action.

(b) This section shall not apply to a receiver appointed by the court to temporarily operate a long-term health care facility pursuant to Article 8 (commencing with Section 1325).

(Amended by Stats. 2000, Ch. 451, Sec. 3. Effective January 1, 2001.)

1253.1. (a) Any skilled nursing facility or intermediate care facility that on the effective date of this section is providing care for the developmentally disabled may utilize beds designated for that purpose to provide intermediate care for the developmentally disabled without obtaining a certificate of need, a change in licensure category, or a change in bed classification pursuant to subdivision (c) of Section 1250.1, provided the facility meets and continues to meet the following criteria:

(1) The facility was surveyed on or before July 18, 1977, by the State Department of Health for certification under the federal ICF/MR program pursuant to Section 449.13 of Title 42 of the Code of Federal Regulations, and the beds designated for intermediate care for the developmentally disabled were certified by the state department, either before or after that date, to meet the standards set forth in Section 449.13 of Title 42 of the Code of Federal Regulations.

(2) Not less than 95 percent of the beds so certified for intermediate care for the developmentally disabled are utilized exclusively for provision of care to residents with a developmental disability, as defined in subdivision (a) of Section 4512 of the Welfare and Institutions Code. Nothing in this paragraph shall require continuous bed occupancy, but a bed certified for intermediate care for

the developmentally disabled shall be deemed to be converted to another use if occupied by a resident who is not developmentally disabled.

(3) On and after the effective date of regulations implementing this section, no change of ownership has occurred with respect to the facility requiring issuance of a new license, except a change occurring because of a decrease in the number of partners of a licensed partnership or a reorganization of the governing structure of a licensee in which there is no change in the relative ownership interests.

(b) Any facility receiving an exemption under subdivision (a) shall, with respect to beds designated for intermediate care for the developmentally disabled, be subject to regulations of the state department applicable to that level of care, rather than the level of care for which the beds are licensed. The state department shall indicate on the license of any facility receiving an exemption pursuant to subdivision (a) that the licensee has been determined by the state department to meet the criteria of subdivision (a).

(c) The licensee of any facility receiving an exemption under this section shall notify the state department not less than 30 days prior to taking action that will cause the facility to cease meeting the criteria specified in paragraph (2) or (3) of subdivision (a).

(d) Upon a change of ownership of the facility or change in ownership interests not meeting the criterion for continued exemption specified in paragraph (3) of subdivision (a), the applicant for relicensure shall elect as follows:

(1) To reclassify all skilled nursing beds that have been exempted under this section to the intermediate care-developmental disabilities classification, or to continue the skilled nursing classification with respect to skilled nursing beds that have received the exemption.

(2) To reclassify intermediate care beds that have been exempted under this section to the intermediate care-developmental disabilities classification, or to reclassify intermediate care beds that have received the exemption to the intermediate care-other classification.

Reclassification of beds pursuant to this subdivision shall not constitute a “project” within the meaning of Section 127170 and shall not be subject to any requirement for a certificate of need under Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.

(Amended by Stats. 1996, Ch. 1023, Sec. 155.5. Effective September 29, 1996.)

1253.2. As used in Section 1253.3, the following definitions shall apply:

(a) “Applicant” means any person, as defined in Section 19, that has submitted an application for a license, pursuant to Section 1265, to operate a health facility as defined under subdivision (k).

(b) “Application” means those materials, set forth in Section 1265, that an applicant submits to the department for a license to operate a health facility.

(c) “Beneficial ownership interest” means any of the following:

(1) The possession by a person, as defined in Section 19, of an ownership interest, including a combination of direct and indirect ownership interests, totaling 5 percent or more in any licensed health facility.

(2) An ownership interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by a licensee of or applicant for licensure of a health facility if that interest equals at least 5 percent of the value of the property or assets of the applicant or licensed health facility.

(3) Is an officer or director of a licensed health facility or applicant for licensure of a health facility that is organized as a corporation.

(4) Is a partner in a licensed health facility or applicant for licensure of a health facility that is organized as a partnership.

(5) Is a member of a licensed health facility or applicant for licensure of a health facility that is organized as a limited liability company.

(d) “Chain” means a group of two or more licenses that are owned directly or indirectly, as defined in this section, by the same persons, companies, or entities.

(e) “Change of ownership” means any of the following:

(1) For a partnership, the removal, addition, or substitution of a partner.

(2) For a corporation, the merger of the applicant’s or licensee’s corporation into another corporation, or the consolidation of two or more corporations of the licensee, resulting in the creation of a new corporation; however, the transfer of corporate stock, the

merger of another corporation into the applicant's or licensee's corporation, or the approved lawful conversion of a corporation to a limited liability company does not constitute a change of ownership.

(3) For a limited liability company, the merger of the applicant's or licensee's limited liability company into another limited liability company, or the consolidation of two or more limited liability companies, of the licensee, resulting in the creation of a new limited liability company; however, the transfer of limited liability company interest, the merger of another limited liability company into the applicant's or licensee's limited liability company or the approved lawful conversion of a limited liability company to a corporation does not constitute a change of ownership.

(4) The sale, conveyance, transfer, or disposition of title and property of a licensed health facility or licensee of a licensed health facility to another person or entity who is not the licensee where, as a result of the sale, conveyance, transfer or disposition, the licensee has lost the right to possess and occupy the physical structures, buildings, or real property that comprise the operational location of the health facility approved by the department.

(5) The lease of all or part of the health facility's property and assets to a person or entity who is not the licensee, where the lease is either a new lease or a transfer, sublease, or assignment of the licensee's right to possess or occupy the physical structures, buildings, or real property that comprise the operational location of the health facility approved by the department.

(f) "License" means a basic permit to operate a health facility with an authorized number and classification of beds. A license shall not be transferable.

(g) "Manage" means to assume operational control over a facility, to make financial decisions for the facility, to direct or control aspects of patient care and quality within the facility, or to be involved in the hiring, firing, supervision, and direction of direct care staff when these actions are completed by a management company hired, retained, or authorized to act on behalf of a licensee. Manage does not include financing exchanged between multifacility organizations.

(h) "Managing employee" means any general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of a licensed health facility.

(i) "Management company" means an entity that directly or indirectly conducts the day-to-day operations or exercises managerial control of a health facility licensed by the department but is not the licensee.

(j) "Ownership interest" means the possession of equity in the capital, the stock, the principal property and assets, or the profits of the licensed health facility. An ownership interest may be either direct or indirect.

(1) A direct ownership interest is an interest in the licensed health facility or applicant for licensure of a health facility.

(2) An indirect ownership interest is an ownership interest in an entity that itself has an ownership interest in a licensed health facility or of an applicant for licensure of a health facility.

(k) "Operate" means to own, lease, sublease, establish, maintain, conduct the affairs of, or manage a skilled nursing facility.

(l) "Parent corporation" or "parent organization" means an organization that is the legal entity owning a controlling interest in an organization licensed by the department. The parent organization is the "ultimate" parent, or the top entity in a hierarchy (which may include other parent organizations) of subsidiary organizations that is not itself a subsidiary of any corporation. A legal entity may be its own parent organization if it is not a subsidiary of any other organization.

(Added by Stats. 2022, Ch. 578, Sec. 3. (AB 1502) Effective January 1, 2023.)

1253.3. (a) No person, as defined in Section 19, nor an applicant for licensure, change of ownership, or change of management shall acquire, either directly or indirectly, an ownership interest in a skilled nursing facility nor operate, establish, manage, conduct, or maintain a skilled nursing facility prior to department review, approval, and issuance of a license under this chapter.

(1) An applicant for a license under this section shall submit an application to the department at least 120 calendar days prior to acquiring, operating, establishing, managing, conducting, or maintaining a skilled nursing facility.

(2) A licensee or party that plans to relinquish ownership, operations, or management of a skilled nursing facility shall report the change to the department on a form provided by the department 120 calendar days prior to the anticipated change of ownership. No licensee may relinquish ownership, operations, or management of a skilled nursing facility until the department completes its review and approval of the application of the prospective licensee or management company.

(3) Notwithstanding the requirements of this section, if a facility is subject to receivership under Section 1325, subject to temporary management under Section 1325.5, at immediate risk of decertification, license revocation or suspension or closure, or other exigent circumstances exist that the department in its discretion concludes that the health and safety of the residents would be best served by bringing in an interim manager, the applicant may request an expedited application review. The applicant shall submit a complete application to the department. The department shall expedite the determination that the applicant is reputable and responsible to assume the facility's license. The applicant may operate the facility once the reputability and responsibility

assessment has been conducted while the remainder of the application review occurs. The interim manager may only operate the facility until the department completes the application review and approval of the application of the prospective licensee.

(b) This section applies to any form of change of ownership, operations, or management involving a skilled nursing facility, including, but not limited to, the following transactions:

(1) Establishment of interim or longer-term management agreements wherein operational control or management responsibilities are transferred from the owner or licensee to a new entity.

(2) Establishment of any type of agreement with an entity or person to make financial decisions for the facility, to direct or control aspects of patient care and quality within the facility, or to be involved in the hiring, firing, supervision, and direction of direct care staff when these actions are completed by a management company hired, retained, or authorized to act on behalf of a licensee.

(3) The transfer, purchase, or sale of ownership interest in the facility or licensee of 5 percent or more.

(4) Transactions described in Section 1267.5 or 1253 and other applicable laws and regulations.

(5) Sale or transfer of the entity licensed by the department.

(6) The lease of all or part of a facility.

(c) An application for a license under this section shall be filed on forms established and furnished by the department, that shall require, but not be limited to, all of the following information:

(1) Information required by Sections 1265 and 1267.5.

(2) Whether the applicant is a for-profit, not-for-profit, or government entity.

(3) Name and address of the applicant.

(4) Names of all prospective owners and their prospective ownership percentages.

(5) Names of all prospective directors, board members, and managers of the licensee.

(6) Name and address of any and all parent organizations.

(7) Names and addresses of all directors, board members, and managers of any and all parent organizations.

(8) Evidence satisfactory to the department that the applicant is reputable and responsible to assume the facility's license or management of its operations and meets the requirements of this chapter, other applicable laws, and the department's rules and regulations.

(9) Evidence that the applicant has the financial capacity to operate the facility and to provide services required by state and federal laws and regulations for 90 days.

(10) If applicable, all of the following information:

(A) The name, address, license number, and licensing agency name of other skilled nursing, health, residential, or community care facilities owned, managed, or operated by the same applicant or by any parent organization of the applicant.

(B) If part of a chain, a diagram indicating the relationship between the applicant and the persons or entities that are part of the chain and the name, address, and license number, if applicable, for each person or entity in the diagram.

(C) The name and address of any persons, organizations, or entities that own the real property on which the facility seeking licensure and the licensed facilities described in subparagraph (A) are located along with copies of any existing or proposed property or lease agreements.

(D) The name and address of the prospective property owner if the real property is being transferred or sold.

(E) The name and address of any management company that would manage the facility and the same information required of applicants for the management company and copies of any existing or proposed management agreements or contracts between the licensee and the management company.

(11) The name of the chief executive officer, general partner, owner, and that person's prior or present service as an administrator, chief executive officer, general partner, director, or as a person who has held or holds a beneficial ownership interest of 5 percent or more in, any skilled nursing facility, intermediate care facility, residential care facility for the elderly, community care facility, health facility, or a similarly licensed facility in California or any other state within the past five years.

(12) The following information regarding the applicant and each individual or entity identified pursuant to paragraph (11) for the past five years:

(A) Any revocation, suspension, probation, exclusion order, termination of Medicare or Medicaid certification, receivership, appointment of a temporary manager, designation as a special focus facility or special focus facility candidate by the federal Centers for Medicare and Medicaid Services, or other similar administrative enforcement or disciplinary action that was initiated in California or any other state or by the federal government, or is in the process of being adjudicated, against a facility associated with the applicant or a person identified pursuant to paragraph (11), by any authority responsible for the licensing of health, residential, or community care facilities.

(B) Copies of findings, orders, or both, issued by any health, residential, or community care licensing agency, certification agency, or any court relevant to the actions described in subparagraph (A).

(C) Any injunctions, corporate integrity agreements, judgments, or settlements resulting from actions filed by the Attorney General, the Department of Justice, a district attorney's office, or other federal, state, or local law enforcement agency against the applicant or any facilities that they have owned, operated, or managed.

(D) Any petition for bankruptcy relief involving the applicant's operation or closure of a health, residential, or community care facility licensed in California or any other state, the court, date, and case number of the filing, and whether a discharge was granted. If a discharge was not granted, the applicant shall provide copies of any court findings supporting denial of discharge.

(E) The identity of any skilled nursing facility operated, managed, or owned by the applicant that has been subject to foreclosures, judgment liens, utility cutoffs, or disruptions in staffing, services, or supplies due to failures to meet payroll or pay bills.

(13) The expected date of sale, assignment, lease, change of management company, or other change in the license status of a health facility.

(14) Any other information as may be required by the department for the proper administration and enforcement of this chapter.

(15) Applicable fees.

(d) The information required by this section shall be provided to the department upon initial application for licensure, and any change in the information shall be provided to the department within 10 calendar days of that change unless a shorter timeframe is required by the department. A licensee of multiple facilities may provide a single notice of changes to the department on behalf of all licensed facilities within the chain. This single notice shall clearly identify which changes apply to which facilities within the chain.

(e) The applicant shall provide complete and accurate information to the department.

(f) (1) An applicant's failure to provide complete and accurate information to the department in its submission of an application or the applicant's failure to correct deficiencies in an application noted by the department may be grounds for the denial of the application.

(g) (1) The department may deny an application for licensure or may subsequently revoke a license under this chapter if the applicant withheld information or made a false statement of material fact with regard to information that was required by the application for licensure.

(2) The department may deny an application for licensure or may subsequently revoke a license under this chapter if the applicant did not disclose administrative disciplinary or enforcement actions on the application as required by paragraph (12) of subdivision (c).

(3) The applicant shall provide any additional information related to the consideration of the application regarding the reputability and responsibility of the applicant.

(4) The department shall consider the criminal history of the prospective licensee, or prospective management company, including all officers, directors, or shareholders having a beneficial ownership interest of 5 percent or more in the applicant corporation or partnership, and general or limited partners thereof, or other individuals or entities enumerated in Section 1267.5. The department's criminal history review shall be in accordance with Sections 1265.1 and 1265.2.

(5) The department shall cross-check all information and evidence submitted by the applicant concerning its reputability and responsibility, including, but not limited to, by verifying ownership and compliance histories through its own records, cross-checking with other licensing agencies in this state, other states, and territories.

(6) If the applicant holds a health care professional's license issued by the state, the department shall contact the appropriate licensing agencies to obtain information about disciplinary actions taken against the licensees and to confirm that their licenses are in good standing.

(7) To the extent not prohibited by federal or state law, the department may obtain any information deemed necessary to make a determination on whether the applicant is reputable and responsible for licensure.

(8) In making a determination on whether an applicant is reputable and responsible, the department shall thoroughly examine the compliance histories of facilities that are or have been owned, operated, or managed by the applicant and of any skilled nursing facility chain that is associated with the applicant. The department's review shall consider compliance histories during the five-year period before the date of the application.

(9) The department may review and consider information and evidence concerning the applicant's reputability and responsibility, including, but not limited to, the department's inspection findings for health facilities owned, operated, or managed by the applicant in the five years prior to the application, including federal and state findings resulting in regulatory violations, citations, other enforcement penalties, temporary manager appointments, findings of violations of required staffing levels, financial instability related to the operation of the health facility, special focus facility status, and any other information the department considers necessary for its determination on whether an applicant is reputable and responsible.

(10) The applicant shall provide or cause to be provided, at the department's request, any additional information related to consideration of the application regarding the reputability and responsibility of the applicant.

(11) The department may deny an application if the applicant fails to establish through the evidence satisfactory to the department submitted pursuant to this section that the applicant is reputable and responsible, has ability to comply with the rules and regulations of the department, and has the education, experience, and financial resources for the operation of the skilled nursing facility.

(12) Any of the following within the prior five years or during the application review period shall automatically disqualify an applicant from being determined reputable and responsible for licensure:

(A) The applicant or anyone with a beneficial ownership interest of 5 percent or more in the applicant entity has owned, operated, or managed a skilled nursing facility, nursing facility, intermediate care facility, assisted living facility, community care facility, or other type of long-term care facility in this state or any other state or territory that, while under their ownership, operation, or management, was terminated from the federal Medicare program or the Medi-Cal program due to noncompliance, had its license suspended or revoked, or was subjected to receivership or temporary management.

(B) The applicant is on the List of Excluded Individuals/Entities of the United States Department of Health and Human Services Office of Inspector General.

(C) The applicant has owned, operated, or managed a long-term care health facility that, while under their ownership, operation, or management, has been issued two or more of any combination of "AA" citations or "A" citations involving the death of a resident at the facility within a consecutive 24-month period within the prior five years.

(D) The applicant owns, operates, or manages 10 percent or more of the licensed skilled nursing facilities in the state upon the date of submission of the application for licensure to the department, unless the department in its discretion concludes that the interests of resident health and safety requires that an exception is warranted.

(13) Notwithstanding Section 1265.2 or paragraph (4), if the applicant has had a felony conviction related to the services or care provided in a health or community care facility, regardless of the length of time between the date of the application for licensure and the felony conviction, the applicant shall automatically be disqualified from being determined reputable and responsible for licensure.

(h) The department shall review and make a determination within 120 calendar days of an applicant's submission of a complete application.

(1) The department may extend the 120-day time period by up to an additional 60 calendar days if it cannot complete its determination due to extenuating circumstances. The department shall notify the applicant in writing of the extension and the estimated date of its determination.

(2) If the department determines the application submitted is incomplete, the department shall provide written notice of missing information to the applicant. If the applicant does not submit a completed application within 45 days of notification of missing information, the application shall be denied.

(3) The applicant shall not acquire, operate, establish, manage, conduct, or maintain a skilled nursing facility prior to obtaining a favorable determination from the department on a licensure application. A transfer of ownership, operations, or management of the facility shall not take place prior to the department's approval, whether interim, long term, or permanent.

(i) If the department approves the application, the department shall notify the applicant in writing if it determines that the applicant is reputable and responsible and has complied with all requirements of this section and other applicable statutory and regulatory requirements for licensure. The applicant and licensee shall notify the department within 10 days of the final transactions effecting the orderly transfer of the health facility operations from the licensee to the applicant. The final orderly transfer of the health facility operations shall occur no later than 120 days after the department's notice of approval of the application for licensure. The applicant may apply for one 60-day extension notifying the department of the expected date of the transfer, and the reasons for delay in the transfer beyond the initial 120 days from the department's notice.

(j) If the department denies the application, the department shall notify the applicant in writing of its determination and the basis for the determination. Within 20 days of service of the department's notice of denial on the applicant, the applicant may serve upon the director, or the director's designee, a written petition for an appeal and request for administrative hearing regarding the department's denial. Upon timely service by the applicant of the written petition, as set forth in this subdivision, a hearing shall be set and the proceedings shall be conducted in accordance with Article 1 (commencing with Section 131071) of Chapter 2 of Part 1 of Division 112. During the pendency of the appeal, the applicant shall not acquire, operate, establish, manage, conduct, or maintain the facility that is the subject of the appeal, and management and operational control of the facility shall remain with the current licensee.

(k) The following actions may immediately be taken if an applicant acquires, operates, establishes, manages, conducts, or maintains a skilled nursing facility before the department acts on its application, following the department's denial of its application, or in any instance when a person or entity acquires, operates, establishes, manages, conducts, or maintains a skilled nursing facility without first applying to and obtaining a license from the department for that purpose:

(1) If an applicant for licensure or prospective licensee assumes management or operational control of a facility on behalf of a licensee prior to submitting an application to and receiving approval from the department for a license, or if a licensee fails to report changes to the department, as required by this chapter, the department may issue a class "B" citation and civil penalty, in an amount not less than five hundred dollars ($500) and not exceeding two thousand dollars ($2,000) for each and every citation. Where a licensee or prospective licensee has failed to correct a violation of this chapter within the time specified in the citation, the department shall assess the licensee or prospective licensee an additional civil penalty in the amount of five hundred dollars ($500) for each day that the deficiency continues beyond the date specified for correction. If a licensee or prospective licensee desires to contest a class "B" citation assessed under this section, the licensee or prospective licensee shall, within 15 working days after service of the citation, notify the director or the director's designee that they wish to appeal the class "B" citation through the procedures set forth in Section 1428. Nothing in this section shall preclude the department from taking additional state or federal enforcement actions it may determine are necessary to preserve and protect the health and safety of the residents in the skilled nursing facility, including misdemeanor penalties for willful or repeated violations, as provided in Section 1290. Any penalty assessed pursuant to this paragraph shall be paid prior to the issuance of the permanent license. If at the time of issuance of the permanent license there is a balance due, the remaining balance shall be collected by Medi-Cal offset. Penalties collected pursuant to this paragraph shall be deposited into the State Health Facilities Citation Penalties Account created pursuant to Section 1417.2.

(2) The department may, subsequent to licensure, assess a civil penalty of ten thousand dollars ($10,000) for a material violation of this section. The civil penalty shall be issued and enforced, except as provided in this subdivision, in the same manner as a class "A" violation, and shall include the right of appeal as specified in Section 1428.

(3) If an applicant acquires, operates, establishes, or manages a facility following the department's denial of its application, the department shall ensure that the facility's operation is transitioned to a qualified operator in a manner that will protect the health and safety of the residents.

(4) The facility administrator shall advise all residents, their representatives, and the state and local long-term care ombudsperson offices of the circumstances, and inform them of the sanctions that are being imposed and of the residents' right to remain at the facility while corrective actions are taken.

(l) If any proposed sale, transfer of operations, or change in management of a facility to an applicant for licensure does not occur after the applicant's submission of an application for licensure to the department, the licensee shall notify the department within 10 days of the event terminating the sale, transfer, or change, including, but not limited to, the end of contract negotiations or a transaction not closing escrow.

(m) All applications prepared pursuant to this section shall be considered public records, except to the extent the information in the application is confidential or privileged under applicable state or federal privacy laws, pursuant to the Information Practices Act of 1977, or is otherwise exempt under the California Public Records Act.

(n) This section does not apply to a skilled nursing facility that is operated as a distinct part of an acute care hospital or to receivers or temporary managers that are appointed in accordance with state or federal laws. This section does apply to changes of ownership of a distinct part skilled nursing facility that will be separated from the hospital's license.

(o) This section applies only to license applications or reports of changes submitted after July 1, 2023.

(p) On or before April 1, 2023, the department shall convene a stakeholder group to discuss, review, and determine the feasibility of establishing a new methodology to calculate application fees for skilled nursing facilities that reflect departmental costs to process required applications.

(Added by Stats. 2022, Ch. 578, Sec. 4. (AB 1502) Effective January 1, 2023.)

1253.5. (a) The State Department of Public Health, upon issuance and renewal of a license for a general acute care hospital as defined in subdivision (a) of Section 1250, an acute psychiatric hospital as defined in subdivision (b) of Section 1250, or a special hospital as defined in subdivision (f) of Section 1250, shall separately identify on the license each supplemental service, including the address of where each outpatient service is provided and the type of services provided at each outpatient location.

(b) On or before July 1, 2010, the department shall post and make available on its Web site a listing of all outpatient services of licensed hospitals identified on the hospital's license as a supplemental service pursuant to subdivision (a). The listing shall include the name and physical address of where the outpatient service is provided. The department's Web site shall include a disclaimer that the information contained in the listing is limited to the outpatient service information reported to the department by licensed hospitals.

(c) The department shall work with stakeholders to review, streamline, and revise the initial and renewal license application form prescribed and furnished by the department to any person, firm, association, partnership, or corporation desiring a license, a change in licensed beds or services, or renewing a license for a hospital, acute psychiatric hospital, or special hospital.

(Added by Stats. 2008, Ch. 396, Sec. 1. Effective January 1, 2009.)

1253.6. (a) This section shall govern applications by general acute care hospitals for supplemental services approval for outpatient clinic services.

(b) Upon receipt of an initial application by a licensed general acute care hospital to add a new or modify an existing outpatient service as a supplemental service, the department shall, within 30 days of receipt of the initial application, review the entire application, determine whether the application is missing information or has insufficient information, and, on the basis of this determination, provide the hospital with guidance on how to provide the missing information.

(c) Upon determination by the department that an application for an outpatient clinic service as a supplemental service is complete pursuant to subdivision (b), the department shall investigate the facts set forth in the application and, if the department finds that the statements contained in the application are true, that the establishment of the operation of the supplemental service are in conformity with the intent and purpose of this chapter, and that the applicant is in compliance with this chapter and the rules and regulations of the department, the department shall approve the additional or modified outpatient clinic service, add it to the hospital license, and issue a new license. However, if the department determines in the course of the investigation that additional information is needed to determine whether the statements contained in the application are true or that the establishment or the continued operation of the supplemental service are in conformity with the intent and purpose of this chapter, or that the applicant is in compliance with this chapter and the rules and regulations of the department, the applicant shall provide the additional information to the department upon request. If the department finds that the statements contained in the application are not true, or that the establishment of the outpatient service as a supplemental service is not in conformity with the intent and purpose of this chapter, or if the applicant fails to provide any additional information to the department within 30 days of the request, the department shall deny the outpatient clinic services application. The department shall either grant or deny the application for the outpatient clinic service as a supplemental service within 100 days of the filing of a completed application.

(d) If a licensed general acute care hospital has previously been approved for an outpatient clinic service within 30 days after receipt of a completed application for an additional outpatient clinic service, the department shall approve the additional or modified outpatient clinic service, add it to the hospital license, and issue a new license, unless the applicant does not meet the requirements of this section. Notwithstanding any other law, the department shall not be required to conduct an onsite inspection prior to approval of an outpatient clinic service pursuant to this section. However, nothing shall preclude the department from conducting an onsite inspection at any time, or denying an application, in accordance with subdivision (c). If the department determines that the applicant does not meet the requirements of this section, the department shall provide the hospital, in writing, the particular basis for this determination.

(e) A completed application for purposes of this section shall include all of the following:

(1) The appropriate forms, fees, and documentation, as determined by the department.

(2) A description of the type of outpatient clinic service to be operated, the character and scope of the service to be provided, and a complete description of the building, its location and proximity to the main hospital building, facilities, equipment, apparatus, and appliances to be furnished and used in the operation of the outpatient clinic service and evidence satisfactory to the department that the hospital owns and will operate the outpatient clinic service that is the subject of the application.

(3) Written policies and procedures governing the operation of the outpatient clinic service and its reporting relationship to the applicant.

(4) Evidence of the hospital's compliance with applicable building standards and possession of a fire clearance for the outpatient clinic service space.

(f) The outpatient clinic service that is the subject of the application shall be limited to providing nonemergency primary health care services in a clinical environment to patients who remain in the outpatient clinic for less than 24 hours.

(g) For purposes of this section "outpatient clinic services" shall have the same meaning as the services that may be provided by a primary care clinic in accordance with subdivision (a) of Section 1204. Nothing in this section shall be interpreted to mean that supplemental outpatient services established by a general acute care hospital pursuant to this section shall be considered primary care clinics for licensing, regulatory, or enforcement purposes.

(Added by Stats. 2009, Ch. 543, Sec. 2. (AB 1544) Effective January 1, 2010.)

1253.7. (a) For purposes of this chapter, "observation services" means outpatient services provided by a general acute care hospital and that have been ordered by a provider, to those patients who have unstable or uncertain conditions potentially serious enough to warrant close observation, but not so serious as to warrant inpatient admission to the hospital. Observation services may include the use of a bed, monitoring by nursing and other staff, and any other services that are reasonable and necessary to safely evaluate a patient's condition or determine the need for a possible inpatient admission to the hospital.

(b) When a patient in an inpatient unit of a hospital or in an observation unit, as defined in subdivision (c), is receiving observation services, or following a change in a patient's status from inpatient to observation, the patient shall receive written notice, as soon as practicable, that he or she is on observation status. The notice shall state that while on observation status, the patient's care is being provided on an outpatient basis, which may affect his or her health care coverage reimbursement.

(c) For purposes of this chapter, "observation unit" means an area in which observation services are provided in a setting outside of any inpatient unit and that is not part of an emergency department of a general acute care hospital. A hospital may establish one or more observation units that shall be marked with signage identifying the observation unit area as an outpatient area. The signage shall use the term "outpatient" in the title of the designated area to indicate clearly to all patients and family members that the observation services provided in the center are not inpatient services. Identifying an observation unit by a name or term other than that used in this subdivision does not exempt the general acute care hospital from compliance with the requirements of this section.

(d) Notwithstanding subdivisions (d) and (e) of Section 1275, an observation unit shall comply with the same licensed nurse-to-patient ratios as supplemental emergency services. This subdivision is not intended to alter or amend the effect of any regulation adopted pursuant to Section 1276.4 as of the effective date of the act that added this subdivision.

(Added by Stats. 2016, Ch. 723, Sec. 1. (SB 1076) Effective January 1, 2017.)

1254. (a) Except as provided in subdivisions (e) and (f), the state department shall inspect and license health facilities. The state department shall license health facilities to provide their respective basic services specified in Section 1250. Except as provided in Section 1253, the state department shall inspect and approve a general acute care hospital to provide special services as specified in Section 1255. The state department shall develop and adopt regulations to implement the provisions contained in this section.

(b) Upon approval, the state department shall issue a separate license for the provision of the basic services enumerated in subdivision (c) or (d) of Section 1250 whenever these basic services are to be provided by an acute care hospital, as defined in subdivision (a), (b), or (f) of that section, where the services enumerated in subdivision (c) or (d) of Section 1250 are to be provided in any separate freestanding facility, whether or not the location of the separate freestanding facility is contiguous to the acute care hospital. The same requirement shall apply to any new freestanding facility constructed for the purpose of providing basic services, as defined in subdivision (c) or (d) of Section 1250, by any acute care hospital on or after January 1, 1984.

(c) (1) Those beds licensed to an acute care hospital which, prior to January 1, 1984, were separate freestanding beds and were not part of the physical structure licensed to provide acute care, and which beds were licensed to provide those services enumerated in subdivision (c) or (d) of Section 1250, are exempt from the requirements of subdivision (b).

(2) All beds licensed to an acute care hospital and located within the physical structure in which acute care is provided are exempt from the requirements of subdivision (b) irrespective of the date of original licensure of the beds, or the licensed category of the beds.

(3) All beds licensed to an acute care hospital owned and operated by the State of California or any other public agency are exempt from the requirements of subdivision (b).

(4) All beds licensed to an acute care hospital in a rural area as defined by Chapter 1010, of the Statutes of 1982, are exempt from the requirements of subdivision (b), except where there is a freestanding skilled nursing facility or intermediate care facility which

has experienced an occupancy rate of 95 percent or less during the past 12 months within a 25-mile radius or which may be reached within 30 minutes using a motor vehicle.

(5) All beds licensed to an acute care hospital which meet the criteria for designation within peer group six or eight, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982, and published by the California Health Facilities Commission, and all beds in hospitals which have fewer than 76 licensed acute care beds and which are located in a census designation place of 15,000 or less population, are exempt from the requirements of subdivision (b), except where there is a freestanding skilled nursing facility or intermediate care facility which has experienced an occupancy rate of 95 percent or less during the past 12 months within a 25-mile radius or which may be reached within 30 minutes using a motor vehicle.

(6) All beds licensed to an acute care hospital which has had a certificate of need approved by a health systems agency on or before July 1, 1983, are exempt from the requirements of subdivision (b).

(7) All beds licensed to an acute care hospital are exempt from the requirements of subdivision (b), if reimbursement from the Medi-Cal program for beds licensed for the provision of services enumerated in subdivision (c) or (d) of Section 1250 and not otherwise exempt does not exceed the reimbursement which would be received if the beds were in a separately licensed facility.

(d) Except as provided in Section 1253, the state department shall inspect and approve a general acute care hospital to provide special services as specified in Section 1255. The state department shall develop and adopt regulations to implement subdivisions (a) to (d), inclusive, of this section.

(e) The State Department of Health Care Services shall inspect and license psychiatric health facilities. The State Department of Health Care Services shall license psychiatric health facilities to provide their basic services specified in Section 1250.2. The State Department of Health Care Services shall develop, adopt, or amend regulations to implement this subdivision.

(f) The State Department of Health Care Services shall inspect and license psychiatric residential treatment facilities as defined in Section 1250.10.

(Amended by Stats. 2022, Ch. 589, Sec. 4. (AB 2317) Effective January 1, 2023.)

1254.1. (a) The State Department of Health Care Services shall license psychiatric health facilities to provide their basic services specified in Section 1250.

(b) Any reference in any statute to Section 1254 shall be deemed and construed to also be a reference to this section.

(Amended by Stats. 2013, Ch. 23, Sec. 9. (AB 82) Effective June 27, 2013.)

1254.2. (a) The state department, in addition to the licensing duties imposed by Section 1254, shall license chemical dependency recovery hospitals to provide the basic services specified in subdivision (a) of Section 1250.3.

(b) Any reference in any statute to Section 1254 shall be deemed and construed to also be a reference to this section.

(Added by Stats. 1980, Ch. 707.)

1254.4. (a) A general acute care hospital shall adopt a policy for providing family or next of kin with a reasonably brief period of accommodation, as described in subdivision (b), from the time that a patient is declared dead by reason of irreversible cessation of all functions of the entire brain, including the brain stem, in accordance with Section 7180, through discontinuation of cardiopulmonary support for the patient. During this reasonably brief period of accommodation, a hospital is required to continue only previously ordered cardiopulmonary support. No other medical intervention is required.

(b) For purposes of this section, a “reasonably brief period” means an amount of time afforded to gather family or next of kin at the patient’s bedside.

(c) (1) A hospital subject to this section shall provide the patient’s legally recognized health care decisionmaker, if any, or the patient’s family or next of kin, if available, with a written statement of the policy described in subdivision (a), upon request, but no later than shortly after the treating physician has determined that the potential for brain death is imminent.

(2) If the patient’s legally recognized health care decisionmaker, family, or next of kin voices any special religious or cultural practices and concerns of the patient or the patient’s family surrounding the issue of death by reason of irreversible cessation of all functions of the entire brain of the patient, the hospital shall make reasonable efforts to accommodate those religious and cultural practices and concerns.

(d) For purposes of this section, in determining what is reasonable, a hospital shall consider the needs of other patients and prospective patients in urgent need of care.

(e) There shall be no private right of action to sue pursuant to this section.

(Added by Stats. 2008, Ch. 465, Sec. 1. Effective January 1, 2009.)

1254.5. (a) The Legislature finds and declares that the disease of eating disorders is not simply medical or psychiatric, but involves biological, sociological, psychological, family, medical, and spiritual components. In addition, the Legislature finds and declares that the treatment of eating disorders is multifaceted, and like the treatment of chemical dependency, does not fall neatly into either the traditional medical or psychiatric milieu.

(b) The inpatient treatment of eating disorders shall be provided only in state licensed hospitals, which may be general acute care hospitals as defined in subdivision (a) of Section 1250, acute psychiatric hospitals as defined in subdivision (b) of Section 1250, or any other licensed health facility designated by the State Department of Public Health.

(c) “Eating disorders,” for the purposes of this section, shall have the meaning of the term as defined in the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association.

(Amended by Stats. 2015, Ch. 435, Sec. 1. (AB 614) Effective January 1, 2016.)

1254.6. (a) A hospital shall provide, free of charge, information and instructional materials regarding sudden infant death syndrome, as described in Section 1596.847, explaining the medical effects upon infants and young children and emphasizing measures that may reduce the risk.

(b) The information and materials described in subdivision (a) shall be provided to parents or guardians of each newborn, upon discharge from the hospital. In the event of home birth attended by a licensed midwife, the midwife shall provide the information and instructional materials to the parents or guardians of the newborn.

(c) To the maximum extent practicable, the materials provided to parents or guardians of each newborn shall substantially reflect the information contained in materials approved by the state department for public circulation. The state department shall make available to hospitals, free of charge, information in camera-ready typesetting format. Nothing in this section prohibits a hospital from obtaining free and suitable information from any other public or private agency.

(Added by Stats. 1997, Ch. 263, Sec. 2. Effective January 1, 1998.)

1254.7. (a) It is the intent of the Legislature that pain be assessed and treated promptly, effectively, and for as long as pain persists.

(b) A health facility licensed pursuant to this chapter shall, as a condition of licensure, include pain as an item to be assessed. The health facility shall ensure that pain assessment is performed in a consistent manner that is appropriate to the patient. The pain assessment shall be noted in the patient’s chart.

(Amended by Stats. 2017, Ch. 615, Sec. 2. (AB 1048) Effective January 1, 2018.)

1255. (a) In addition to the basic services offered under the license, a general acute care hospital may be approved in accordance with subdivision (c) of Section 1277 to offer special services, including, but not limited to, the following:

(1) Radiation therapy department.

(2) Burn center.

(3) Emergency center.

(4) Hemodialysis center (or unit).

(5) Psychiatric.

(6) Intensive care newborn nursery.

(7) Cardiac surgery.

(8) Cardiac catheterization laboratory.

(9) Renal transplant.

(10) Other special services as the department may prescribe by regulation.

(b) A general acute care hospital that exclusively provides acute medical rehabilitation center services may be approved in accordance with subdivision (b) of Section 1277 to offer special services not requiring surgical facilities.

(c) The department shall adopt standards for special services and other regulations as may be necessary to implement this section.

(d) (1) For cardiac catheterization laboratory service, the department shall, at a minimum, adopt standards and regulations that specify the type of services, including diagnostic services, that may be offered by a general acute care hospital or a multispecialty clinic as defined in subdivision (l) of Section 1206 that is approved to provide cardiac catheterization laboratory service but is not also approved to provide cardiac surgery service, together with the conditions under which the cardiac catheterization laboratory service may be offered.

(2) Except as provided in paragraph (3), a cardiac catheterization laboratory service shall be located in a general acute care hospital that is either licensed to perform cardiovascular procedures requiring extracorporeal coronary artery bypass that meets all of the applicable licensing requirements relating to staff, equipment, and space for service, or shall, at a minimum, have a licensed intensive care service and coronary care service and maintain a written agreement for the transfer of patients to a general acute care hospital that is licensed for cardiac surgery or shall be located in a multispecialty clinic as defined in subdivision (l) of Section 1206. The transfer agreement shall include protocols that will minimize the need for duplicative cardiac catheterizations at the hospital in which the cardiac surgery is to be performed.

(3) Commencing March 1, 2013, a general acute care hospital that has applied for program flexibility on or before July 1, 2012, to expand cardiac catheterization laboratory services may utilize cardiac catheterization space that is in conformance with applicable building code standards, including those promulgated by the Office of Statewide Health Planning and Development, now known as the Department of Health Care Access and Information, provided that all of the following conditions are met:

(A) The expanded laboratory space is located in the building so that the space is connected to the general acute care hospital by an enclosed all-weather passageway that is accessible by staff and patients who are accompanied by staff.

(B) The service performs cardiac catheterization services on no more than 25 percent of the hospital's inpatients who need cardiac catheterizations.

(C) The service complies with the same policies and procedures approved by hospital medical staff for cardiac catheterization laboratories that are located within the general acute care hospital, and the same standards and regulations prescribed by the department for cardiac catheterization laboratories located inside general acute care hospitals, including, but not limited to, appropriate nurse-to-patient ratios under Section 1276.4, and with all standards and regulations prescribed by the Office of Statewide Health Planning and Development, now known as the Department of Health Care Access and Information. Emergency regulations allowing a general acute care hospital to operate a cardiac catheterization laboratory service shall be adopted by the department and by the Office of Statewide Health Planning and Development by February 28, 2013.

(D) Emergency regulations implementing this paragraph have been adopted by the department and by the Office of Statewide Health Planning and Development by February 28, 2013.

(E) This paragraph shall not apply to more than two general acute care hospitals.

(4) After March 1, 2014, an acute care hospital may only operate a cardiac catheterization laboratory service pursuant to paragraph (3) if the department and the Office of Statewide Health Planning and Development, now known as the Department of Health Care Access and Information, have adopted regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code that provide adequate protection to patient health and safety including, but not limited to, building standards contained in Part 2.5 (commencing with Section 18901) of Division 13.

(5) Notwithstanding Section 129885, cardiac catheterization laboratory services expanded in accordance with paragraph (3) shall be subject to all applicable building standards. The Office of Statewide Health Planning and Development, now known as the Department of Health Care Access and Information, shall review the services for compliance with the OSHPD 3 requirements of the most recent version of the California Building Standards Code.

(e) For purposes of this section, "multispecialty clinic," as defined in subdivision (l) of Section 1206, includes an entity in which the multispecialty clinic holds at least a 50-percent general partner interest and maintains responsibility for the management of the service, if all of the following requirements are met:

(1) The multispecialty clinic existed as of March 1, 1983.

(2) Prior to March 1, 1985, the multispecialty clinic did not offer cardiac catheterization services, dynamic multiplane imaging, or other types of coronary or similar angiography.

(3) The multispecialty clinic creates only one entity that operates its service at one site.

(4) These entities shall have the equipment and procedures necessary for the stabilization of patients in emergency situations prior to transfer and patient transfer arrangements in emergency situations that shall be in accordance with the standards established by the Emergency Medical Services Authority, including the availability of comprehensive care and the qualifications of any general acute care hospital expected to provide emergency treatment.

(f) Except as provided in this section and in Sections 100921 and 100922, cardiac catheterizations shall not be performed outside of a general acute care hospital or a multispecialty clinic, as defined in subdivision (l) of Section 1206, that qualifies for this definition as of March 1, 1983.

(Amended by Stats. 2024, Ch. 136, Sec. 1. (SB 1464) Effective January 1, 2025.)

1255.1. (a) Any hospital that provides emergency medical services under Section 1255 shall, as soon as possible, but not later than 180 days prior to a planned reduction or elimination of the level of emergency medical services, provide notice of the intended change to the department, the local government entity in charge of the provision of health services, and all health care service plans or other entities under contract with the hospital to provide services to enrollees of the plan or other entity.

(b) In addition to the notice required by subdivision (a), the hospital shall provide, at the same time as the notice specified in subdivision (a), public notice of the intended change in a manner that is likely to reach a significant number of residents of the community serviced by that facility.

(c) A hospital shall not be subject to this section or Section 1255.2 if the department does either of the following:

(1) Determines that the use of resources to keep the emergency center open substantially threatens the stability of the hospital as a whole.

(2) Cites the emergency center for unsafe staffing practices.

(d) For purposes of this section, the public notice required in subdivision (b) shall include, but not be limited to, all of the following:

(1) Written notice to the city council of the city in which the hospital is located.

(2) A continuous notice posted in a conspicuous location on the home page of the hospital's internet website.

(3) A notice published in a conspicuous location within a newspaper of general circulation serving the local geographical area in which the hospital is located. The notice shall continue for a minimum of 15 publication dates.

(4) A continuous notice posted in a conspicuous location within the internet website of a newspaper of general circulation serving the local geographical area in which the hospital is located.

(5) A notice posted at the entrance of every community clinic within the affected county in which the hospital is located that grants voluntary permission for posting.

(Amended by Stats. 2020, Ch. 95, Sec. 1. (AB 2037) Effective January 1, 2021.)

1255.2. A health facility implementing a downgrade or change shall make reasonable efforts to ensure that the community served by its facility is informed of the downgrade or closure. Reasonable efforts may include, but not be limited to, advertising the change in terms likely to be understood by a layperson, soliciting media coverage regarding the change, informing patients of the facility of the impending change, and notifying contracting health care service plans as required in Section 1255.1.

(Added by Stats. 1998, Ch. 995, Sec. 2. Effective January 1, 1999.)

1255.25. (a) (1) Except as provided in subparagraph (3), not less than 120 days prior to closing a health facility, as defined in subdivision (a) or (b) of Section 1250, or 90 days prior to eliminating a supplemental service, as defined in Section 70067 of Chapter 1 of Division 5 of Title 22 of the California Code of Regulations, the facility shall provide public notice of the proposed closure or elimination of the supplemental service, including a notice posted at the entrance to all affected facilities, a notice to all contracted Medi-Cal managed care plans, as defined in subdivision (j) of Section 14181.101 of the Welfare and Institutions Code, and a notice to the department and the board of supervisors of the county in which the health facility is located.

(2) Not less than 90 days prior to relocating the provision of supplemental services to a different campus, a health facility, as defined in subdivision (a) or (b) of Section 1250, shall provide public notice of the proposed relocation of supplemental services, including a notice posted at the entrance to all affected facilities and notice to the department and the board of supervisors of the county in which the health facility is located.

(3) (A) Not less than 120 days prior to eliminating a supplemental service of either an inpatient psychiatric unit or a perinatal unit, a health facility, as defined in subdivisions (a) and (b) of Section 1250, shall provide public notice of the proposed elimination of the supplemental service, including a notice posted at the entrance to all affected facilities, a notice to all contracted Medi-Cal managed care plans, as defined in subdivision (j) of Section 141814.101 of the Welfare and Institutions Code, and a notice to the department and the board of supervisors of the county in which the health facility is located.

(B) The health facility shall conduct at least one noticed public hearing within 60 days of providing public notice of the proposed elimination of the inpatient psychiatric unit or perinatal unit, in addition to accepting public comment pursuant to subparagraph (C) of paragraph (1) of subdivision (b). The health facility shall post the public hearing notice and the agenda alongside their public notice for the proposed elimination of services, pursuant to paragraph (2) of subdivision (b). The health facility holding the public hearing held shall comply with all of the following requirements:

(i) Hold the public hearing within the county in which the health facility is located and within 25 miles of the health facility and be accessible to the public remotely.

(ii) Accept written public comment in advance of the hearing and reserve adequate time on the agenda for public comments from individuals attending in-person and remotely.

(iii) Notify the board of supervisors of the county in which the health facility is located when a public hearing is scheduled and invite the board of supervisors to provide testimony on the impacts of the elimination of services to the county and community health systems.

(b) (1) The public notice required by subdivision (a) shall include all of the following:

(A) A description of the proposed closure, elimination, or relocation. The description shall be limited to publicly available data, including the number of beds eliminated, if any, the probable decrease in the number of personnel, and a summary of any service that is being eliminated, if applicable.

(B) A description of the three nearest available comparable services in the community. If the health facility closing these services serves Medi-Cal or Medicare patients, this health facility shall specify if the providers of the nearest available comparable services serve these patients.

(C) A telephone number, address, and email address for each of the following, where interested parties may offer comments:

(i) The health facility.

(ii) The parent entity, if any, or contracted company, if any, that acts as the corporate administrator of the health facility.

(iii) The chief executive officer.

(D) Statistically deidentified and aggregated data about the health facility's patients who received either inpatient psychiatric services or perinatal services, as applicable, within the past five years, including, but not limited to, all of the following:

(i) The conditions treated.

(ii) The ethnicities of patients served, if the patient voluntarily shared their ethnicity with the health facility. Data on ethnicities shall only be shared on the public notice to the extent to which it does not disclose any personal information in a manner that would link the information disclosed to the individual to whom it pertains.

(iii) The ages of patients served.

(iv) Whether the patients served had private insurance, Medi-Cal, Medicare, or no insurance.

(v) A justification for the health facility's decision to eliminate services.

(2) For purposes of this section, the public notice required in subdivision (a) shall include, but not be limited to, all of the following:

(A) Written notice to the city council of the city in which the health facility is located.

(B) A continuous notice posted in a conspicuous location on the homepage of the health facility's internet website.

(C) A notice published in a conspicuous location within a newspaper of general circulation serving the local geographical area in which the health facility is located. The notice shall continue for a minimum of 15 publication dates.

(D) A continuous notice posted in a conspicuous location within the internet website of a newspaper of general circulation serving the local geographical area in which the health facility is located.

(E) A notice posted at the entrance of every community clinic within the affected county in which the health facility is located that grants voluntary permission for posting.

(c) Notwithstanding subdivisions (a) and (b), this section shall not apply to county facilities subject to Section 1442.5.

(d) This section shall not apply to a health facility that is forced to close or eliminate a service as a result of a natural disaster or state of emergency that prevents the health facility from being able to operate at its current level.

(Amended by Stats. 2024, Ch. 894, Sec. 1. (SB 1300) Effective January 1, 2025.)

1255.3. On or before June 30, 1999, with the state department as the lead agency, the state department and the Emergency Medical Services Authority, in consultation with hospitals and other health care providers and local emergency medical services agencies, shall designate signage requirements for a health facility holding a special permit for a standby emergency medical service located in an urban area. The signage shall not include the word “emergency” and shall reflect the type of emergency services provided by the facility, and be easily understood by the average person. The facility shall not post signs, distribute literature, or advertise that emergency services are available at the facility. Nothing in this section shall be construed to mean that a facility is no longer providing emergency services for purposes of billing or reimbursement. A small and rural hospital, as defined in Section 124840, is not subject to the requirements of this section.

(Added by Stats. 1998, Ch. 995, Sec. 3. Effective January 1, 1999.)

1255.5. For purposes of Section 1255, the following definitions apply:

(a) “Cardiac catheterization” includes an intravascular insertion of a catheter into the heart for the primary definition and diagnosis of an anatomic cardiac lesion. For the purposes of this definition, the insertion of a Swan-Ganz thermodilution cardiac output catheter, a venous line, and a temporary pacemaking electrode catheter are excluded.

(b) “Cardiac surgery” means surgery on the heart or great vessels requiring a thoracotomy and extracorporeal circulation.

(c) “Cardiovascular surgery service” means a program of a general acute care hospital which has the capability of performing cardiac catheterizations and cardiac surgery as defined in this section. Under no circumstances shall there exist in a general acute care hospital a cardiac surgery service without a cardiac catheterization laboratory service.

(d) “Cardiac catheterization laboratory service” means a program of a general acute care hospital which has the capability of performing cardiac catheterization. Cardiac catheterization laboratory service does not include pediatric cardiac catheterization laboratory service.

(e) “Pediatric cardiac surgery service” means a program of a general acute care hospital which has the capability of performing cardiac catheterization and cardiac surgery, as defined in this section, for the diagnosis and treatment of congenital defects in children. Cardiac catheterization for pediatric patients shall be performed only in a general acute care hospital that has the capability to perform cardiac surgery on pediatric patients.

(f) “Intensive care newborn nursery services” means the provision of comprehensive and intensive care for all contingencies of the newborn infant, including intensive, intermediate, and continuing care. Policies, procedures, and space requirements for intensive, intermediate, and continuing care services shall be based upon the standards and recommendations of the American Academy of Pediatrics Guidelines for Perinatal Care, 1983.

(Amended by Stats. 1998, Ch. 775, Sec. 2. Effective January 1, 1999.)

1255.6. During cardiovascular surgery, a perfusionist, as defined by Chapter 5.67 (commencing with Section 2590) of Division 2 of the Business and Professions Code, shall operate the extracorporeal equipment under the immediate supervision of the cardiovascular surgeon or anesthesiologist. The determination of the qualifications and competence of a perfusionist, and the awarding of appropriate privileges, shall be the responsibility of the general acute care hospital or its medical staff.

(Added by Stats. 1998, Ch. 775, Sec. 3. Effective January 1, 1999.)

1255.7. (a) (1) For purposes of this section, “safe-surrender site” means either of the following:

(A) A location designated by the board of supervisors of a county or by a local fire agency, upon the approval of the appropriate local governing body of the agency, to be responsible for accepting physical custody of a minor child who is 72 hours old or younger from a parent or individual who has lawful custody of the child and who surrenders the child pursuant to Section 271.5 of the Penal Code. Before designating a location as a safe-surrender site pursuant to this subdivision, the designating entity shall consult with the governing body of a city, if the site is within the city limits, and with representatives of a fire department and a child welfare agency that may provide services to a child who is surrendered at the site, if that location is selected.

(B) A location within a public or private hospital that is designated by that hospital to be responsible for accepting physical custody of a minor child who is 72 hours old or younger from a parent or individual who has lawful custody of the child and who surrenders the child pursuant to Section 271.5 of the Penal Code.

(2) For purposes of this section, “parent” means a birth parent of a minor child who is 72 hours old or younger.

(3) For purposes of this section, “personnel” means a person who is an officer or employee of a safe-surrender site or who has staff privileges at the site.

(4) A hospital and a safe-surrender site designated by the county board of supervisors or by a local fire agency, upon the approval of the appropriate local governing body of the agency, shall post a sign displaying a statewide logo that has been adopted by the State Department of Social Services that notifies the public of the location where a minor child 72 hours old or younger may be safely surrendered pursuant to this section.

(b) Personnel on duty at a safe-surrender site shall accept physical custody of a minor child 72 hours old or younger pursuant to this section if a parent or other individual having lawful custody of the child voluntarily surrenders physical custody of the child to personnel who are on duty at the safe-surrender site. Safe-surrender site personnel shall ensure that a qualified person does all of the following:

(1) Places a coded, confidential ankle bracelet on the child.

(2) Provides, or makes a good faith effort to provide, to the parent or other individual surrendering the child a copy of a unique, coded, confidential ankle bracelet identification in order to facilitate reclaiming the child pursuant to subdivision (f). However, possession of the ankle bracelet identification, in and of itself, does not establish parentage or a right to custody of the child.

(3) Provides, or makes a good faith effort to provide, to the parent or other individual surrendering the child a medical information questionnaire, which may be declined, voluntarily filled out and returned at the time the child is surrendered, or later filled out and mailed in the envelope provided for this purpose. This medical information questionnaire shall not require identifying information about the child or the parent or individual surrendering the child, other than the identification code provided in the ankle bracelet placed on the child. Every questionnaire provided pursuant to this section shall begin with the following notice in no less than 12-point type:

“NOTICE: THE BABY YOU HAVE BROUGHT IN TODAY MAY HAVE SERIOUS MEDICAL NEEDS IN THE FUTURE THAT WE DON’T KNOW ABOUT TODAY. SOME ILLNESSES, INCLUDING CANCER, ARE BEST TREATED WHEN WE KNOW ABOUT FAMILY MEDICAL HISTORIES. IN ADDITION, SOMETIMES RELATIVES ARE NEEDED FOR LIFE-SAVING TREATMENTS. TO MAKE SURE THIS BABY WILL HAVE A HEALTHY FUTURE, YOUR ASSISTANCE IN COMPLETING THIS QUESTIONNAIRE FULLY IS ESSENTIAL. THANK YOU.”

(c) Personnel of a safe-surrender site that has physical custody of a minor child pursuant to this section shall ensure that a medical screening examination and any necessary medical care is provided to the minor child. Notwithstanding any other provision of law, the consent of the parent or other relative shall not be required to provide that care to the minor child.

(d) (1) As soon as possible, but in no event later than 48 hours after the physical custody of a child has been accepted pursuant to this section, personnel of the safe-surrender site that has physical custody of the child shall notify child protective services or a county agency providing child welfare services pursuant to Section 16501 of the Welfare and Institutions Code, that the safe-surrender site has physical custody of the child pursuant to this section. In addition, medical information pertinent to the child’s health, including, but not limited to, information obtained pursuant to the medical information questionnaire described in paragraph (3) of subdivision (b) that has been received by or is in the possession of the safe-surrender site shall be provided to that child protective services or county agency.

(2) Any personal identifying information that pertains to a parent or individual who surrenders a child that is obtained pursuant to the medical information questionnaire is confidential and shall be exempt from disclosure by the child protective services or county agency under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code). Personal identifying information that pertains to a parent or individual who surrenders a child shall be redacted from any medical information provided to child protective services or the county agency providing child welfare services.

(e) Child protective services or the county agency providing child welfare services pursuant to Section 16501 of the Welfare and Institutions Code shall assume temporary custody of the child pursuant to Section 300 of the Welfare and Institutions Code immediately upon receipt of notice under subdivision (d). Child protective services or the county agency providing child welfare services pursuant to Section 16501 of the Welfare and Institutions Code shall immediately investigate the circumstances of the case and file a petition pursuant to Section 311 of the Welfare and Institutions Code. Child protective services or the county agency providing child welfare services pursuant to Section 16501 of the Welfare and Institutions Code shall immediately notify the State Department of Social Services of each child to whom this subdivision applies upon taking temporary custody of the child pursuant to Section 300 of the Welfare and Institutions Code. As soon as possible, but no later than 24 hours after temporary custody is assumed, child protective services or the county agency providing child welfare services pursuant to Section 16501 of the Welfare and Institutions Code shall report all known identifying information concerning the child, except personal identifying information pertaining to the parent or individual who surrendered the child, to the California Missing Children Clearinghouse and to the National Crime Information Center.

(f) If, prior to the filing of a petition under subdivision (e), a parent or individual who has voluntarily surrendered a child pursuant to this section requests that the safe-surrender site that has physical custody of the child pursuant to this section return the child and the safe-surrender site still has custody of the child, personnel of the safe-surrender site shall either return the child to the parent or

individual or contact a child protective agency if any personnel at the safe-surrender site knows or reasonably suspects that the child has been the victim of child abuse or neglect. The voluntary surrender of a child pursuant to this section is not in and of itself a sufficient basis for reporting child abuse or neglect. The terms “child abuse,” “child protective agency,” “mandated reporter,” “neglect,” and “reasonably suspects” shall be given the same meanings as in Article 2.5 (commencing with Section 11164) of Title 1 of Part 4 of the Penal Code.

(g) Subsequent to the filing of a petition under subdivision (e), if, within 14 days of the voluntary surrender described in this section, the parent or individual who surrendered custody returns to claim physical custody of the child, the child welfare agency shall verify the identity of the parent or individual, conduct an assessment of that person’s circumstances and ability to parent, and request that the juvenile court dismiss the petition for dependency and order the release of the child, if the child welfare agency determines that none of the conditions described in subdivisions (a) to (d), inclusive, of Section 319 of the Welfare and Institutions Code currently exist.

(h) A safe-surrender site, or the personnel of a safe-surrender site, shall not have liability of any kind for a surrendered child prior to taking actual physical custody of the child. A safe-surrender site, or personnel of the safe-surrender site, that accepts custody of a surrendered child pursuant to this section shall not be subject to civil, criminal, or administrative liability for accepting the child and caring for the child in the good faith belief that action is required or authorized by this section, including, but not limited to, instances where the child is older than 72 hours or the parent or individual surrendering the child did not have lawful physical custody of the child. A safe-surrender site, or the personnel of a safe-surrender site, shall not be subject to civil, criminal, or administrative liability for a surrendered child prior to the time that the site or its personnel know, or should know, that the child has been surrendered. This subdivision does not confer immunity from liability for personal injury or wrongful death, including, but not limited to, injury resulting from medical malpractice.

(i) (1) In order to encourage assistance to persons who voluntarily surrender physical custody of a child pursuant to this section or Section 271.5 of the Penal Code, no person who, without compensation and in good faith, provides assistance for the purpose of effecting the safe surrender of a minor 72 hours old or younger shall be civilly liable for injury to or death of the minor child as a result of the person’s acts or omissions. This immunity does not apply to an act or omission constituting gross negligence, recklessness, or willful misconduct.

(2) For purposes of this section, “assistance” means transporting the minor child to the safe-surrender site as a person with lawful custody, or transporting or accompanying the parent or person with lawful custody at the request of that parent or person to effect the safe surrender, or performing any other act in good faith for the purpose of effecting the safe surrender of the minor.

(j) For purposes of this section, “lawful custody” means physical custody of a minor 72 hours old or younger accepted by a person from a parent of the minor, who the person believes in good faith is the parent of the minor, with the specific intent and promise of effecting the safe surrender of the minor.

(k) Any identifying information that pertains to a parent or individual who surrenders a child pursuant to this section, that is obtained as a result of the questionnaire described in paragraph (3) of subdivision (b) or in any other manner, is confidential, shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), and shall not be disclosed by any personnel of a safe-surrender site that accepts custody of a child pursuant to this section.

(Amended by Stats. 2021, Ch. 615, Sec. 220. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

1255.8. (a) For purposes of this section, the following terms have the following meanings:

(1) “Colonized” means that a pathogen is present on the patient’s body, but is not causing any signs or symptoms of an infection.

(2) “Committee” means the Healthcare Associated Infection Advisory Committee established pursuant to Section 1288.5.

(3) “Health facility” means a facility as defined in subdivision (a) of Section 1250.

(4) “Health-care-associated infection,” “health-facility-acquired infection,” or “HAI” means a health-care-associated infection as defined by the National Healthcare Safety Network of the federal Centers for Disease Control and Prevention, unless the department adopts a definition consistent with the recommendations of the committee or its successor.

(5) “MRSA” means Methicillin-resistant Staphylococcus aureus.

(b) (1) Each patient who is admitted to a health facility shall be tested for MRSA in the following cases, within 24 hours of admission:

(A) The patient is scheduled for inpatient surgery and has a documented medical condition making the patient susceptible to infection, based either upon federal Centers for Disease Control and Prevention findings or the recommendations of the committee or its successor.

(B) It has been documented that the patient has been previously discharged from a general acute care hospital within 30 days prior to the current hospital admission.

(C) The patient will be admitted to an intensive care unit or burn unit of the hospital.

(D) The patient receives inpatient dialysis treatment.

(E) The patient is being transferred from a skilled nursing facility.

(2) The department may interpret this subdivision to take into account the recommendations of the federal Centers for Disease Control and Prevention, or recommendations of the committee or its successor.

(3) If a patient tests positive for MRSA, the attending physician shall inform the patient or the patient's representative immediately or as soon as practically possible.

(4) A patient who tests positive for MRSA infection shall, prior to discharge, receive oral and written instruction regarding aftercare and precautions to prevent the spread of the infection to others.

(c) Commencing January 1, 2011, a patient tested in accordance with subdivision (b) and who shows evidence of increased risk of invasive MRSA shall again be tested for MRSA immediately prior to discharge from the facility. This subdivision shall not apply to a patient who has tested positive for MRSA infection or colonization upon entering the facility.

(d) A patient who is tested pursuant to subdivision (c) and who tests positive for MRSA infection shall receive oral and written instructions regarding aftercare and precautions to prevent the spread of the infection to others.

(e) The infection control policy required pursuant to Section 70739 of Title 22 of the California Code of Regulations, at a minimum, shall include all of the following:

(1) Procedures to reduce health care associated infections.

(2) Regular disinfection of all restrooms, countertops, furniture, televisions, telephones, bedding, office equipment, and surfaces in patient rooms, nursing stations, and storage units.

(3) Regular removal of accumulations of bodily fluids and intravenous substances, and cleaning and disinfection of all movable medical equipment, including point-of-care testing devices such as glucometers, and transportable medical devices.

(4) Regular cleaning and disinfection of all surfaces in common areas in the facility such as elevators, meeting rooms, and lounges.

(f) Each facility shall designate an infection control officer who, in conjunction with the hospital infection control committee, shall ensure implementation of the testing and reporting provisions of this section and other hospital infection control efforts. The reports shall be presented to the appropriate committee within the facility for review. The name of the infection control officer shall be made publicly available, upon request.

(g) The department shall establish a health care acquired infection program pursuant to this section.

(Added by Stats. 2008, Ch. 296, Sec. 3. Effective January 1, 2009.)

1255.9. (a) (1) A skilled nursing facility shall have a full-time, dedicated Infection Preventionist (IP).

(2) The IP role may be filled either by one full-time IP staff member or by two staff members sharing the IP responsibilities, as long as the total time dedicated to the IP role equals at least the time of one full-time staff member.

(3) The IP shall meet the following requirements:

(A) Have primary professional training as a licensed nurse, medical technologist, microbiologist, epidemiologist, public health professional, or other health care related field.

(B) Be qualified by education, training, clinical or health care experience, or certification.

(C) Have completed specialized training in infection prevention and control.

(4) The IP shall not be included in the calculation of three and one-half hours of direct patient care per day provided to skilled nursing facility residents.

(b) A skilled nursing facility shall have a plan in place for infection prevention quality control.

(c) A skilled nursing facility shall ensure all health care personnel receive infection prevention and control training on an annual basis.

(Amended by Stats. 2021, Ch. 181, Sec. 1. (AB 1585) Effective January 1, 2022.)

1256. (a) The use of the name or title “hospital” by any person or persons to identify or represent a facility for the diagnosis, care, and treatment of human illness other than a facility subject to or specifically exempted from the licensure provisions of this chapter is prohibited. Notwithstanding any other provisions of the laws of this state, the name or title “hospital” shall not be used by any sanitarium, nursing home, convalescent home, or maternity home, unless preceded by some qualifying descriptive word such as convalescent, geriatric, rehabilitation, or nursing.

(b) This section shall not prohibit the use of the word “hospital” to identify or represent an approved pediatric supplemental service of a general acute care hospital that is either of the following:

(1) A children’s hospital as defined by Section 10727 of the Welfare and Institutions Code.

(2) A University of California children’s hospital as defined by Section 10728 of the Welfare and Institutions Code.

(Amended by Stats. 2001, Ch. 290, Sec. 1. Effective January 1, 2002.)

1256.01. (a) The Elective Percutaneous Coronary Intervention (PCI) Program is hereby established in the department. The purpose of the program is to allow the department to certify general acute care hospitals that do not offer cardiac surgery services but are licensed to provide cardiac catheterization laboratory service in California, and that meet the requirements of this section, to perform scheduled, elective percutaneous transluminal coronary angioplasty and stent placement for eligible patients.

(b) For purposes of this section, the following terms have the following meanings:

(1) “Certified hospital” means an eligible hospital that is certified by the department to participate in the Elective Percutaneous Coronary Intervention (PCI) Program established by this section.

(2) “Elective Percutaneous Coronary Intervention (elective PCI)” means scheduled percutaneous transluminal coronary angioplasty and stent placement. Elective PCI does not include urgent or emergent PCI that is scheduled on an ad hoc basis.

(3) “Eligible hospital” means a general acute care hospital that has an approved cardiac catheterization laboratory, does not have onsite cardiac surgery, and is in substantial compliance with all applicable state and federal licensing laws and regulations.

(4) “Interventionalist” means a licensed cardiologist who meets the requirements for performing elective PCI.

(c) To participate in the Elective PCI Program, an eligible hospital shall obtain certification from the department and shall meet all of the following requirements:

(1) Demonstrate that it complies with the recommendations of the Society for Cardiovascular Angiography and Interventions (SCAI), the American College of Cardiology Foundation, and the American Heart Association, for performance of PCI without onsite cardiac surgery, as those recommendations may evolve over time.

(2) Provide evidence showing the full support from hospital administration in fulfilling the necessary institutional requirements, including, but not limited to, appropriate support services such as respiratory care and blood banking.

(3) Participate in, and provide timely submission of data to, the American College of Cardiology-National Cardiovascular Data Registry.

(4) Confer rights to transfer the data submitted pursuant to paragraph (3) to the Office of Statewide Health Planning and Development, now known as the Department of Health Care Access and Information.

(5) Any additional requirements the department deems necessary to protect patient safety or ensure quality of care.

(d) An eligible hospital shall submit an application to the department pursuant to Section 1265 to obtain certification to participate in the Elective PCI Program. The application shall include sufficient information to demonstrate compliance with the standards set forth in this section, and shall also include the effective date for initiating elective PCI service, the general service area, a description of the population to be served, a description of the services to be provided, a description of backup emergency services, the availability of comprehensive care, and the qualifications of the eligible hospital. The department may require that additional information be submitted with the application. Failure to submit any required criteria or additional information shall disqualify the applicant from the

application process and from consideration for participation in the program. The department may deny an Elective PCI Program applicant pursuant to Article 2 (commencing with Section 1265).

(e) An eligible hospital that, as of December 31, 2014, was participating in the Elective Percutaneous Coronary Intervention Pilot Program established under Chapter 295 of the Statutes of 2008, as amended by Chapter 202 of the Statutes of 2013, may continue to perform elective PCI and shall be considered a certified hospital until January 1, 2016. On and after January 1, 2016, a hospital described in this subdivision shall not be considered a certified hospital unless the hospital has obtained a certification under this section.

(f) The Office of Statewide Health Planning and Development, now known as the Department of Health Care Access and Information, shall, using the data transferred pursuant to paragraph (4) of subdivision (c), annually develop and make available to the public a report regarding each certified hospital's performance on mortality, stroke rate, and emergency coronary artery bypass graft rate.

(g) The department may establish an advisory oversight committee composed of two interventionalists from certified hospitals, two interventionalists from general acute care hospitals that are not certified hospitals, and a representative of the department, for the purpose of analyzing the report issued under subdivision (f) and making recommendations for changing the data to be included in future reports issued under subdivision (f).

(h) If at any time a certified hospital fails to meet the criteria set forth in this section for being a certified hospital or fails to safeguard patient safety, as determined by the department, the department may suspend or revoke, pursuant to Section 70309 of Title 22 of the California Code of Regulations, the certification issued to that hospital under this section. A hospital whose certification is revoked pursuant to this subdivision may request an appeal with the department and is not precluded from reapplying for certification under this section.

(i) The department may charge certified hospitals a supplemental licensing fee, the amount of which shall not exceed the reasonable cost to the department of overseeing the program.

(j) The department may contract with a professional entity with medical program knowledge to meet the requirements of this section.

(Amended by Stats. 2024, Ch. 136, Sec. 2. (SB 1464) Effective January 1, 2025.)

1256.1. A general acute care hospital shall not hold itself out directly or indirectly by any sign, brochure, or advertisement as providing any service or services that require a supplemental or special service unless that general acute care hospital has first obtained a supplemental or special service approval from the State Department of Public Health to operate that service.

(Amended by Stats. 2017, Ch. 561, Sec. 101. (AB 1516) Effective January 1, 2018.)

1256.2. (a) (1) No general acute care hospital may promulgate policies or implement practices that determine differing standards of obstetrical care based upon a patient's source of payment or ability to pay for medical services.

(2) Each hospital holding an obstetrical services permit shall provide the licensing and certification division of the department with a written policy statement reflecting paragraph (1) and shall post written notices of this policy in the obstetrical admitting areas of the hospital by July 1, 1999. Notices posted pursuant to this section shall be posted in the predominant language or languages spoken in the hospital's service area.

(b) It shall constitute unprofessional conduct within the meaning of the Medical Practice Act, Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, for a physician or surgeon to deny, or threaten to withhold pain management services from a woman in active labor, based upon that patient's source of payment, or ability to pay for medical services.

(Added by Stats. 1998, Ch. 652, Sec. 2. Effective January 1, 1999.)

1257. The state department may delegate to local health departments the authority to verify compliance with the licensing and approval provisions of this chapter, to provide consultation, and to recommend disciplinary action by the department against those licensed or approved under the provisions of this chapter. In exercising the authority so delegated, the local health department shall conform to the requirements of this chapter and to the rules and regulations of the state department. Payment to the local health departments for services performed pursuant to this section shall be in accordance with a budget submitted by the local health department and approved by the state department. Such expenditures shall not exceed amounts appropriated by the Legislature for the purpose of such inspection and enforcement.

(Added by Stats. 1973, Ch. 1202.)

1257.5. (a) All registered nurses, certified nurse assistants, licensed vocational nurses, and physicians working in skilled nursing facilities, as defined in subdivision (c) of Section 1250, or congregate living health facilities, as defined in subdivision (i) of Section

1250, shall participate in a training program, to be prescribed by the department, that focuses on preventing and eliminating discrimination based on sexual orientation and gender identity.

(b) The department may incorporate the training prescribed in subdivision (a) into any existing training program that is designed to prevent or eliminate discrimination in senior care facilities.

(c) The department may charge each licensee who is subject to subdivision (a) a fee associated with determining compliance. The fee shall not exceed the department's costs for the enforcement of this section.

(d) "Sexual orientation" and "gender identity" have the same meanings as those terms are used in Section 422.56 of the Penal Code.

(Added by Stats. 2008, Ch. 550, Sec. 2. Effective January 1, 2009.)

1257.7. (a) After July 1, 2010, all hospitals licensed pursuant to subdivisions (a), (b), and (f) of Section 1250 shall conduct, not less than annually, a security and safety assessment and, using the assessment, develop, and annually update based on the assessment, a security plan with measures to protect personnel, patients, and visitors from aggressive or violent behavior. The security and safety assessment shall examine trends of aggressive or violent behavior at the facility. These hospitals shall track incidents of aggressive or violent behavior as part of the quality assessment and improvement program and for the purposes of developing a security plan to deter and manage further aggressive or violent acts of a similar nature. The plan may include, but shall not be limited to, security considerations relating to all of the following:

(1) Physical layout.

(2) Staffing.

(3) Security personnel availability.

(4) Policy and training related to appropriate responses to violent acts.

(5) Efforts to cooperate with local law enforcement regarding violent acts in the facility.

In developing this plan, the hospital shall consider guidelines or standards on violence in health care facilities issued by the department, the Division of Occupational Safety and Health, and the federal Occupational Safety and Health Administration. As part of the security plan, a hospital shall adopt security policies including, but not limited to, personnel training policies designed to protect personnel, patients, and visitors from aggressive or violent behavior. In developing the plan and the assessment, the hospital shall consult with affected employees, including the recognized collective bargaining agent or agents, if any, and members of the hospital medical staff organized pursuant to Section 2282 of the Business and Professions Code. This consultation may occur through hospital committees.

(b) The individual or members of a hospital committee responsible for developing the security plan shall be familiar with all of the following:

(1) The role of security in hospital operations.

(2) Hospital organization.

(3) Protective measures, including alarms and access control.

(4) The handling of disturbed patients, visitors, and employees.

(5) Identification of aggressive and violent predicting factors.

(6) Hospital safety and emergency preparedness.

(7) The rudiments of documenting and reporting crimes, including, by way of example, not disturbing a crime scene.

(c) The hospital shall have sufficient personnel to provide security pursuant to the security plan developed pursuant to subdivision (a). Persons regularly assigned to provide security in a hospital setting shall be trained regarding the role of security in hospital operations, including the identification of aggressive and violent predicting factors and management of violent disturbances.

(d) Any act of assault, as defined in Section 240 of the Penal Code, or battery, as defined in Section 242 of the Penal Code, that results in injury or involves the use of a firearm or other dangerous weapon, against any on-duty hospital personnel shall be reported to the local law enforcement agency within 72 hours of the incident. Any other act of assault, as defined in Section 240 of the Penal Code, or battery, as defined in Section 242 of the Penal Code, against any on-duty hospital personnel may be reported to the local law enforcement agency within 72 hours of the incident. No health facility or employee of a health facility who reports a known or

suspected instance of assault or battery pursuant to this section shall be civilly or criminally liable for any report required by this section. No health facility or employee of a health facility who reports a known or suspected instance of assault or battery that is authorized, but not required, by this section, shall be civilly or criminally liable for the report authorized by this section unless it can be proven that a false report was made and the health facility or its employee knew that the report was false or was made with reckless disregard of the truth or falsity of the report, and any health facility or employee of a health facility who makes a report known to be false or with reckless disregard of the truth or falsity of the report shall be liable for any damages caused. Any individual knowingly interfering with or obstructing the lawful reporting process shall be guilty of a misdemeanor. “Dangerous weapon,” as used in this section, means any weapon the possession or concealed carrying of which is prohibited by any provision listed in Section 16590 of the Penal Code.

(Amended by Stats. 2010, Ch. 178, Sec. 36. (SB 1115) Effective January 1, 2011. Operative January 1, 2012, by Sec. 107 of Ch. 178.)

1257.8. (a) All hospital employees regularly assigned to the emergency department shall receive, by July 1, 1995, and thereafter, on a continuing basis as provided for in the security plan developed pursuant to Section 1257.7, security education and training relating to the following topics:

(1) General safety measures.

(2) Personal safety measures.

(3) The assault cycle.

(4) Aggression and violence predicting factors.

(5) Obtaining patient history from a patient with violent behavior.

(6) Characteristics of aggressive and violent patients and victims.

(7) Verbal and physical maneuvers to diffuse and avoid violent behavior.

(8) Strategies to avoid physical harm.

(9) Restraining techniques.

(10) Appropriate use of medications as chemical restraints.

(11) Any resources available to employees for coping with incidents of violence, including, by way of example, critical incident stress debriefing or employee assistance programs.

(b) As provided in the security plan developed pursuant to Section 1257.7, members of the medical staff of each hospital and all other practitioners, including, but not limited to, nurse practitioners, physician assistants, and other personnel, who are regularly assigned to the emergency department or other departments identified in the security plan shall receive the same training as that provided to hospital employees or, at a minimum, training determined to be sufficient pursuant to the security plan.

(c) Temporary personnel shall be oriented as required pursuant to the security plan. This section shall not be construed to preempt state law or regulations generally affecting temporary personnel in hospitals.

(Added by Stats. 1993, Ch. 936, Sec. 3. Effective January 1, 1994.)

1257.9. (a) (1) The department shall recommend training for general acute care hospitals, as defined in subdivision (a) of Section 1250, and special hospitals, as defined in subdivision (f) of Section 1250, that is intended to improve breast-feeding rates among mothers and infants. This recommended training should be designed for general acute care hospitals that provide maternity care and have exclusive patient breast-feeding rates in the lowest 25 percent, according to the data published yearly by the State Department of Public Health, when ranked from highest to lowest rates. The training offered shall include a minimum of eight hours of training provided to appropriate administrative and supervisory staff on hospital policies and recommendations that promote exclusive breast-feeding. Hospitals that meet the minimum criteria for exclusive breast-feeding rates prescribed in the most current Healthy People Guidelines of the United States Department of Health and Human Services shall be excluded from the training requirements recommended by this paragraph.

(2) The department shall notify the hospital director or other person in charge of a hospital to which paragraph (1) applies, that the eight-hour model training course developed pursuant to subdivision (b) of Section 123360, is available, upon request, to the hospital.

(b) The recommendations provided for in this section are advisory only. Nothing in this section shall require a hospital to comply with the training recommended by this section. Section 1290 shall not apply to this section, nor shall meeting the recommendations of this section be a condition of licensure.

(Added by Stats. 2007, Ch. 460, Sec. 2. Effective January 1, 2008.)

1258. No health facility which permits sterilization operations for contraceptive purposes to be performed therein, nor the medical staff of such health facility, shall require the individual upon whom such a sterilization operation is to be performed to meet any special nonmedical qualifications, which are not imposed on individuals seeking other types of operations in the health facility. Such prohibited nonmedical qualifications shall include, but not be limited to, age, marital status, and number of natural children.

Nothing in this section shall prohibit requirements relating to the physical or mental condition of the individual or affect the right of the attending physician to counsel or advise his patient as to whether or not sterilization is appropriate. This section shall not affect existing law with respect to individuals below the age of majority.

(Added by Stats. 1974, Ch. 755.)

1259. (a) (1) The Legislature finds and declares that California is becoming a land of people whose languages and cultures give the state a global quality. The Legislature further finds and declares that access to basic health care services is the right of every resident of the state, and that access to information regarding basic health care services is an essential element of that right.

(2) Therefore, it is the intent of the Legislature that when language or communication barriers exist between patients and the staff of any general acute care hospital, arrangements shall be made for interpreters or bilingual professional staff to ensure adequate and speedy communication between patients and staff.

(b) As used in this section:

(1) “Interpreter” means a person fluent in English and in the necessary second language, who can accurately speak, read, and readily interpret the necessary second language, or a person who can accurately sign and read sign language. Interpreters shall have the ability to translate the names of body parts and to describe competently symptoms and injuries in both languages. Interpreters may include members of the medical or professional staff.

(2) “Language or communication barriers” means:

(A) With respect to spoken language, barriers that are experienced by individuals who are limited-English-speaking or non-English-speaking individuals who speak the same primary language and who comprise at least 5 percent of the population of the geographical area served by the hospital or of the actual patient population of the hospital. In cases of dispute, the State Department of Public Health shall determine, based on objective data, whether the 5 percent population standard applies to a given hospital.

(B) With respect to sign language, barriers that are experienced by individuals who are deaf and whose primary language is sign language.

(c) To ensure access to health care information and services for limited-English-speaking or non-English-speaking residents and deaf residents, licensed general acute care hospitals shall:

(1) Review existing policies regarding interpreters for patients with limited-English proficiency and for patients who are deaf, including the availability of staff to act as interpreters.

(2) (A) (i) Adopt and review annually a policy for providing language assistance services to patients with language or communication barriers. The policy shall include procedures for providing, to the extent possible, as determined by the hospital, the use of an interpreter whenever a language or communication barrier exists, except when the patient, after being informed of the availability of the interpreter service, chooses to use a family member or friend who volunteers to interpret. The procedures shall be designed to maximize efficient use of interpreters and minimize delays in providing interpreters to patients. The procedures shall ensure, to the extent possible, as determined by the hospital, that interpreters are available, either on the premises or accessible by telephone, 24 hours a day.

(ii) The hospital shall, on or before July 1, 2016, and every January 1 thereafter, make the updated policy and a notice of availability of language assistance services available to the public on its Internet Web site. The notice shall be in English and in the other languages most commonly spoken in the hospital’s service area. For purposes of this paragraph, the hospital shall make the notice available in the language of individuals who meet the definition of having a language barrier pursuant to subparagraph (A) of paragraph (2) of subdivision (b); however, a hospital is not required to make the notice available in more than five languages other than English.

(B) (i) The hospital shall, on or before July 1, 2016, and every January 1 thereafter, transmit to the department a copy of the updated policy and shall include a description of its efforts to ensure adequate and speedy communication between patients with language or communication barriers and staff.

(ii) The department shall make the updated policy available to the public on its Internet Web site.

(3) Develop, and post in conspicuous locations, notices that advise patients and their families of the availability of interpreters, the procedure for obtaining an interpreter, and the telephone numbers where complaints may be filed concerning interpreter service problems, including, but not limited to, a TDD number for the deaf or hard of hearing. The notices shall be posted, at a minimum, in the emergency room, the admitting area, the entrance, and in outpatient areas. Notices shall inform patients that interpreter services are available upon request, shall list the languages for which interpreter services are available, shall instruct patients to direct complaints regarding interpreter services to the department, and shall provide the local address and telephone number of the department, including, but not limited to, a TDD number for the deaf or hard of hearing.

(4) Identify and record a patient's primary language and dialect on one or more of the following: patient medical chart, hospital bracelet, bedside notice, or nursing card.

(5) Prepare and maintain as needed a list of interpreters who have been identified as proficient in sign language and in the languages of the population of the geographical area serviced who have the ability to translate the names of body parts, injuries, and symptoms.

(6) Notify employees of the hospital's commitment to provide interpreters to all patients who request them.

(7) Review all standardized written forms, waivers, documents, and informational materials available to patients upon admission to determine which to translate into languages other than English.

(8) Consider providing its nonbilingual staff with standardized picture and phrase sheets for use in routine communications with patients who have language or communication barriers.

(9) Consider developing community liaison groups to enable the hospital and the limited-English-speaking and deaf communities to ensure the adequacy of the interpreter services.

(d) Noncompliance with this section shall be reportable to licensing authorities.

(e) Section 1290 does not apply to this section.

(Amended by Stats. 2017, Ch. 561, Sec. 102. (AB 1516) Effective January 1, 2018.)

1259.3. (a) This section shall be known, and may be cited, as Tyler's Law.

(b) If a person is treated at a general acute care hospital and the hospital conducts a urine drug screening to assist in diagnosing the patient's condition, the hospital shall include testing for fentanyl in the urine drug screening.

(c) As used in this section, "urine drug screening" means a chemical analysis intended to test patients for the presence of multiple drugs, including cocaine, opioids, and phencyclidine.

(d) This section shall remain in effect only until January 1, 2028, and as of that date is repealed.

(Added by Stats. 2022, Ch. 169, Sec. 1. (SB 864) Effective January 1, 2023. Repealed as of January 1, 2028, by its own provisions.)

1259.5. By January 1, 1995, each general acute care hospital, acute psychiatric hospital, special hospital, psychiatric health facility, and chemical dependency recovery hospital shall establish written policies and procedures to screen patients routinely for the purpose of detecting spousal or partner abuse. The policies shall include guidelines on all of the following:

(a) Identifying, through routine screening, spousal or partner abuse among patients.

(b) Documenting patient injuries or illnesses attributable to spousal or partner abuse.

(c) Educating appropriate hospital staff about the criteria for identifying, and the procedures for handling, patients whose injuries or illnesses are attributable to spousal or partner abuse.

(d) Advising patients exhibiting signs of spousal or partner abuse of crisis intervention services that are available either through the hospital facility or through community-based crisis intervention and counseling services.

(e) Providing to patients who exhibit signs of spousal or partner abuse information on domestic violence and a referral list, to be updated periodically, of private and public community agencies that provide, or arrange for, evaluation of and care for persons experiencing spousal or partner abuse, including, but not limited to, hot lines, local domestic violence shelter-based programs, legal services, and information about temporary restraining orders.

(Amended by Stats. 2022, Ch. 197, Sec. 10. (SB 1493) Effective January 1, 2023.)

1259.6. (a) On or before January 1, 2025, a general acute care hospital shall establish and adopt written policies and procedures to screen patients who are 12 years of age and older for purposes of detecting a risk for suicidal ideation and behavior.

(b) The procedures established pursuant to this section shall accomplish all of the following:

(1) Identify, as part of a medical screening, a patient's risk for suicidal ideation and behavior.

(2) Document in the medical record a patient's risk for suicidal ideation and behavior.

(3) Provide to a patient who exhibits a sign of a risk for suicidal ideation and behavior a current referral list of private and public community agencies that provide, or arrange for, the evaluation, counseling, and care of persons experiencing a risk of suicidal ideation and behavior, including, but not limited to, hotlines and locally available mental health services.

(4) Designate the licensed staff to be responsible for the implementation of these policies and procedures.

(c) After the adoption of written policies and procedures pursuant to subdivision (a), a general acute care hospital shall routinely screen patients who are 12 years of age and older for a risk of suicidal ideation and behavior in compliance with those policies and procedures.

(d) It is the intent of the Legislature that a general acute care hospital, for purposes of satisfying the requirements of this section, adopt guidelines similar to the validated or evidence-based screening tools and suicide risk assessment tools recommended by the Joint Commission regarding screening for suicidal ideation and behavior risk and protocols to follow when a patient exhibits a sign of being at imminent risk for suicidal ideation and behavior. The Legislature recognizes that, while guidelines evolve and change, the validated or evidence-based screening tools and suicide risk assessment tools recommended by the Joint Commission may serve, at this time, as a model to follow.

(Added by Stats. 2022, Ch. 101, Sec. 1. (AB 1394) Effective January 1, 2023.)

1260. (a) Except as provided in subdivision (b), any member of the board of directors of a nonprofit corporation that is subject to Section 5914 of the Corporations Code, who negotiates the terms and conditions of a sale or transfer of assets, as described in Section 5914 of the Corporations Code, is prohibited from receiving, directly or indirectly, any salary, compensation, payment, or other form of remuneration from the for-profit corporation or entity or mutual benefit corporation following the close of the sale or other transfer of assets. This prohibition shall not apply to any reimbursement or payment made to a member of the board of directors, who is a physician or other health care provider, for direct patient care services provided to patients covered by a health insurer, health care service plan, employer, or other entity that provides health care coverage, and that is owned, operated, or affiliated with the purchasing for-profit corporation or entity, provided that the amounts payable for the services rendered are no greater than the amounts payable to other physicians or health care providers providing the same or similar services.

For the purpose of this section, "direct patient care services" mean health care services provided directly to a patient, and do not include services provided through an intermediary. Further, in order to qualify for the exemption in this subdivision, the direct patient care services must be health care services that are regularly provided by other physicians or other health care providers in the community who are also receiving reimbursements or payments from the same health insurer, health care service plan, employer, or other entity that is owned or operated by, or affiliated with, the purchasing for-profit corporation or entity.

(b) After a period of two years following the close of the sale or other transfer of assets, a person who was a member of the board of directors of the nonprofit corporation who is prohibited from receiving any remuneration from the for-profit corporation or entity or mutual benefit corporation under subdivision (a) may enter into usual and customary business transactions with the for-profit corporation or entity or mutual benefit corporation so long as the following facts are established:

(1) Prior to authorizing or approving the transaction, the representative of the for-profit corporation or entity or mutual benefit corporation considered and in good faith determined after reasonable investigation under the circumstances that the corporation could not have obtained a more advantageous arrangement with reasonable effort under the circumstances.

(2) The for-profit corporation or entity or mutual benefit corporation, in fact could not have obtained a more advantageous arrangement with reasonable effort under the circumstances.

(c) Any person who is a member of management of the nonprofit corporation and who presents information or opinions to the board regarding the sale or other transfer of assets as described in subdivision (a) that are relied upon, or considered by, any of the board members in making decisions regarding the sale or transfer, may make a written affirmative declaration that he or she will not work for, or receive any form of remuneration from, the for-profit corporation or entity or the mutual benefit corporation in the future.

(d) In making any decision regarding the sale or other transfer of the nonprofit corporation's assets, as described in Section 5914 of the Corporations Code, the board of the nonprofit corporation is prohibited from substantially relying on any information presented by

any person to whom subdivision (c) applies who has not made a written affirmative declaration pursuant to subdivision (c). This subdivision shall not apply to any person whose only role in the sale or transfer is to provide to the nonprofit corporation exclusively factual information about the nonprofit corporation, community, financial status, or other similar data.

(e) In performing those duties of a director set forth in subdivision (d), the board of directors may contract with independent counsel, accountants, financial analysts, or other professionals whom the board believes to be reliable and competent in the matters presented, to review and evaluate information and advice presented by an employee who has not signed an affirmative declaration pursuant to subdivision (c). Any director who substantially relies on information and advice presented by such an independent professional shall be deemed to have not violated subdivision (d).

(Added by Stats. 1997, Ch. 890, Sec. 1. Effective October 12, 1997.)

1260.1. (a) Except as provided in subdivision (b), any member of the board of directors of a nonprofit corporation that is subject to Section 5920 of the Corporations Code, who negotiates the terms and conditions of a sale or transfer of assets, as described in Section 5920 of the Corporations Code, is prohibited from receiving, directly or indirectly, any salary, compensation, payment, or other form of remuneration from the purchasing public benefit corporation or entity following the close of the sale or other transfer of assets. This prohibition shall not apply to any reimbursement or payment made to a member of the board of directors, who is a physician or other health care provider, for direct patient care services provided to patients covered by a health insurer, health care service plan, employer, or other entity that provides health care coverage, and that is owned, operated, or affiliated with the purchasing public benefit corporation or entity, provided that the amounts payable for the services rendered are no greater than the amounts payable to other physicians or health care providers providing the same or similar services.

For the purpose of this section, “direct patient care services” means health care services provided directly to a patient, and does not include services provided through an intermediary. Further, in order to qualify for the exemption in this subdivision, the direct patient care services must be health care services that are regularly provided by other physicians or other health care providers in the community who are also receiving reimbursements or payments from the same health insurer, health care service plan, employer, or other entity that is owned or operated by, or affiliated with, the purchasing public benefit corporation or entity.

(b) After a period of two years following the close of the sale or other transfer of assets, a person who was a member of the board of directors of the selling nonprofit corporation who is prohibited from receiving any remuneration from the purchasing public benefit corporation or entity under subdivision (a) may enter into usual and customary business transactions with the purchasing public benefit corporation or entity so long as the following facts are established:

(1) Prior to authorizing or approving the transaction, the representative of the purchasing public benefit corporation or entity considered and in good faith determined after reasonable investigation under the circumstances that the purchasing public benefit corporation could not have obtained a more advantageous arrangement with reasonable effort under the circumstances.

(2) The purchasing public benefit corporation or entity, in fact, could not have obtained a more advantageous arrangement with reasonable effort under the circumstances.

(c) Any person who is a member of management of the selling nonprofit corporation and who presents information or opinions to the board regarding the sale or other transfer of assets as described in subdivision (a) that are relied upon, or considered by, any of the board members in making decisions regarding the sale or transfer, may make a written affirmative declaration that he or she will not work for, or receive any form of remuneration from, the purchasing public benefit corporation or entity in the future.

(d) In making any decision regarding the sale or other transfer of the nonprofit corporation’s assets, as described in Section 5920 of the Corporations Code, the board of the selling nonprofit corporation is prohibited from substantially relying on any information presented by any person to whom subdivision (c) applies who has not made a written affirmative declaration pursuant to subdivision (c). This subdivision shall not apply to any person whose only role in the sale or transfer is to provide to the selling nonprofit corporation exclusively factual information about the selling nonprofit corporation, community, financial status, or other similar data.

(e) In performing those duties of a director set forth in subdivision (d), the board of directors may contract with independent counsel, accountants, financial analysts, or other professionals whom the board believes to be reliable and competent in the matters presented, to review and evaluate information and advice presented by an employee who has not signed an affirmative declaration pursuant to subdivision (c). Any director who substantially relies on information and advice presented by the independent professional shall be deemed to have not violated subdivision (d).

(Added by Stats. 1999, Ch. 850, Sec. 12. Effective January 1, 2000.)

1261. (a) A health facility shall allow a patient’s domestic partner, the children of the patient’s domestic partner, and the domestic partner of the patient’s parent or child to visit, unless one of the following is met:

(1) No visitors are allowed.

(2) The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of a facility.

(3) The patient has indicated to health facility staff that the patient does not want this person to visit.

(b) This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

(c) For purposes of this section, "domestic partner" has the same meaning as that term is used in Section 297 of the Family Code.

(Added by Stats. 1999, Ch. 588, Sec. 4. Effective January 1, 2000.)

1261.3. (a) Notwithstanding any other provision of law, for a patient aged 50 years or older, a registered nurse or licensed pharmacist may administer in a skilled nursing facility, as defined in subdivision (c) of Section 1250, influenza and pneumococcal immunizations pursuant to standing orders and without patient-specific orders if all of the following criteria are met:

(1) The skilled nursing facility medical director, as defined in Section 72305 of Title 22 of the California Code of Regulations, has approved the immunization standing orders established by the facility.

(2) The standing orders meet the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the federal Centers for Disease Control and Prevention.

(b) Nothing in this section amends, alters, or restricts the scope of registered nurse practice including, but not limited to, the scope of practice set forth in Article 2 (commencing with Section 2725) of Chapter 6 of Division 2 of the Business and Professions Code, the implementing regulations, and interpretative bulletins or practice advisories issued by the Board of Registered Nursing.

(Added by Stats. 2005, Ch. 58, Sec. 1. Effective January 1, 2006.)

1261.4. (a) (1) A skilled nursing facility shall not contract with a person as a medical director if the person is not, or will not be within five years of the date of initial hire as the facility's medical director, certified by the American Board of Post-Acute and Long-Term Care Medicine, or an equivalent organization as determined by the department, as a Certified Medical Director, except as set forth in paragraph (2).

(2) A medical director already employed in a skilled nursing facility as of January 1, 2022, shall have until January 1, 2027, to become a Certified Medical Director pursuant to this section.

(b) A skilled nursing facility shall submit to the department all of the following information on the medical director on an initial application:

(1) An HS 215A form or its successor form.

(2) A résumé.

(3) Whether its medical director is certified as a Certified Medical Director according to the requirements established by the American Board of Post-Acute and Long-Term Care Medicine or an equivalent organization as determined by the department.

(4) If the medical director is not yet certified, the expected date of certification.

(c) A skilled nursing facility shall notify the department of any changes in its medical director by submitting an HS 215A form or its successor form, a résumé, and proof of certification or progress toward certification for its medical director within 10 calendar days of those changes.

(d) All skilled nursing facilities shall report to the department the name and certification status of the facility's medical director by submitting an HS 215A form or its successor form, a résumé, and proof of certification or progress toward certification for its medical director no later than June 30, 2022.

(e) (1) Subdivisions (a) through (d), inclusive, do not apply to a skilled nursing facility that is operated as a distinct part of an acute care hospital.

(2) A skilled nursing facility that is operated as a distinct part of an acute care hospital shall designate a qualified physician as a medical director who is responsible for standards, coordination, surveillance, and planning for improvement of medical care in the facility.

(3) For purposes of paragraph (2), "qualified physician" means either of the following:

(A) The physician is certified, or pursuing certification, by the American Board of Post-Acute and Long-Term Care Medicine as a Certified Medical Director.

(B) The physician is board certified in a medical specialty consistent with the type of care provided in the skilled nursing facility, including, but not limited to, physical medicine and rehabilitation or pulmonology, and whose role as the medical director of the skilled nursing facility has been reviewed and approved by the hospital's leadership.

(f) This section shall remain in effect only until January 1, 2032, and as of that date is repealed.

(Added by Stats. 2021, Ch. 586, Sec. 1. (AB 749) Effective January 1, 2022. Repealed as of January 1, 2032, by its own provisions.)

1261.5. (a) The number of oral dosage form or suppository form drugs provided by a pharmacy to a health facility licensed pursuant to subdivision (c) or (d), or both subdivisions (c) and (d), of Section 1250 of this code for storage in a secured emergency supplies container, pursuant to Section 4119 of the Business and Professions Code, shall be limited to 48. The State Department of Public Health may limit the number of doses of each drug available to not more than 16 doses of any separate drug dosage form in each emergency supply.

(b) Not more than four of the 48 oral form or suppository form drugs secured for storage in the emergency supplies container shall be psychotherapeutic drugs, except that the department may grant a program flexibility request to the facility to increase the number of psychotherapeutic drugs in the emergency supplies container to not more than 10 if the facility can demonstrate the necessity for an increased number of drugs based on the needs of the patient population at the facility. In addition, the four oral form or suppository form psychotherapeutic drug limit shall not apply to a special treatment program service unit distinct part, as defined in Section 1276.9. The department shall limit the number of doses of psychotherapeutic drugs available to not more than four doses in each emergency supply. Nothing in this section shall alter or diminish informed consent requirements, including, but not limited to, the requirements of Section 1418.9.

(c) Any limitations established pursuant to subdivisions (a) and (b) on the number and quantity of oral dosage or suppository form drugs provided by a pharmacy to a health facility licensed pursuant to subdivision (c) or (d), or both subdivisions (c) and (d), of Section 1250 for storage in a secured emergency supplies container shall not apply to an automated drug delivery system, as defined in Section 1261.6, when a pharmacist controls access to the drugs.

(Amended by Stats. 2010, Ch. 328, Sec. 111. (SB 1330) Effective January 1, 2011.)

1261.6. (a) (1) For purposes of this section and Section 1261.5, an "automated drug delivery system" means a mechanical system that performs operations or activities, other than compounding or administration, relative to the storage, dispensing, or distribution of drugs. An automated drug delivery system shall collect, control, and maintain all transaction information to accurately track the movement of drugs into and out of the system for security, accuracy, and accountability. For purposes of this section, an automated drug delivery system shall include an automated unit dose system, as defined in subdivision (b) of Section 4017.3 of the Business and Professions Code.

(2) For purposes of this section, "facility" means a health facility licensed pursuant to subdivision (c), (d), (k), or (n) of Section 1250 that has an automated drug delivery system provided by a pharmacy.

(3) For purposes of this section, "pharmacy services" means the provision of both routine and emergency drugs and biologicals to meet the needs of the patient, as prescribed by a physician.

(b) Transaction information shall be made readily available in a written format for review and inspection by individuals authorized by law. These records shall be maintained in the facility for a minimum of three years.

(c) Individualized and specific access to automated drug delivery systems shall be limited to facility and contract personnel authorized by law to administer drugs.

(d) (1) The facility and the pharmacy shall develop and implement written policies and procedures to ensure safety, accuracy, accountability, security, patient confidentiality, and maintenance of the quality, potency, and purity of stored drugs. Policies and procedures shall define access to the automated drug delivery system and limits to access to equipment and drugs.

(2) All policies and procedures shall be maintained at the pharmacy operating the automated drug delivery system and the location where the automated drug delivery system is being used.

(e) When used as an emergency pharmaceutical supplies container, drugs removed from the automated drug delivery system shall be limited to the following:

(1) A new drug order given by a prescriber for a patient of the facility for administration prior to the next scheduled delivery from the pharmacy, or 72 hours, whichever is less. The drugs shall be retrieved only upon authorization by a pharmacist and after the pharmacist has reviewed the prescriber's order and the patient's profile for potential contraindications and adverse drug reactions.

(2) Drugs that a prescriber has ordered for a patient on an as-needed basis, if the utilization and retrieval of those drugs are subject to ongoing review by a pharmacist.

(3) Drugs designed by the patient care policy committee or pharmaceutical service committee of the facility as emergency drugs or acute onset drugs. These drugs may be retrieved from an automated drug delivery system pursuant to the order of a prescriber for emergency or immediate administration to a patient of the facility. Within 48 hours after retrieval under this paragraph, the case shall be reviewed by a pharmacist.

(f) When used to provide pharmacy services pursuant to Section 4017.3 of, and Article 25 (commencing with Section 4427) of Chapter 9 of Division 2 of, the Business and Professions Code, the automated drug delivery system shall be subject to all of the following requirements:

(1) Drugs removed from the automated drug delivery system for administration to a patient shall be in properly labeled units of administration containers or packages.

(2) A pharmacist shall review and approve all orders prior to a drug being removed from the automated drug delivery system for administration to a patient. The pharmacist shall review the prescriber's order and the patient's profile for potential contraindications and adverse drug reactions.

(3) The pharmacy providing services to the facility pursuant to Article 25 (commencing with Section 4427) of Chapter 9 of Division 2 of the Business and Professions Code shall control access to the drugs stored in the automated drug delivery system.

(4) Access to the automated drug delivery system shall be controlled and tracked using an identification or password system or biosensor.

(5) The automated drug delivery system shall make a complete and accurate record of all transactions that will include all users accessing the system and all drugs added to, or removed from, the system.

(6) After the pharmacist reviews the prescriber's order, access by licensed personnel to the automated drug delivery system shall be limited only to drugs ordered by the prescriber and reviewed by the pharmacist and that are specific to the patient. When the prescriber's order requires a dosage variation of the same drug, licensed personnel shall have access to the drug ordered for that scheduled time of administration.

(7) (A) Systems that allow licensed personnel to have access to multiple drugs and are not patient specific in their design, shall be allowed under this subdivision if those systems have electronic and mechanical safeguards in place to ensure that the drugs delivered to the patient are specific to that patient. Each facility using such an automated drug delivery system shall notify the department in writing prior to the utilization of the system. The notification submitted to the department pursuant to this paragraph shall include, but is not limited to, information regarding system design, personnel with system access, and policies and procedures covering staff training, storage, and security, and the facility's administration of these types of systems.

(B) As part of its routine oversight of these facilities, the department shall review a facility's medication training, storage, and security, and its administration procedures related to its use of an automated drug delivery system to ensure that adequate staff training and safeguards are in place to make sure that the drugs delivered are appropriate for the patient. If the department determines that a facility is not in compliance with this section, the department may revoke its authorization to use automated drug delivery systems granted under subparagraph (A).

(g) The stocking of an automated drug delivery system shall be performed by a pharmacist. If the automated drug delivery system utilizes removable pockets, cards, drawers, similar technology, or unit of use or single dose containers as defined by the United States Pharmacopoeia, the stocking system may be done outside of the facility and be delivered to the facility if all of the following conditions are met:

(1) The task of placing drugs into the removable pockets, cards, drawers, or unit of use or single dose containers is performed by a pharmacist, or by an intern pharmacist or a pharmacy technician working under the direct supervision of a pharmacist.

(2) The removable pockets, cards, drawers, or unit of use or single dose containers are transported between the pharmacy and the facility in a secure tamper-evident container.

(3) The facility, in conjunction with the pharmacy, has developed policies and procedures to ensure that the removable pockets, cards, drawers, or unit of use or single dose containers are properly placed into the automated drug delivery system.

(h) Review of the drugs contained within, and the operation and maintenance of, the automated drug delivery system shall be done in accordance with law and shall be the responsibility of the pharmacy. The review shall be conducted on a monthly basis by a pharmacist and shall include a physical inspection of the drugs in the automated drug delivery system, an inspection of the automated drug delivery system machine for cleanliness, and a review of all transaction records in order to verify the security and accountability of the system.

(i) Drugs dispensed from an automated drug delivery system that meets the requirements of this section shall not be subject to the labeling requirements of Section 4076 of the Business and Professions Code or Section 111480 of this code if the drugs to be placed into the automated drug delivery system are in unit dose packaging or unit of use and if the information required by Section 4076 of the Business and Professions Code and Section 111480 of this code is readily available at the time of drug administration. For purposes of this section, unit dose packaging includes blister pack cards.

(j) This section shall become operative on July 1, 2019.

(Amended by Stats. 2022, Ch. 111, Sec. 1. (AB 1852) Effective January 1, 2023.)

1262. (a) When a mental health patient is being discharged from one of the facilities specified in subdivision (c), the patient and the patient's conservator, guardian, or other legally authorized representative, as applicable, shall be given a written aftercare plan prior to the patient's discharge from the facility. The written aftercare plan shall include, to the extent known, all of the following components:

(1) The nature of the illness and followup required.

(2) Medications including side effects and dosage schedules. If the patient was given an informed consent form with their medications, the form shall satisfy the requirement for information on side effects of the medications.

(3) Expected course of recovery.

(4) Recommendations regarding treatment that are relevant to the patient's care.

(5) Referrals to providers of medical and mental health services.

(6) Other relevant information.

(b) The patient shall be advised by facility personnel that they may designate another person to receive a copy of the aftercare plan. A copy of the aftercare plan shall be given to any person designated by the patient.

(c) Subdivision (a) applies to all of the following facilities:

(1) A state mental hospital.

(2) A general acute care hospital as described in subdivision (a) of Section 1250.

(3) An acute psychiatric hospital as described in subdivision (b) of Section 1250.

(4) A psychiatric health facility as described in Section 1250.2.

(5) A mental health rehabilitation center as described in Section 5675 of the Welfare and Institutions Code.

(6) A skilled nursing facility with a special treatment program, as described in Section 51335 and Sections 72443 to 72475, inclusive, of Title 22 of the California Code of Regulations.

(7) A psychiatric residential treatment facility as described in Section 1250.10.

(d) For purposes of this section, "mental health patient" means a person who is admitted to the facility primarily for the diagnosis or treatment of a mental disorder.

(Amended by Stats. 2022, Ch. 589, Sec. 5. (AB 2317) Effective January 1, 2023.)

1262.4. (a) No hospital, as defined in subdivisions (a), (b), and (f) of Section 1250, may cause the transfer of homeless patients from one county to another county for the purpose of receiving supportive services from a social services agency, health care service provider, or nonprofit social services provider within the other county, without prior notification to, and authorization from, the social services agency, health care service provider, or nonprofit social services provider.

(b) For purposes of this section, "homeless patient" means an individual who lacks a fixed and regular nighttime residence, or who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations, or who is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.

(Amended by Stats. 2007, Ch. 130, Sec. 152. Effective January 1, 2008.)

1262.5. (a) Each hospital shall have a written discharge planning policy and process.

(b) The policy required by subdivision (a) shall require that appropriate arrangements for posthospital care, including, but not limited to, care at home, in a skilled nursing or intermediate care facility, or from a hospice, are made prior to discharge for those patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. If the hospital determines that the patient and family members or interested persons need to be counseled to prepare them for posthospital care, the hospital shall provide for that counseling.

(c) As part of the discharge planning process, the hospital shall provide each patient who has been admitted to the hospital as an inpatient with an opportunity to identify one family caregiver who may assist in posthospital care, and shall record this information in the patient's medical chart.

(1) In the event that the patient is unconscious or otherwise incapacitated upon admittance to the hospital, the hospital shall provide the patient or patient's legal guardian with an opportunity to designate a caregiver within a specified time period, at the discretion of the attending physician, following the patient's recovery of consciousness or capacity. The hospital shall promptly document the attempt in the patient's medical record.

(2) In the event that the patient or legal guardian declines to designate a caregiver pursuant to this section, the hospital shall promptly document this declination in the patient's medical record, when appropriate.

(d) The policy required by subdivision (a) shall require that the patient's designated family caregiver be notified of the patient's discharge or transfer to another facility as soon as possible and, in any event, upon issuance of a discharge order by the patient's attending physician. If the hospital is unable to contact the designated caregiver, the lack of contact shall not interfere with, delay, or otherwise affect the medical care provided to the patient or an appropriate discharge of the patient. The hospital shall promptly document the attempted notification in the patient's medical record.

(e) The process required by subdivision (a) shall require that the patient and family caregiver be informed of the continuing health care requirements following discharge from the hospital. The right to information regarding continuing health care requirements following discharge shall also apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient, if the patient is unable to make those decisions for himself or herself. The hospital shall provide an opportunity for the patient and his or her designated family caregiver to engage in the discharge planning process, which shall include providing information and, when appropriate, instruction regarding the posthospital care needs of the patient. This information shall include, but is not limited to, education and counseling about the patient's medications, including dosing and proper use of medication delivery devices, when applicable. The information shall be provided in a culturally competent manner and in a language that is comprehensible to the patient and caregiver, consistent with the requirements of state and federal law, and shall include an opportunity for the caregiver to ask questions about the posthospital care needs of the patient.

(f) (1) A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of the hospital. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan, and shall be signed by the physician.

(2) A copy of the transfer summary shall be given to the patient and the patient's legal representative, if any, prior to transfer to a skilled nursing or intermediate care facility.

(g) A hospital shall establish and implement a written policy to ensure that each patient receives, at the time of discharge, information regarding each medication dispensed, pursuant to Section 4074 of the Business and Professions Code.

(h) A hospital shall provide every patient anticipated to be in need of long-term care at the time of discharge with contact information for at least one public or nonprofit agency or organization dedicated to providing information or referral services relating to community-based long-term care options in the patient's county of residence and appropriate to the needs and characteristics of the patient. At a minimum, this information shall include contact information for the area agency on aging serving the patient's county of residence, local independent living centers, or other information appropriate to the needs and characteristics of the patient.

(i) A contract between a general acute care hospital and a health care service plan that is issued, amended, renewed, or delivered on or after January 1, 2002, shall not contain a provision that prohibits or restricts any health care facility's compliance with the requirements of this section.

(j) Discharge planning policies adopted by a hospital in accordance with this section shall ensure that planning is appropriate to the condition of the patient being discharged from the hospital and to the discharge destination and meets the needs and acuity of patients.

(k) This section does not require a hospital to do any of the following:

(1) Adopt a policy that would delay discharge or transfer of a patient.

(2) Disclose information if the patient has not provided consent that meets the standards required by state and federal laws governing the privacy and security of protected health information.

(3) Comply with the requirements of this section in an area of the hospital where clinical care is provided, unless medically indicated.

(l) This section does not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

(m) For the purposes of this section, “family caregiver” means a relative, friend, or neighbor who provides assistance related to an underlying physical or mental disability but who is unpaid for those services.

(n) (1) Each hospital, as defined in subdivisions (a), (b), and (f) of Section 1250, shall include within its hospital discharge policy a written homeless patient discharge planning policy and process.

(2) The policy shall require a hospital to inquire about a patient’s housing status during the discharge planning process. Housing status may not be used to discriminate against a patient or prevent medically necessary care or hospital admission.

(3) The policy shall require an individual discharge plan for a homeless patient that helps prepare the homeless patient for return to the community by connecting him or her with available community resources, treatment, shelter, and other supportive services. The discharge planning shall be guided by the best interests of the homeless patient, his or her physical and mental condition, and the homeless patient’s preferences for placement. The homeless patient shall be informed of available placement options.

(4) Unless the homeless patient is being transferred to another licensed health facility, the policy shall require the hospital to identify a postdischarge destination for the homeless patient as follows, with priority given to identifying a sheltered destination with supportive services:

(A) A social services agency, nonprofit social services provider, or governmental service provider that has agreed to accept the homeless patient, if he or she has agreed to the placement. Notwithstanding paragraph (2) of subdivision (k) and subdivision (l), the hospital shall provide potential receiving agencies or providers written or electronic information about the homeless patient’s known posthospital health and behavioral health care needs and shall document the name of the person at the agency or provider who agreed to accept the homeless patient.

(B) The homeless patient’s residence. In the case of a homeless patient, “residence” for the purposes of this subparagraph means the location identified to the hospital by the homeless patient as his or her principal dwelling place.

(C) An alternative destination, as indicated by the homeless patient pursuant to the discharge planning process described in paragraph (3). The hospital shall document the destination indicated by the homeless patient or his or her representative.

(5) The policy shall require that information regarding discharge or transfer be provided to the homeless patient in a culturally competent manner and in a language that is understood by the homeless patient.

(o) The hospital shall document all of the following prior to discharging a homeless patient:

(1) The treating physician has determined the homeless patient’s clinical stability for discharge, including, but not limited to, an assessment as to whether the patient is alert and oriented to person, place, and time, and the physician or designee has communicated postdischarge medical needs to the homeless patient.

(2) The homeless patient has been offered a meal, unless medically indicated otherwise.

(3) If the homeless patient’s clothing is inadequate, the hospital shall offer the homeless patient weather-appropriate clothing.

(4) The homeless patient has been referred to a source of followup care, if medically necessary.

(5) The homeless patient has been provided with a prescription, if needed, and, for a hospital with an onsite pharmacy licensed and staffed to dispense outpatient medication, an appropriate supply of all necessary medication, if available.

(6) The homeless patient has been offered or referred to screening for infectious disease common to the region, as determined by the local health department.

(7) The homeless patient has been offered vaccinations appropriate to the homeless patient’s presenting medical condition.

(8) The treating physician has provided a medical screening examination and evaluation. If the treating physician determines that the results of the medical screening examination and evaluation indicate that followup behavioral health care is needed, the homeless patient shall be treated or referred to an appropriate provider. The hospital shall make a good faith effort to contact one of the following, if applicable:

(A) The homeless patient's health plan, if the homeless patient is enrolled in a health plan.

(B) The homeless patient's primary care provider, if the patient has identified one.

(C) Another appropriate provider, including, but not limited to, the coordinated entry system.

(9) The homeless patient has been screened for, and provided assistance to enroll in, any affordable health insurance coverage for which he or she is eligible.

(10) The hospital has offered the homeless patient transportation after discharge to the destination identified in paragraph (4) of subdivision (n), if that destination is within a maximum travel time of 30 minutes or a maximum travel distance of 30 miles of the hospital. This requirement shall not be construed to prevent a hospital from offering transportation to a more distant destination.

(p) A hospital shall develop a written plan for coordinating services and referrals for homeless patients with the county behavioral health agency, health care and social services agencies in the region, health care providers, and nonprofit social services providers, as available, to assist with ensuring appropriate homeless patient discharge. The plan shall be updated annually and shall include all of the following:

(1) A list of local homeless shelters, including their hours of operation, admission procedures and requirements, client population served, and general scope of medical and behavioral health services available.

(2) The hospital's procedures for homeless patient discharge referrals to shelter, medical care, and behavioral health care.

(3) The contact information for the homeless shelter's intake coordinator.

(4) Training protocols for discharge planning staff.

(q) Each hospital shall maintain a log of homeless patients discharged and the destinations to which they were released after discharge pursuant to paragraph (10) of subdivision (o), if any. The hospital shall maintain evidence of completion of the homeless patient discharge protocol in the log or in the patient's medical record.

(r) For purposes of this section, "homeless patient" has the same meaning as provided in Section 1262.4.

(s) It is the intent of the Legislature that nothing in this section shall be construed to preempt, limit, prohibit, or otherwise affect, the adoption, implementation, or enforcement of local ordinances, codes, regulations, or orders related to the homeless patient discharge processes, except to the extent that any such provision of law is inconsistent with the provisions of this section, and then only to the extent of the inconsistency. A local ordinance, code, regulation, or order is not deemed inconsistent with this section if it affords greater protection to homeless patients than the requirements set forth in this section. Where local ordinances, codes, regulations, or orders duplicate or supplement this section, this section shall be construed as providing alternative remedies and shall not be construed to preempt the field.

(t) Nothing in this section alters the health and social service obligations described in Section 17000 of the Welfare and Institutions Code.

(u) Subdivisions (n) to (t), inclusive, do not apply to the state hospitals under the jurisdiction of the State Department of State Hospitals, as specified in Sections 4100 and 7200 of the Welfare and Institutions Code.

(v) This section shall become operative on July 1, 2019.

(Repealed and added by Stats. 2018, Ch. 981, Sec. 2. (SB 1152) Effective January 1, 2019. Section operative July 1, 2019, by its own provisions.)

1262.6. (a) Each hospital shall provide each patient, upon admission or as soon thereafter as reasonably practical, written information regarding the patient's right to the following:

(1) To be informed of continuing health care requirements following discharge from the hospital.

(2) To be informed that, if the patient so authorizes, that a friend or family member may be provided information about the patient's continuing health care requirements following discharge from the hospital.

(3) Participate actively in decisions regarding medical care. To the extent permitted by law, participation shall include the right to refuse treatment.

(4) Appropriate pain assessment and treatment consistent with Sections 124960 and 124961.

(5) To be free of discrimination on the basis of race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language, or immigration status as set forth in Section 51 of the Civil Code.

(6) Information on how to file a complaint with the following:

(A) The State Department of Public Health, in accordance with Section 1288.4.

(B) The Civil Rights Department.

(C) The Medical Board of California.

(b) A hospital may include the information required by this section with other notices to the patient regarding patient rights. If a hospital chooses to include this information along with existing notices to the patient regarding patient rights, any newly required information shall be provided when the hospital exhausts its existing inventory of written materials and prints new written materials.

(Amended by Stats. 2022, Ch. 48, Sec. 55. (SB 189) Effective June 30, 2022.)

1262.7. (a) A skilled nursing facility, as defined in subdivision (c) of Section 1250, shall admit a patient only upon a physician's order and only if the facility is able to provide necessary care for the patient.

(b) The administrator or designee of a skilled nursing facility shall be responsible for screening patients for admission to the facility to ensure that the facility admits only those patients for whom it can provide necessary care. The administrator, or his or her designee, shall conduct preadmission personal interviews as appropriate with the patient's physician, the patient, the patient's next of kin or sponsor, or the representative of the facility from which the patient is being transferred. A telephone interview may be conducted when a personal interview is not feasible.

(Added by Stats. 2001, Ch. 691, Sec. 4. Effective January 1, 2002.)

1262.8. (a) A noncontracting hospital shall not bill a patient who is an enrollee of a health care service plan for poststabilization care, except for applicable copayments, coinsurance, and deductibles, unless one of the following conditions are met:

(1) The patient or the patient's spouse or legal guardian refuses to consent, pursuant to subdivision (f), for the patient to be transferred to the contracting hospital as requested and arranged for by the patient's health care service plan.

(2) The hospital is unable to obtain the name and contact information of the patient's health care service plan as provided in subdivision (c).

(b) If a patient with an emergency medical condition, as defined by Section 1317.1, is covered by a health care service plan that requires prior authorization for poststabilization care, a noncontracting hospital, except as provided in subdivision (n), shall, prior to providing poststabilization care, do all of the following once the emergency medical condition has been stabilized, as defined by Section 1317.1:

(1) Seek to obtain the name and contact information of the patient's health care service plan. The hospital shall document its attempt to ascertain this information in the patient's medical record, which shall include requesting the patient's health care service plan member card or asking the patient, or a family member or other person accompanying the patient, if he or she can identify the patient's health care service plan, or any other means known to the hospital for accurately identifying the patient's health care service plan.

(2) Contact the patient's health care service plan, or the health plan's contracting medical provider, for authorization to provide poststabilization care, if identification of the plan was obtained pursuant to paragraph (1).

(A) The hospital shall make the contact described in this subparagraph by either following the instructions on the patient's health care service plan member card or using the contact information provided by the patient's health care service plan pursuant to subdivision (j) or (k).

(B) A representative of the hospital shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the hospital upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the hospital who makes the telephone call may be, but is not required to be, a physician and surgeon.

(3) Upon request of the patient's health care service plan, or the health plan's contracting medical provider, provide to the plan, or its contracting medical provider, the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary for the health care service plan or the plan's contracting medical provider to make a decision to authorize poststabilization care or to assume management of the patient's care by prompt transfer.

(c) A noncontracting hospital that is not able to obtain the name and contact information of the patient's health care service plan pursuant to subdivision (b) is not subject to the requirements of this section.

(d) (1) A health care service plan, or its contracting medical provider, that is contacted by a noncontracting hospital pursuant to paragraph (2) of subdivision (b), shall, within 30 minutes from the time the noncontracting hospital makes the initial contact, do either of the following:

(A) Authorize poststabilization care.

(B) Inform the noncontracting hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

(2) If the health care service plan, or its contracting medical provider, does not notify the noncontracting hospital of its decision pursuant to paragraph (1) within 30 minutes, the poststabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay charges for the care, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) and any regulation adopted thereunder.

(3) If the health care service plan, or its contracting medical provider, notified the noncontracting hospital that it would assume management of the patient's care by prompt transfer, but either the health care service plan or its contracting medical provider fails to transfer the patient within a reasonable time, the poststabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay charges, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and any regulation adopted thereunder, for the care until the enrollee is transferred.

(4) If the health care service plan, or its contracting medical provider, provides authorization to the noncontracting hospital for specified poststabilization care and services, the health care service plan, or its contracting medical provider, shall be responsible to pay for that authorized care.

(e) If a health care service plan, or its contracting medical provider, decides to assume management of the patient's care by prompt transfer, the health care service plan, or its contracting medical provider, shall do all of the following:

(1) Arrange and pay the reasonable charges associated with the transfer of the patient.

(2) Pay for all of the immediately required medically necessary care rendered to the patient prior to the transfer in order to maintain the patient's clinical stability.

(3) Be responsible for making all arrangements for the patient's transfer, including, but not limited to, finding a contracted facility available for the transfer of the patient.

(f) (1) If the patient, or the patient's spouse or legal guardian refuses to consent to the patient's transfer under subdivision (e), the noncontracting hospital shall promptly provide a written notice to the patient or the patient's spouse or legal guardian indicating that the patient will be financially responsible for any further poststabilization care provided by the hospital.

(2) For patients whose primary language is one of the Medi-Cal threshold languages, the notice shall be delivered to them in their primary language.

(3) The Department of Managed Health Care shall translate the notice required by this subdivision in all Medi-Cal threshold languages and make the translations available to the hospitals subject to this section.

(4) The written notice provided pursuant to this subdivision shall include the following statement:

THIS NOTICE MUST BE PROVIDED TO YOU UNDER CALIFORNIA LAW

"You have received emergency care at a hospital that is not a part of your health plan's provider network. Under state law, emergency care must be paid by your health plan no matter where you get that care. The doctor who is caring for you has decided that you may be safely moved to another hospital for the additional care you need. Because you no longer need emergency care, your health plan has not authorized further care at this hospital. Your health plan has arranged for you to be moved to a hospital that is in your health plan's provider network.

If you agree to be moved, your health plan will pay for your care at that hospital. You will only have to pay for your deductible, copayments, or coinsurance for care. You will not have to pay for your deductible, copayments, or coinsurance for transportation costs to another hospital that is covered by your health plan.

IF YOU CHOOSE TO STAY AT THIS HOSPITAL FOR YOUR ADDITIONAL CARE, YOU WILL HAVE TO PAY THE FULL COST OF CARE NOW THAT YOU NO LONGER NEED EMERGENCY CARE. This cost may include the cost of the doctor or doctors, the hospital, and any laboratory, radiology, or other services that you receive.

If you do not think you can be safely moved, talk to the doctor about your concerns. If you would like additional help, you may contact:

Your health plan member services department. Look on your health plan member card for that phone number. You can file a grievance with your plan.

The HMO Helpline at 888-HMO-2219. The HMO Helpline is available 24 hours a day, 7 days a week. The HMO Helpline can work with your health plan to address your concerns, but you may still have to pay the full cost of care at this hospital if you stay."

(5) The hospital shall give one copy of the written notice required by this subdivision to the patient, or the patient's spouse or legal guardian, for signature and may retain a copy in the patient's medical record.

(6) The hospital shall ensure prompt delivery of the notice to the patient or his or her spouse or legal guardian. The hospital shall obtain signed acceptance of the written notice required by this subdivision, and signed acceptance of any other documents the hospital requires for any further poststabilization care, from the patient or the patient's spouse or legal guardian, and shall provide the health care service plan, or its contracting medical provider, with confirmation of the patient's, or his or her spouse or legal guardian's, receipt of the written notice.

(7) If the noncontracting hospital fails to meet the requirements of this subdivision, the hospital shall not bill the patient or the patient's health care service plan, or its contracting medical provider, for poststabilization care provided to the patient.

(8) If the patient, or the patient's spouse or legal guardian, refuses to sign the notice, the noncontracting hospital shall document in the patient's medical record that the notice was provided and signature was refused. Upon the patient's refusal to sign, the patient shall assume financial responsibility for any further poststabilization care provided by the hospital.

(9) The Department of Managed Health Care may, by regulation, modify the wording of the notice required under this subdivision for clarity, readability, and accuracy of the information provided.

(10) The Department of Managed Health Care may, in conjunction with consumer groups, health care service plans, and hospitals, modify the wording of the notice to include language regarding Medicare beneficiaries, if appropriate under Medicare rules. The initial modification shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340, et. seq.) of Part 1 of Division 3 of Title 2 of the Government Code).

(g) If poststabilization care has been authorized by the health care service plan, the noncontracting hospital shall request the patient's medical record from the patient's health care service plan or its contracting medical provider.

(h) The health care service plan, or its contracting medical provider, shall, upon conferring with the noncontracting hospital, transmit any appropriate portion of the patient's medical record, if the records are in the plan's possession, via facsimile transmission or electronic mail, whichever method is requested by the noncontracting hospital's representative or the noncontracting physician and surgeon. The health care service plan, or its contracting medical provider, shall transmit the patient's medical record in a manner that complies with all legal requirements to protect the patient's privacy.

(i) A health care service plan, or its contracting medical provider, that requires prior authorization for poststabilization care shall provide 24-hour access for patients and providers, including noncontracting hospitals, to obtain timely authorization for medically necessary poststabilization care.

(j) A health care service plan shall provide all noncontracting hospitals in the state with specific contact information needed to make the contact required by this section. The contact information provided to hospitals shall be updated as necessary, but no less than once a year.

(k) In addition to meeting the requirements of subdivision (j), a health care service plan shall provide the contact information described in subdivision (j) to the Department of Managed Health Care. The contact information provided pursuant to this subdivision shall be updated as necessary, but no less than once a year. The receiving department shall post this contact information on its Internet Web site no later than January 1 of each calendar year.

(l) This section shall only apply to a noncontracting hospital.

(m) For purposes of this section, the following definitions shall apply:

(1) "Health care service plan" means a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 that covers hospital, medical, or surgical expenses.

(2) "Noncontracting hospital" means a general acute care hospital, as defined in subdivision (a) of Section 1250 or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that does not have a written contract with the patient's health care service plan to provide health care services to the patient.

(3) "Poststabilization care" means medically necessary care provided after an emergency medical condition has been stabilized, as defined by subdivision (j) of Section 1317.1.

(4) "Contracting medical provider" means a medical group, independent practice association, or any other similar organization that, pursuant to a signed written contract, has agreed to accept responsibility for provision or reimbursement of a noncontracting

hospital for emergency and poststabilization services provided to a health plan's enrollees.

(n) Subdivisions (b) to (h), inclusive, shall not apply to minor treatment procedures, if all of the following apply:

(1) The procedure is provided in the treatment area of the emergency department.

(2) The procedure concludes the treatment of the presenting emergency medical condition of a patient and is related to that condition, even though the treatment may not resolve the underlying medical condition.

(3) The procedure is performed according to accepted standards of practice.

(4) The procedure would result in the direct discharge or release of the patient from the emergency department following this care.

(o) Nothing in this section is intended to prevent a health care service plan or its contracting medical provider from assuming management of the patient's care at any time after the initial provision of poststabilization care by the noncontracting hospital before the patient has been discharged. Upon the request of the health care service plan or its contracting medical provider, the noncontracting hospital shall provide the health care service plan or its contracting medical provider with any information specified in paragraph (3) of subdivision (b).

(p) Nothing in this section shall authorize a provider of health care services to bill a Medi-Cal beneficiary enrolled in a Medi-Cal managed care plan or otherwise alter the provisions of subdivision (a) of Section 14019.3 of the Welfare and Institutions Code.

(Repealed and added by Stats. 2008, Ch. 603, Sec. 2. Effective January 1, 2009.)

1263. (a) This section shall be known and may be cited as the Dementia Training Standards Act of 2001.

(b) (1) Any certified nurse assistant employed by a skilled nursing facility or intermediate care facility shall have completed at least two hours of initial dementia-specific training as part of the facility's orientation program. The training shall be completed within the first 40 hours of employment.

(2) The facility shall develop a dementia-specific training component within the existing orientation program, to be implemented no later than July 1, 2002.

(3) The facility's modified orientation program shall be reviewed by the department in a phasein schedule that begins no later than July 1, 2002, and is completed no later than July 1, 2005.

(c) Any certified nursing assistant employed by a skilled nursing facility or intermediate care facility shall participate in a minimum of five hours of dementia-specific in-service training per year, as part of the facility's in-service training.

(d) Freestanding and hospital-based pediatric skilled nursing facilities with exclusively pediatric occupancy shall be exempt from the requirements set forth in this section.

(Added by Stats. 2001, Ch. 339, Sec. 1. Effective January 1, 2002.)

1264. (a) Any health facility licensed under Section 1250 that provides prenatal screening ultrasound to detect congenital heart defects shall require that the ultrasound be performed by a sonographer who is nationally certified in obstetrical ultrasound by the American Registry for Diagnostic Medical Sonography (ARDMS), nationally certified in cardiac sonography by Cardiovascular Credentialing International (CCI), or credentialed in sonography by the American Registry of Radiologic Technologists (ARRT).

(b) For purposes of this section, the following shall apply:

(1) A sonographer is also known as an "ultrasound technologist" or "sonologist."

(2) "Sonographer" means any nonphysician who is qualified by national certification or academic or clinical experience to perform diagnostic medical ultrasound, with a subspecialty in obstetrical ultrasound.

(c) (1) Any sonographer who is certified as required in subdivision (a) or otherwise meets the requirements of this section, shall, in performing a prenatal ultrasound to detect congenital heart defects, perform the work under the supervision of a licensed physician and surgeon.

(2) For purposes of this section, licensed physician and surgeon means any physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(d) Any person with a minimum of two years of full-time work experience in this state as a sonographer in prenatal ultrasound and has obtained, or is in the process of obtaining, 30 continuing medical education credits over a three-year period in ultrasound shall be deemed to be in compliance with the requirements of this section.

(e) A health facility shall develop policies and procedures to implement the requirements of this section.

(f) This section and policies and procedures adopted pursuant to this section shall not prohibit any physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code from performing a prenatal ultrasound nor in any other way limit the ability of a licensed physician and surgeon to practice medicine in a manner consistent with that license.

(g) This section and policies and procedures adopted pursuant to this section shall not apply to any physician and surgeon, sonologist, certified nurse-midwife, or nurse practitioner who performs limited prenatal ultrasounds for the purpose of obtaining an amniotic fluid index, fetal position, a biophysical profile or dating a pregnancy prior to 20 weeks gestation.

(h) Article 4 (commencing with Section 1235) and any other provision relating to criminal sanctions for violations of this chapter shall not apply to any person who violates this section or any regulation adopted pursuant to this section.

(i) This section shall become operative on July 1, 2006.

(Added by Stats. 2004, Ch. 770, Sec. 2. Effective January 1, 2005. Section operative July 1, 2006, by its own provisions.)