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 Health Facilities [1250 - 1339.59] *(Chapter 2 repealed and added by Stats. 1973, Ch. 1202.)*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 3. Regulations [1275 - 1289.5] *(Article 3 added by Stats. 1973, Ch. 1202.)*

1275. (a) (1) The department shall adopt, amend, or repeal, in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code and Chapter 4 (commencing with Section 18935) of Part 2.5 of Division 13, any reasonable rules and regulations as may be necessary or proper to carry out the purposes and intent of this chapter and to enable the state department to exercise the powers and perform the duties conferred upon it by this chapter, not inconsistent with any other law including, but not limited to, the California Building Standards Law, Part 2.5 (commencing with Section 18901) of Division 13.

(2) All regulations in effect on December 31, 1973, which were adopted by the State Board of Public Health, the State Department of Public Health, the State Department of Mental Hygiene, or the State Department of Health relating to licensed health facilities shall remain in full force and effect until altered, amended, or repealed by the director or pursuant to Section 25 or other provisions of law.

(b) Notwithstanding this section or any other law, the Office of Statewide Health Planning and Development shall adopt and enforce regulations prescribing building standards for the adequacy and safety of health facility physical plants.

(c) The building standards adopted by the State Fire Marshal, and the Office of Statewide Health Planning and Development pursuant to subdivision (b), for the adequacy and safety of freestanding physical plants housing outpatient services of a health facility licensed under subdivision (a) or (b) of Section 1250 shall not be more restrictive or comprehensive than the comparable building standards established, or otherwise made applicable, by the State Fire Marshal and the Office of Statewide Health Planning and Development to clinics and other facilities licensed pursuant to Chapter 1 (commencing with Section 1200).

(d) Except as provided in subdivision (f), the licensing standards adopted by the department under subdivision (a) for outpatient services located in a freestanding physical plant of a health facility licensed under subdivision (a) or (b) of Section 1250 shall not be more restrictive or comprehensive than the comparable licensing standards applied by the department to clinics and other facilities licensed under Chapter 1 (commencing with Section 1200).

(e) Except as provided in subdivision (f), the state agencies specified in subdivisions (c) and (d) shall not enforce any standard applicable to outpatient services located in a freestanding physical plant of a health facility licensed pursuant to subdivision (a) or (b) of Section 1250, to the extent that the standard is more restrictive or comprehensive than the comparable licensing standards applied to clinics and other facilities licensed under Chapter 1 (commencing with Section 1200).

(f) All health care professionals providing services in settings authorized by this section shall be members of the organized medical staff of the health facility to the extent medical staff membership would be required for the provision of the services within the health facility. All services shall be provided under the respective responsibilities of the governing body and medical staff of the health facility.

(g) (1) 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, update references in the California Code of Regulations to health care standards of practice adopted by a recognized state or national association when the state or national association and its outdated standards are already named in the California Code of Regulations. When updating these references, the department shall:

(A) Post notice of the department's proposed adoption of the state or national association's health care standards of practice on its Internet Web site for at least 45 days. The notice shall include the name of the state or national association, the title of the health care standards of practice, and the version of the updated health care standards of practice to be adopted.

(B) Notify stakeholders that the proposed standards have been posted on the department's Internet Web site by issuing a mailing to the most recent stakeholder list on file with the department's Office of Regulations.

(C) Submit to the Office of Administrative Law the notice required pursuant to this paragraph. The office shall publish in the California Regulatory Notice Register any notice received pursuant to this subparagraph.

(D) Accept public comment for at least 30 days after the conclusion of the 45-day posting period specified in subparagraph (A).

(2) If a member of the public requests a public hearing during the public comment period, a hearing shall be held and comments shall be considered prior to the adoption of the state or national association's health care standards of practice.

(3) If no member of the public requests a public hearing, the department shall consider any comments received during the public comment period prior to the adoption of the health care standards.

(4) Written responses to public comments shall not be required. If public comments are submitted in opposition to the adoption of the proposed standards, or the state or national association named in the California Code of Regulations no longer exists, the department shall seek adoption of the standards using the regulatory process specified in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. A state or national association named in the California Code of Regulations that has changed its name does not constitute an association that no longer exists.

(5) If no opposition is received by the department, the department shall update its Internet Web site to notify the public that the standard has been adopted and the effective date of that standard.

(h) For purposes of this section, "freestanding physical plant" means any building which is not physically attached to a building in which inpatient services are provided.

(Amended by Stats. 2015, Ch. 435, Sec. 2. (AB 614) Effective January 1, 2016.)

1275.1. (a) Notwithstanding any rules or regulations governing other health facilities, the regulations developed by the State Department of Health Care Services, or a predecessor, for psychiatric health facilities shall prevail. The regulations applying to psychiatric health facilities shall prescribe standards of adequacy, safety, and sanitation of the physical plant, of staffing with duly qualified licensed personnel, and of services based on the needs of the persons served thereby.

(b) (1) The regulations shall include standards appropriate for treatment of three levels of disorder:

(A) Involuntary ambulatory patients receiving treatment for a mental health disorder.

(B) Voluntary ambulatory patients receiving treatment for a mental health disorder.

(C) Involuntary ambulatory patients receiving treatment for a severe substance use disorder, as defined in subdivision (o) of Section 5008 of the Welfare and Institutions Code.

(2) For purposes of this subdivision, "ambulatory patients" shall include, but not be limited to, persons who are deaf, blind, or have physical disabilities. Disoriented persons who are not bedridden or wheelchair users shall also be considered ambulatory patients.

(c) The regulations shall not require, but may permit building and services requirements for hospitals which are only applicable to physical health care needs of patients that can be met in an affiliated hospital or in outpatient settings including, but not limited to, such requirements as surgical, dietary, laboratory, laundry, central supply, radiologic, and pharmacy.

(d) The regulations shall include provisions for an "open planning" architectural concept.

(e) The regulations shall exempt from seismic requirements all structures of Type V and of one-story construction.

(f) Standards for involuntary patients shall include provisions to allow for restraint and seclusion of patients. These standards shall provide for adequate safeguards for patient safety and protection of patient rights.

(g) The regulations shall provide for the retention by the psychiatric health facility of a consultant pharmacist, who shall supervise and review pharmaceutical services within the facility and perform any other services, including prevention of the unlawful diversion of controlled substances subject to abuse, as the State Department of Health Care Services may by regulation require. Regulations adopted pursuant to this subdivision shall take into consideration the varying bed sizes of psychiatric health facilities.

(Amended by Stats. 2024, Ch. 644, Sec. 2. (SB 1238) Effective January 1, 2025.)

1275.2. (a) Notwithstanding any rules or regulations governing other health facilities, the regulations adopted by the state department for chemical dependency recovery hospitals shall prevail. The regulations applying to chemical dependency recovery hospitals shall prescribe standards of adequacy, safety, and sanitation of the physical plant, of staffing with duly qualified personnel, and of services based on the needs of the persons served thereby.

(b) The regulations shall include provisions for an “open planning” architectural concept.

(c) Notwithstanding the provisions of Chapter 1 (commencing with Section 15000) of Division 12.5, the regulations shall exempt from seismic requirements all freestanding structures of a chemical dependency recovery hospital. Chemical dependency recovery services provided as a supplemental service in general acute care beds or general acute psychiatric beds shall not be exempt from seismic requirements.

(d) Regulations shall be developed pursuant to this section and presented for adoption at a public hearing within 180 days of the effective date of this section.

(e) In order to assist in the rapid development of regulations for chemical dependency recovery hospitals, the director of the state department, not later than 30 days after the effective date of this section, shall convene an advisory committee composed of two representatives of the State Department of Health Care Services, one representative of the Office of Statewide Health Planning and Development, two persons with experience operating facilities with alcohol or medicinal drug dependency programs, and any other persons having a professional or personal nonfinancial interest in development of such regulations. The members of such advisory committee who are not state officers or employees shall pay their own expenses related to participation on the committee. The committee shall meet at the call of the director until such time as the proposed regulations are presented for adoption at public hearing.

(Amended by Stats. 2013, Ch. 22, Sec. 14. (AB 75) Effective June 27, 2013. Operative July 1, 2013, by Sec. 110 of Ch. 22.)

1275.3. (a) The State Department of Public Health and the State Department of Developmental Services shall jointly develop and implement licensing regulations appropriate for an intermediate care facility/developmentally disabled-nursing and an intermediate care facility/developmentally disabled-continuous nursing.

(b) The regulations adopted pursuant to subdivision (a) shall ensure that residents of an intermediate care facility/developmentally disabled-nursing and an intermediate care facility/developmentally disabled-continuous nursing receive appropriate medical and nursing services, and developmental program services in a normalized, least restrictive physical and programmatic environment appropriate to individual resident need.

In addition, the regulations shall do all of the following:

(1) Include provisions for the completion of a clinical and developmental assessment of placement needs, including medical and other needs, and the degree to which they are being met, of clients placed in an intermediate care facility/developmentally disabled-nursing and an intermediate care facility/developmentally disabled-continuous nursing and for the monitoring of these needs at regular intervals.

(2) Provide for maximum utilization of generic community resources by clients residing in a facility.

(3) Require the State Department of Developmental Services to review and approve an applicant’s facility program plan as a prerequisite to the licensing and certification process.

(4) Require that the physician providing the certification that placement in the intermediate care facility/developmentally disabled-nursing or intermediate care facility/developmentally disabled-continuous nursing is needed, consult with the physician who is the physician of record at the time the person’s proposed placement is being considered by the interdisciplinary team.

(c) Regulations developed pursuant to this section shall include licensing fee schedules appropriate to facilities which will encourage their development.

(d) Until the departments adopt regulations pursuant to this section relating to services by an intermediate care facility/developmentally disabled-nursing, the licensed intermediate care facility/developmentally disabled-nursing shall comply with federal certification standards for intermediate care facilities for individuals with intellectual disabilities, as specified in Sections 483.400 to 483.480, inclusive, of Title 42 of the Code of Federal Regulations, in effect immediately preceding January 1, 2018.

(e) This section shall not supersede the authority of the State Fire Marshal pursuant to Sections 13113, 13113.5, 13143, and 13143.6 to the extent that these sections are applicable to community care facilities.

(Amended by Stats. 2018, Ch. 34, Sec. 6. (AB 1810) Effective June 27, 2018.)

1275.4. (a) On or before January 1, 2017, each skilled nursing facility, as defined in subdivision (c) of Section 1250, shall adopt and implement an antimicrobial stewardship policy that is consistent with antimicrobial stewardship guidelines developed by the federal Centers for Disease Control and Prevention, the federal Centers for Medicare and Medicaid Services, the Society for Healthcare Epidemiology of America, or similar recognized professional organizations.

(b) All skilled nursing facilities, as defined in subdivision (c) of Section 1250, shall comply with this section. Failure to comply with the requirements of this section may subject the facility to the enforcement actions set forth in Section 1423.

(Added by Stats. 2015, Ch. 764, Sec. 2. (SB 361) Effective October 10, 2015.)

1275.41. (a) (1) In the event of a declared emergency related to a communicable disease, a skilled nursing facility, as defined in subdivision (c) of Section 1250, shall report communicable disease data in a format and schedule as required by the State Department of Public Health.

(2) The communicable disease data reported pursuant to this section shall include, but not be limited to, information about each disease-related death and suspected disease-related death, which shall be reported to the State Department of Public Health within 24 hours of the death.

(3) The State Department of Public Health shall make the total number of disease-related deaths and suspected disease-related deaths reported pursuant to this section and the location at which they occurred, in a manner that protects patients' medical privacy, available on its internet website on a weekly basis.

(b) During a declared emergency related to a communicable disease, a skilled nursing facility shall notify residents and their representatives and family members about cases of the communicable disease in compliance with state and federal privacy laws, as instructed by the department.

(c) 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 (AFL) or similar instruction.

(Added by Stats. 2020, Ch. 287, Sec. 2. (AB 2644) Effective January 1, 2021.)

1275.5. (a) The regulations relating to the licensing of hospitals, heretofore adopted by the State Department of Public Health pursuant to former Chapter 2 (commencing with Section 1400) of Division 2, and in effect immediately prior to July 1, 1973, shall remain in effect and shall be fully enforceable with respect to any hospital required to be licensed by this chapter, unless and until the regulations are readopted, amended, or repealed by the director.

(b) The regulations relating to private institutions receiving or caring for persons with mental health disorders, persons with developmental disabilities, and persons who lack legal competence to make decisions heretofore adopted by the Department of Mental Hygiene pursuant to Chapter 1 (commencing with Section 7000) of Division 7 of the Welfare and Institutions Code, and in effect immediately prior to July 1, 1973, shall remain in effect and shall be fully enforceable with respect to any facility, establishment, or institution for the reception and care of persons with mental health disorders, persons with developmental disabilities, and persons who lack legal competence to make decisions required to be licensed by the provisions of this chapter unless and until those regulations are readopted, amended, or repealed by the director.

(c) (1) All regulations relating to the licensing of psychiatric health facilities heretofore adopted by the State Department of Health Services, pursuant to authority now vested in the State Department of Health Care Services by Section 4080 of the Welfare and Institutions Code, and in effect immediately preceding September 20, 1988, shall remain in effect and shall be fully enforceable by the State Department of Health Care Services with respect to any facility or program required to be licensed as a psychiatric health facility, unless and until readopted, amended, or repealed by the Director of Health Care Services.

(2) The State Department of Health Care Services shall succeed to and be vested with all duties, powers, purposes, functions, responsibilities, and jurisdiction as they relate to licensing psychiatric health facilities.

(Amended by Stats. 2014, Ch. 144, Sec. 28. (AB 1847) Effective January 1, 2015.)

1275.6. (a) A health facility licensed pursuant to subdivision (a) or (b) of Section 1250 may provide in any alternative setting health care services and programs which may be provided by any other provider of health care outside of a hospital building or which are not otherwise specifically prohibited by this chapter. In addition, the state department and the Office of Statewide Health Planning and Development shall adopt and enforce standards which permit the ability of a health facility licensed pursuant to subdivision (a) or (b) of Section 1250 to use its space for alternative purposes.

(b) In adopting regulations implementing this section, and in reviewing an application or other request by a health facility licensed pursuant to subdivision (a) or (b) of Section 1250, pursuant to Section 1265, and subdivision (b) of Section 1276, relating to services provided in alternative settings, the state department may adopt or impose reasonable standards and conditions which promote and protect patient health, safety, security, and quality of health care.

(c) Pending the adoption of regulations referred to in subdivision (b), the state department may condition approval of the alternative service or alternative setting on reasonable standards consistent with this section and subdivisions (d) and (e) of Section 1275. The state department and the Office of Statewide Health Planning and Development may adopt these standards by mutual agreement with a health facility proposing a service and may, after consultation with appropriate professional and trade associations, establish guidelines for hospitals wishing to institute an alternative service or to provide a service in an alternative setting. Services provided

outside of a hospital building under this section shall be subject to the licensing standards, if any, that are applicable to the same or similar service provided by nonhospital providers outside of a hospital building. The intent of this subdivision is to assure timely introduction of safe and efficacious innovations in health care services by providing a mechanism for the temporary implementation and evaluation of standards for alternative services and settings and to facilitate the adoption of appropriate regulations by the state department.

(d) All health care professionals providing services in settings authorized by this section shall be members of the organized medical staff of the health facility to the extent medical staff membership would be required for the provision of the services within the health facility. All services shall be provided under the respective responsibilities of the governing body and medical staff of the health facility. Nothing in this section shall be construed to repeal or otherwise affect Section 2400 of the Business and Professions Code, or to exempt services provided under this section from licensing standards, if any, established by or otherwise applicable to, the same or similar service provided by nonhospital providers outside of a hospital building.

(e) For purposes of this section, “hospital building” shall have the same meaning as that term is defined in Section 15026.

(Added by Stats. 1987, Ch. 1171, Sec. 2.)

1275.7. (a) The Legislature makes the following findings and declarations:

(1) The theft of newborn babies from hospitals is a serious societal problem that must be addressed.

(2) There is no statutory requirement that hospitals offering maternity services establish policies and procedures that protect newborns and their parents from physical harm and emotional distress resulting from baby thefts.

(3) Societal change has popularized a more open and natural birthing process, which, unfortunately, increases the risk of thefts of newborns from hospitals and other health facilities offering maternity services.

(4) Baby thefts detrimentally affect the emotional and physical health of newborns and their families.

(5) It is the intent of the Legislature in enacting this chapter to take reasonable steps toward reducing baby thefts.

(b) On or before July 1, 1991, the state department shall adopt regulations requiring any hospital or other health facility offering maternity services to establish written policies and procedures designed to promote the protection of babies and the reduction of baby thefts from hospitals or other health facilities offering maternity services. Those hospitals and facilities shall establish the policies and procedures no later than 60 days after the regulations become effective.

(c) The state department shall review the policies and procedures established by the hospitals and other health facilities, as required by subdivision (b), to determine compliance with the regulations adopted by the state department, pursuant to subdivision (b).

(d) Hospitals and other health facilities offering maternity services shall periodically review their policies and procedures established pursuant to this section. The review need not occur more frequently than every two years.

(Added by Stats. 1990, Ch. 768, Sec. 1.)

1275.8. (a) On or before January 1, 2020, each general acute care hospital, as defined in subdivision (a) of Section 1250, and acute psychiatric hospital, as defined in subdivision (b) of Section 1250, shall adopt and implement a linen laundry processing policy that is consistent and in accordance with the most recent infection control guidelines and standards developed by the following:

(1) The federal Centers for Disease Control and Prevention.

(2) The federal Centers for Medicare and Medicaid Services.

(b) A general acute care hospital and an acute psychiatric hospital that uses a medical laundry service provider shall comply with the requirements of subdivision (a).

(Added by Stats. 2018, Ch. 587, Sec. 2. (AB 2679) Effective January 1, 2019.)

1276. (a) The building standards published in the California Building Standards Code by the Department of Health Care Access and Information, and the regulations adopted by the State Department of Public Health shall, as applicable, prescribe standards of adequacy, safety, and sanitation of the physical plant, of staffing with duly qualified licensed personnel, and of services, based on the type of health facility and the needs of the persons served thereby.

(b) These regulations shall permit program flexibility by the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing of pharmaceuticals, or conducting of pilot projects as long as statutory requirements are met and the use has the prior written approval of the State Department of Public Health or the Department of Health Care Access

and Information, as applicable. The approval of the department or the Department of Health Care Access and Information shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the department or Department of Health Care Access and Information regarding the exception, as applicable.

(c) While it is the intent of the Legislature that health facilities shall maintain continuous, ongoing compliance with the licensing rules and regulations, it is the further intent of the Legislature that the State Department of Public Health expeditiously review and approve, if appropriate, applications for program flexibility. The Legislature recognizes that health care technology, practice, pharmaceutical procurement systems, and personnel qualifications and availability are changing rapidly. Therefore, requests for program flexibility require expeditious consideration.

(d) The department shall, on or before April 1, 1989, develop a standardized form and format for requests by health facilities for program flexibility. Health facilities shall thereafter apply to the department for program flexibility in the prescribed manner. After the department receives a complete application requesting program flexibility, it shall have 60 days within which to approve, approve with conditions or modifications, or deny the application. Denials and approvals with conditions or modifications shall be accompanied by an analysis and a detailed justification for any conditions or modifications imposed. Summary denials to meet the 60-day timeframe shall not be permitted.

(e) To the extent that an application by a health facility for program flexibility, or for an extension of program flexibility, includes a request to allow the health facility to designate a bed or multiple beds in a critical care unit as requiring a lower level of care, including, but not limited to, the level of care provided in an intermediate care, step-down, telemetry, medical-surgical, specialty care, or pediatric services unit, that application shall be referred to as a “critical care unit program flexibility request.” This subdivision and subdivision (f) do not confer on the department any new or additional authority to modify staffing ratios.

(f) (1) The department shall require, as support for a critical care unit program flexibility request, the applicant or licensee to submit supporting evidence that includes documentation establishing the need for program flexibility and that the proposed alternative will not jeopardize the health, safety, and well-being of patients and is needed for increased operational efficiency.

(A) Any critical care unit program flexibility request, including supporting evidence submitted with the request, shall be posted on the department’s publicly accessible internet website within five calendar days of receipt by the department.

(B) The department, at the time it posts a health facility’s critical care unit program flexibility request, shall provide a method to electronically collect public comment specifically on the application for a period of 30 days.

(C) The 60-day timeframe provided for in subdivision (d) shall not commence until a facility’s critical care unit program flexibility request and supporting evidence have been posted on the department’s internet website.

(2) (A) A health facility that makes a critical care unit program flexibility request shall comply with both of the following requirements:

(i) Conspicuously post the critical care unit program flexibility request form and a notice next to its license stating that a critical care unit program flexibility request and supporting evidence have been submitted to the department.

(ii) Immediately make its best effort to notify affected employees and employee representatives of the critical care unit program flexibility request and direction to where to find the request and supporting evidence, and where to provide public comment.

(B) A facility’s critical care unit program flexibility request will not be deemed complete for purposes of the 60-day timeframe pursuant to subdivision (d) until the facility has complied with this paragraph.

(3) In no event shall the department approve a health facility’s critical care unit program flexibility request for a period of more than one year.

(4) Any approval of a health facility’s critical care unit program flexibility request may be revoked by the department at any time, including on the grounds that there is no longer a need for program flexibility, that the approved alternative jeopardizes the health, safety, and well-being of patients, or that the approved alternative does not adequately protect patient safety.

(5) (A) The 30-day comment period required by subparagraph (B) of paragraph (1) shall not apply when a hospital submits a critical care unit program flexibility request due to a health care emergency. Critical care unit program flexibility requests approved pursuant to this paragraph shall not be effective for more than 90 days, and any request to extend the term of critical care unit program flexibility that was approved pursuant to this paragraph shall be subject to the regular process provided for in this subdivision.

(B) For purposes of this paragraph, “health care emergency” means an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to health care delivery requiring immediate medical interventions and care.

(6) This subdivision shall become operative on January 1, 2023.

(g) Notwithstanding any other law or regulation, the State Department of Public Health shall provide flexibility in its pharmaceutical services requirements to permit any state department that operates state facilities subject to these provisions to establish a single statewide formulary or to procure pharmaceuticals through a departmentwide or multidepartment bulk purchasing arrangement. It is the intent of the Legislature that consolidation of these activities be permitted in order to allow the more cost-effective use and procurement of pharmaceuticals for the benefit of patients and residents of state facilities.

(h) On or before February 1, 2023, the department shall post all of the following information on its internet website:

(1) A list of applicants for critical care unit program flexibility and the date of the application.

(2) A list of health facilities with approved critical care unit program flexibility and the effective start and end date of the approval.

(3) If approved, the notification of approval for critical care unit program flexibility, which shall include the application for critical care unit program flexibility; the regulation or regulations impacted; beds, units, or departments affected; and any conditions placed on the approval.

(4) A department contact for the public to submit a complaint related to an approved critical care unit program flexibility.

(Amended by Stats. 2021, Ch. 716, Sec. 1. (AB 1422) Effective January 1, 2022.)

1276.05. (a) The Office of Statewide Health Planning and Development shall allow any general acute care hospital facility that needs to relocate services on an interim basis as part of its approval plan for compliance with Article 8 (commencing with Section 130000) or Article 9 (commencing with Section 130050) in the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 (Chapter 1 (commencing with Section 129675) of Part 7 of Division 107) flexibility in achieving compliance with, or in substantial satisfaction of the objectives of, building standards adopted pursuant to Section 1276 with regard to the use of interim space for the provision of hospital services, or both, on a case-by-case basis so long as public safety is not compromised.

(b) The state department shall allow any facility to which subdivision (a) applies flexibility in achieving compliance with, or in substantial satisfaction of, the objectives of licensing standards, or both, with regard to the use of interim space for the provision of hospital services, or both, on a case-by-case basis so long as public safety is not compromised.

(c) Hospital licensees, upon application for program flexibility under this section, shall provide public notice of the proposed interim use of space that houses at least one of the eight basic services that are required in a general acute care hospital in a manner that is likely to reach a substantial number of residents of the community served by the facility and employees of the facility.

(d) No request shall be approved under this section for a waiver of any primary structural system, fire and life safety requirements, or any requirement with respect to accessibility for persons with disabilities.

(e) In approving any request pursuant to this section for flexibility, the office shall consider public comments.

(f) The state department shall establish a unit with two statewide liaisons for the purposes of the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 (Chapter 1 (commencing with Section 129675) of Part 7 of Division 107), to do all of the following:

(1) Serve as a central resource for hospital representatives on licensing issues relative to Article 8 or Article 9 in the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 and provide licensing information to the public, upon request.

(2) Serve as liaison with the Office of Statewide Health Planning and Development, the State Fire Marshal, the Seismic Safety Commission, and other entities as necessary on hospital operational issues with respect to Article 8 or Article 9 in the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983.

(3) Ensure statewide compliance with respect to licensing issues relative to hospital buildings that are required to meet standards established by Article 8 or Article 9 in the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983.

(4) Process requests for program flexibility under subdivision (a).

(5) Accept and consider public comments on requests for flexibility.

(g) Each compliance plan, in providing for an interim use of space in which flexibility is requested, shall identify the duration of time proposed for the interim use of the space. Upon any amendment of a hospital's approved compliance plan, any hospital for which a flexibility plan has been approved pursuant to subdivision (a) shall provide a copy of the amended plan to the State Department of Health Services within 30 days.

(Amended by Stats. 2001, Ch. 228, Sec. 1. Effective September 4, 2001.)

1276.1. In setting personnel standards for licensed health facilities pursuant to Section 1276, the department may set such standards itself or may adopt them by reference to named standard-setting organizations. If the department adopts standards for a category of health personnel by reference to a specified organization, the department shall either:

(a) List in the regulation the education, training, experience, examinations, or other requirements set by the specified organization; or

(b) Retain on file and available for public inspection a listing of the education, training, experience, examinations, or other requirements set by the specified organization; or

(c) Have direct statutory authority or requirement to use the standards of the specified organization.

(Added by Stats. 1978, Ch. 1106.)

1276.2. Standards and regulations adopted by the state department pursuant to Section 1276 shall not require the use of a registered nurse for the performance of any service or staffing of any position in freestanding skilled nursing facilities that may lawfully be performed or staffed by a licensed vocational nurse pursuant to the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840) of Division 2 of the Business and Professions Code) and applicable federal regulations, when a facility is unable to obtain a registered nurse, except that a licensed vocational nurse employed in accordance with this section shall be a permanent employee of the facility. The facility shall make a good faith effort to obtain a registered nurse prior to determining that it is unable to obtain a registered nurse for the relevant shift, and this effort shall be noted in the facility's records. The facility shall make provision for a registered nurse to be available for consultation and professional assistance during the hours in which a licensed vocational nurse is used as provided by this section. The facility shall maintain a record of the identity and phone number of the registered nurse that is to be available for consultation and professional assistance, as required by this section. If the substitution of a licensed vocational nurse for a registered nurse occurs more often than seven days per month, the facility shall obtain program flexibility approval from the state department pursuant to subdivision (b) of Section 1276. Nothing in this section shall permit a licensed vocational nurse to act as director of nurses pursuant to the Vocational Nursing Practice Act. This section applies to staffing for the evening and night shifts only, except that if the level of care is determined by the state department to be inadequate, the state department may require the facility to provide additional staffing.

This section shall not apply to the Medi-Cal regulations adopted pursuant to Sections 14114 and 14132.25 of the Welfare and Institutions Code.

(Added by Stats. 1994, Ch. 645, Sec. 1. Effective January 1, 1995.)

1276.3. (a) The Legislature finds and declares that the citizens of California are in danger of being injured and killed in the state's surgical suites and procedural rooms in licensed health facilities, because of the many intense heat sources present in an oxygen-rich environment. It is the intent of the Legislature that this section promote maximum fire and panic safety standards in surgical suites and procedural rooms in licensed health facilities, and other areas that pose a danger due to the presence of oxygen, in California.

(b) (1) The state department, shall promote safety by requiring that licensed health facilities that have surgical suites and procedural rooms provide information and training in fire and panic safety in oxygen rich environments, including equipment, safety, and emergency plans, as part of an orientation for new employees, and ongoing inservice training.

(2) The licensed health facilities described in paragraph (1) shall use the fire safety guidelines in oxygen rich environments published by the Association of Operating Room Nurses or any other nationally recognized body or organization, and approved by the state department.

(c) The licensed health facilities described in paragraph (1) of subdivision (b) shall determine the modality of training and the number of hours of training required.

(Added by Stats. 1992, Ch. 992, Sec. 1. Effective January 1, 1993.)

1276.4. (a) By January 1, 2002, the State Department of Public Health shall adopt regulations that establish minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit for all health facilities licensed pursuant to subdivision (a) or (f) of Section 1250. No later than July 31, 2027, or one and one-half years after adoption of emergency regulations pursuant to subdivision (k), whichever is sooner, the State Department of Public Health shall adopt regulations pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), as specified in subdivision (k), that establish minimum, specific, and numerical licensed nurse-to-patient ratios for health facilities licensed pursuant to subdivision (b) of Section 1250. The State Department of Public Health shall adopt these regulations in accordance with the department's licensing and certification regulations as stated in Sections 70053.2, 70215, and 70217 of Title 22 of the California Code of Regulations, and the professional and vocational regulations in Section 1443.5 of Title 16 of the California Code of Regulations. The department shall review these regulations five years after adoption and shall report to the Legislature regarding any proposed changes. Flexibility shall be considered by the department for rural general acute care hospitals

in response to their special needs. As used in this subdivision, “hospital unit” means a critical care unit, burn unit, labor and delivery room, postanesthesia service area, emergency department, operating room, pediatric unit, step-down/intermediate care unit, specialty care unit, telemetry unit, general medical care unit, subacute care unit, and transitional inpatient care unit. The regulation addressing the emergency department shall distinguish between regularly scheduled core staff licensed nurses and additional licensed nurses required to care for critical care patients in the emergency department.

(b) These ratios shall constitute the minimum number of registered and licensed nurses that shall be allocated. Additional staff shall be assigned in accordance with a documented patient classification system for determining nursing care requirements, including the severity of the illness, the need for specialized equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the patient care plan and the ability for self-care, and the licensure of the personnel required for care.

(c) “Critical care unit” as used in this section means a unit that is established to safeguard and protect patients whose severity of medical conditions requires continuous monitoring, and complex intervention by licensed nurses.

(d) All health facilities licensed under subdivision (a), (b), or (f) of Section 1250 shall adopt written policies and procedures for training and orientation of nursing staff.

(e) No registered nurse shall be assigned to a nursing unit or clinical area unless that nurse has first received orientation in that clinical area sufficient to provide competent care to patients in that area, and has demonstrated current competence in providing care in that area.

(f) The written policies and procedures for orientation of nursing staff shall require that all temporary personnel shall receive orientation and be subject to competency validation consistent with Sections 70016.1 and 70214 of Title 22 of the California Code of Regulations.

(g) Requests for waivers to this section that do not jeopardize the health, safety, and well-being of patients affected and that are needed for increased operational efficiency may be granted by the department to rural general acute care hospitals meeting the criteria set forth in Section 70059.1 of Title 22 of the California Code of Regulations.

(h) In case of conflict between this section and any provision or regulation defining the scope of nursing practice, the scope of practice provisions shall control.

(i) The regulations adopted by the department shall augment and not replace existing nurse-to-patient ratios that exist in regulation or law for the intensive care units, the neonatal intensive care units, or the operating room.

(j) The regulations adopted by the department shall not replace existing licensed staff-to-patient ratios for hospitals operated by the State Department of State Hospitals.

(k) (1) The regulations adopted by the department for health facilities licensed under subdivision (b) of Section 1250 that are not operated by the State Department of State Hospitals shall take into account the special needs of the patients served in the psychiatric units.

(2) The department shall adopt emergency regulations pursuant to this subdivision no later than January 31, 2026. The department may readopt any emergency regulation authorized by this subdivision that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this subdivision.

(3) The adoption of emergency regulations pursuant to this subdivision and two readoptions of emergency regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Emergency regulations and readoptions authorized by this section shall be exempt from review by the Office of Administrative Law. The emergency regulations and the readoptions authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State. Notwithstanding any other provision of law, the adoption and readoptions of these emergency regulations shall be exempt from the requirements of subdivision (b) of Section 11346.1 of the Government Code and each shall remain in effect for no more than 180 days.

(4) The emergency regulations adopted pursuant to this subdivision may include, but are not limited to, the following:

(A) Staffing standards, including nurse-to-patient, specific to acute psychiatric hospitals.

(B) Requirements used to determine appropriate staffing based on patient acuity and care needs.

(C) Requirements that the State Department of Public Health deems necessary or relevant to staffing policies and procedures to promote patient safety.

(l) The department may take into consideration the unique nature of the University of California teaching hospitals as educational institutions when establishing licensed nurse-to-patient ratios. The department shall coordinate with the Board of Registered Nursing to ensure that staffing ratios are consistent with the Board of Registered Nursing approved nursing education requirements. This includes nursing clinical experience incidental to a work-study program rendered in a University of California clinical facility approved

by the Board of Registered Nursing provided there will be sufficient direct care registered nurse preceptors available to ensure safe patient care.

(Amended by Stats. 2025, Ch. 21, Sec. 2. (AB 116) Effective June 30, 2025.)

1276.5. (a) The department shall adopt regulations setting forth the minimum number of equivalent nursing hours per patient required in skilled nursing and intermediate care facilities, subject to the specific requirements of Section 14110.7 of the Welfare and Institutions Code. However, notwithstanding Section 14110.7 or any other law, commencing January 1, 2000, the minimum number of actual nursing hours per patient required in a skilled nursing facility shall be 3.2 hours, except as provided in Section 1276.9.

(b) (1) For the purposes of this section, "nursing hours" means the number of hours of work performed per patient day by aides, nursing assistants, or orderlies plus two times the number of hours worked per patient day by registered nurses and licensed vocational nurses (except directors of nursing in facilities of 60 or larger capacity) and, in the distinct part of facilities and freestanding facilities providing care for persons with developmental disabilities or mental health disorders by licensed psychiatric technicians who perform direct nursing services for patients in skilled nursing and intermediate care facilities, except when the skilled nursing and intermediate care facility is licensed as a part of a state-owned hospital or developmental center, and except that nursing hours for skilled nursing facilities means the actual hours of work, without doubling the hours performed per patient day by registered nurses and licensed vocational nurses.

(2) Concurrent with implementation of the first year of rates established under the Medi-Cal Long Term Care Reimbursement Act of 1990 (Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code), for the purposes of this section, "nursing hours" means the number of hours of work performed per patient day by aides, nursing assistants, registered nurses, and licensed vocational nurses (except directors of nursing in facilities of 60 or larger capacity) and, in the distinct part of facilities and freestanding facilities providing care for persons with developmental disabilities or mental health disorders, by licensed psychiatric technicians who performed direct nursing services for patients in skilled nursing and intermediate care facilities, except when the skilled nursing and intermediate care facility is licensed as a part of a state-owned hospital or developmental center.

(c) Notwithstanding Section 1276, the department shall require the utilization of a registered nurse at all times if the department determines that the services of a skilled nursing and intermediate care facility require the utilization of a registered nurse.

(d) (1) Except as otherwise provided by law, the administrator of an intermediate care facility/developmentally disabled, intermediate care facility/developmentally disabled habilitative, or an intermediate care facility/developmentally disabled—nursing shall be either a licensed nursing home administrator or a qualified intellectual disability professional as defined in Section 483.430 of Title 42 of the Code of Federal Regulations.

(2) To qualify as an administrator for an intermediate care facility for the developmentally disabled, a qualified intellectual disability professional shall complete at least six months of administrative training or demonstrate six months of experience in an administrative capacity in a licensed health facility, as defined in Section 1250, excluding those facilities specified in subdivisions (e), (h), and (i).

(Amended by Stats. 2017, Ch. 52, Sec. 2. (SB 97) Effective July 10, 2017.)

1276.6. Each facility shall certify, under penalty of perjury and to the best of their knowledge, on a form provided by the department, that funds received pursuant to increasing the staffing ratio to 3.2, as provided for in Section 1276.5, were expended for this purpose. The facility shall return the form to the department within 30 days of receipt by the facility.

(Added by Stats. 2000, Ch. 93, Sec. 6. Effective July 7, 2000.)

1276.65. (a) For purposes of this section, the following definitions shall apply:

(1) "Direct care service hours" means the actual hours of work performed per patient day by a direct caregiver, as defined in paragraph (2). Until final regulations are promulgated to implement this section as amended by the act that added this paragraph, the department shall recognize the hours performed by direct caregivers, to the same extent as those hours are recognized by the department pursuant to Section 1276.5 on July 1, 2017.

(2) "Direct caregiver" means a registered nurse, as referred to in Section 2732 of the Business and Professions Code, a licensed vocational nurse, as referred to in Section 2864 of the Business and Professions Code, a psychiatric technician, as referred to in Section 4516 of the Business and Professions Code, and a certified nurse assistant, or a nursing assistant participating in an approved training program, as defined in Section 1337, while performing nursing services as described in Sections 72309, 72311, and 72315 of Title 22 of the California Code of Regulations, as those sections read on July 1, 2017.

(3) "Skilled nursing facility" means a skilled nursing facility as defined in subdivision (c) of Section 1250.

(b) A person employed to provide services such as food preparation, housekeeping, laundry, or maintenance services shall not provide nursing care to residents and shall not be counted in determining ratios under this section.

(c) (1) (A) Notwithstanding any other law, the department shall develop regulations that become effective August 1, 2003, that establish staff-to-patient ratios for direct caregivers working in a skilled nursing facility.

(B) Effective July 1, 2018, skilled nursing facilities, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state-owned hospital or developmental center, shall have a minimum number of direct care services hours of 3.5 per patient day, except as set forth in Section 1276.9.

(C) Skilled nursing facilities shall have a minimum of 2.4 hours per patient day for certified nurse assistants in order to meet the requirements in subparagraph (B).

(D) The department shall repeal and amend existing regulations and adopt emergency regulations to implement the amendments made by the act that added this subparagraph. The department shall consult stakeholders prior to promulgation of regulations and shall provide a 90-day notice to stakeholders prior to adopting regulations. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(2) The department, in developing staff-to-patient ratios for direct caregivers and licensed nurses required by this section, shall convert the existing requirement under Section 1276.5 of this code and Section 14110.7 of the Welfare and Institutions Code for direct care service hours per patient day of care and shall verify that no less care is given than is required pursuant to Section 1276.5 of this code and Section 14110.7 of the Welfare and Institutions Code. Further, the department shall develop the ratios in a manner that minimizes additional state costs, maximizes resident quality of care, and takes into account the length of the shift worked. In developing the regulations, the department shall develop a procedure for facilities to apply for a waiver that addresses individual patient needs except that in no instance shall the minimum staff-to-patient ratios be less than the 3.5 direct care service hours per patient day required pursuant to subparagraph (B) of paragraph (1).

(d) The direct care service hour requirements to be developed pursuant to this section shall be minimum standards only. Skilled nursing facilities shall employ and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents and to ensure compliance with all relevant state and federal staffing requirements.

(e) No later than January 1, 2006, and every five years thereafter, the department shall consult with consumers, consumer advocates, recognized collective bargaining agents, and providers to determine the sufficiency of the staffing standards provided in this section and may adopt regulations to increase the minimum staffing ratios to adequate levels.

(f) In a manner pursuant to federal requirements, every skilled nursing facility shall post information about staffing levels that includes the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. This posting shall include staffing requirements developed pursuant to this section.

(g) (1) Notwithstanding any other law, the department shall inspect for compliance with this section during state and federal periodic inspections, including, but not limited to, those inspections required under Section 1422. This inspection requirement shall not limit the department's authority in other circumstances to cite for violations of this section or to inspect for compliance with this section.

(2) A violation of the regulations developed pursuant to this section may constitute a class "B," "A," or "AA" violation pursuant to the standards set forth in Section 1424. The department shall set a timeline for phase-in of penalties pursuant to this section through all-facility letters or other similar instructions.

(h) The requirements of this section are in addition to any requirement set forth in Section 1276.5 of this code and Section 14110.7 of the Welfare and Institutions Code.

(i) Implementation of the staffing standard developed pursuant to requirements set forth in this section shall be contingent on an appropriation in the annual Budget Act and continued federal approval of the Skilled Nursing Facility Quality Assurance Fee pursuant to Article 7.6 (commencing with Section 1324.20).

(j) In implementing this section, the department may contract as necessary, on a bid or nonbid basis, for professional consulting services from nationally recognized higher education and research institutions, or other qualified individuals and entities not associated with a skilled nursing facility, with demonstrated expertise in long-term care. This subdivision establishes an accelerated process for issuing contracts pursuant to this section and contracts entered into pursuant to this section shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(k) This section shall not apply to facilities defined in Section 1276.9.

(l) The department shall adopt emergency regulations or all-facility letters, or other similar instructions, to create a waiver of the direct care service hour requirements established in this section for skilled nursing facilities by July 1, 2018, to address a shortage of available and appropriate health care professionals and direct caregivers. Waivers granted pursuant to these provisions shall be

reviewed annually and either renewed or revoked. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(m) The department shall evaluate the impact of the changes made to this section by the act that added this subdivision regarding patient quality of care and shall work with other state departments, as necessary, to evaluate the workforce available to meet these requirements, including an evaluation of the effectiveness of the minimum requirements of 2.4 hours per patient day for certified nursing assistants specified in subparagraph (C) of paragraph (1) of subdivision (c). The department may contract with a vendor for purposes of conducting this evaluation.

(Amended by Stats. 2017, Ch. 52, Sec. 3. (SB 97) Effective July 10, 2017.)

1276.66. (a) (1) The Skilled Nursing Facility Minimum Staffing Penalty Account is hereby established in the State Treasury. The account shall contain all moneys deposited pursuant to subdivision (b).

(2) Notwithstanding Section 13340 of the Government Code or any other law, the Skilled Nursing Facility Minimum Staffing Penalty Account is hereby continuously appropriated, without regard to fiscal years, to the State Department of Public Health to support the implementation of this section.

(b) (1) The State Department of Public Health shall use the direct care staffing level data it collects to determine whether a skilled nursing facility has met the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable.

(2) (A) The State Department of Public Health shall assess a skilled nursing facility, licensed pursuant to subdivision (c) of Section 1250, an administrative penalty if the State Department of Public Health determines that the skilled nursing facility fails to meet the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable, as follows:

(i) Twenty-five thousand dollars ($25,000) if the facility fails to meet the requirements for 5 percent or more of the audited days up to 49 percent.

(ii) Fifty thousand dollars ($50,000) if the facility fails to meet the requirements for over 49 percent or more of the audited days.

(B) (i) If the skilled nursing facility does not dispute the determination or assessment, the penalties shall be paid in full by the licensee to the State Department of Public Health within 30 days of the facility's receipt of the notice of penalty and deposited into the Skilled Nursing Facility Minimum Staffing Penalty Account.

(ii) The State Department of Public Health may, upon written notification to the licensee, request that the State Department of Health Care Services offset any moneys owed to the licensee by the Medi-Cal program or any other payment program administered by the State Department of Health Care Services to recoup the penalty provided for in this section.

(C) (i) If a facility disputes the determination or assessment made pursuant to this paragraph, the facility shall, within 30 days of the facility's receipt of the determination and assessment, simultaneously submit a request for appeal to both the State Department of Health Care Services and the State Department of Public Health. A request for an appeal may be made by a facility based upon a determination that does not result in an assessment. The request shall include a detailed statement describing the reason for appeal and include all supporting documents the facility will present at the hearing.

(ii) Within 30 days of the State Department of Public Health's receipt of the facility's request for appeal, the State Department of Public Health shall submit, to both the facility and the State Department of Health Care Services, its responsive arguments and all supporting documents that the State Department of Public Health will present at the hearing.

(D) The State Department of Health Care Services shall hear a timely appeal and issue a decision as follows:

(i) The hearing shall commence within 60 days from the date of receipt by the State Department of Health Care Services of the facility's timely request for appeal.

(ii) The State Department of Health Care Services shall issue a decision within 120 days from the date of receipt by the State Department of Health Care Services of the facility's timely request for appeal.

(iii) The decision of the State Department of Health Care Services' hearing officer, when issued, shall be the final decision of the State Department of Public Health.

(E) The appeals process set forth in this paragraph shall be exempt from Chapter 4.5 (commencing with Section 11400), and Chapter 5 (commencing with Section 11500), of Part 1 of Division 3 of Title 2 of the Government Code. The provisions of Sections 100171 and 131071 do not apply to appeals under this paragraph.

(F) If a hearing decision issued pursuant to subparagraph (D) is in favor of the State Department of Public Health, the skilled nursing facility shall pay the penalties to the State Department of Public Health within 30 days of the facility's receipt of the decision. The penalties collected shall be deposited into the Skilled Nursing Facility Minimum Staffing Penalty Account.

(c) The assessment of a penalty under this section shall not prohibit any state or federal enforcement action, including, but not limited to, State Department of Public Health's investigation process or issuance of deficiencies or citations under Chapter 2.4 (commencing with Section 1417).

(d) 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 Public Health may implement this section by means of all-facility letters or other similar instructions without taking regulatory action.

(e) In implementing this section, the State Department of Public Health may contract, as necessary, with California's Medicare Quality Improvement Organization, or other entities deemed qualified by the State Department of Public Health, not associated with a skilled nursing facility. The department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis for purposes of implementing this subdivision. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, the State Administrative Manual, and the State Contracting Manual, and shall be exempt from the review or approval of any division of the State Department of General Services.

(f) Notwithstanding any other law, the State Controller may use the funds in the Skilled Nursing Facility Minimum Staffing Penalty Account for cash flow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(Amended by Stats. 2025, Ch. 21, Sec. 3. (AB 116) Effective June 30, 2025.)

1276.7. (a) (1) On or before May 1, 2001, the department shall determine the need, and provide subsequent recommendations, for any increase in the minimum number of nursing hours per patient day in skilled nursing facilities. The department shall analyze the relationship between staffing levels and quality of care in skilled nursing facilities. The analysis shall include, but not be limited to, all of the following:

(A) A determination of average staffing levels in this state.

(B) A review of facility expenditures on nursing staff, including salary, wages, and benefits.

(C) A review of other states' staffing requirements as relevant to this state.

(D) A review of available research and reports on the issue of staffing levels and quality of care.

(E) The number of Medi-Cal beds in a facility.

(F) The corporate status of the facility.

(G) Information on compliance with both state and federal standards.

(H) Work force availability trends.

(2) The department shall prepare a report on its analysis and recommendations and submit this report to the Legislature, including its recommendations for any staffing increases and proposed timeframes and costs for implementing any increase.

(b) It is the intent of the Legislature to establish sufficient staffing levels required to provide quality skilled nursing care. It is further the intent of the Legislature to increase the minimum number of direct care nursing hours per patient day in skilled nursing facilities to 3.5 hours by 2004 or to whatever staffing levels the department determines are required to provide California nursing home residents with a safe environment and quality skilled nursing care.

(Added by Stats. 2000, Ch. 451, Sec. 7. Effective January 1, 2001.)

1276.8. Notwithstanding any other provision of law, including, but not limited to, Section 1276, the following shall apply:

(a) As used in this code, "respiratory care practitioner," "respiratory therapist," "respiratory therapy technician," and "inhalation therapist" mean a respiratory care practitioner certified under the Respiratory Care Practice Act (Chapter 8.3 (commencing with

Section 3700) of Division 2 of the Business and Professions Code).

(b) The definition of respiratory care services, respiratory therapy, inhalation therapy, or the scope of practice of respiratory care, shall be as described in Section 3702 of the Business and Professions Code.

(c) Respiratory care may be performed in hospitals, ambulatory or in-home care, and other settings where respiratory care is performed under the supervision of a medical director in accordance with the prescription of a physician and surgeon. Respiratory care may also be provided during the transportation of a patient, and under any circumstances where an emergency necessitates respiratory care.

(d) In addition to other licensed health care practitioners authorized to administer respiratory care, a certified respiratory care practitioner may accept, transcribe, and implement the written and verbal orders of a physician and surgeon pertaining to the practice of respiratory care.

(Amended by Stats. 2006, Ch. 538, Sec. 351. Effective January 1, 2007.)

1276.9. (a) A special treatment program service unit distinct part shall have a minimum 2.3 nursing hours per patient per day.

(b) For purposes of this section, “special treatment program service unit distinct part” means an identifiable and physically separate unit of a skilled nursing facility or an entire skilled nursing facility that provides therapeutic programs to an identified population group of persons with mental health disorders.

(c) For purposes of this section, “nursing hours” means the number of hours of work performed per patient day by aides, nursing assistants, or orderlies, plus two times the number of hours worked per patient day by registered nurses and licensed vocational nurses (except directors of nursing in facilities of 60 or larger capacity), and, in the distinct part of facilities and freestanding facilities providing care for persons with developmental disabilities or mental health disorders, by licensed psychiatric technicians who perform direct nursing services for patients in skilled nursing and intermediate care facilities, except when the skilled nursing and intermediate care facility is licensed as a part of a state hospital.

(d) A special treatment program service unit distinct part shall also have an overall average weekly staffing level of 3.2 hours per patient per day, calculated without regard to the doubling of nursing hours, as described in paragraph (1) of subdivision (b) of Section 1276.5, for the special treatment program service unit distinct part.

(e) The calculation of the overall staffing levels in these facilities for the special treatment program service unit distinct part shall include staff from all of the following categories:

(1) Certified nurse assistants.

(2) Licensed vocational nurses.

(3) Registered nurses.

(4) Licensed psychiatric technicians.

(5) Psychiatrists.

(6) Psychologists.

(7) Social workers.

(8) Program staff who provide rehabilitation, counseling, or other therapeutic services.

(Amended by Stats. 2014, Ch. 144, Sec. 30. (AB 1847) Effective January 1, 2015.)

1277. (a) No license shall be issued by the department unless it finds that the premises, the management, the bylaws, rules and regulations, the equipment, the staffing, both professional and nonprofessional, and the standards of care and services are adequate and appropriate, and that the health facility is operated in the manner required by this chapter and by the rules and regulations adopted hereunder.

(b) (1) Notwithstanding any provision of Part 2 (commencing with Section 5600) of Division 5 of, or Division 7 (commencing with Section 7100) of, the Welfare and Institutions Code or any other law to the contrary, the licensure requirements for professional personnel, including, but not limited to, physicians and surgeons, dentists, podiatrists, psychologists, marriage and family therapists, pharmacists, registered nurses, clinical social workers, and professional clinical counselors in the state and other governmental health facilities licensed by the department shall not be less than for those professional personnel in health facilities under private ownership.

(2) Persons employed as psychologists and clinical social workers, while continuing in their employment in the same class as of January 1, 1979, in the same state or other governmental health facility licensed by the department, including those persons on authorized leave, but not including intermittent personnel, shall be exempt from the requirements of paragraph (1).

(3) (A) The requirements of paragraph (1) may be waived by the department solely for persons in the professions of psychology, marriage and family therapy, clinical social work, or professional clinical counseling who are gaining qualifying experience for licensure in that profession in this state. A waiver granted pursuant to this paragraph shall not exceed four years from commencement of the employment in this state in a position that includes qualifying experience, at which time licensure shall have been obtained or the employment shall be terminated, except that an extension of a waiver of licensure may be granted for one additional year, based on extenuating circumstances determined by the department pursuant to subdivision (e). For persons employed as psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors less than full time, an extension of a waiver of licensure may be granted for additional years proportional to the extent of part-time employment, as long as the person is employed without interruption in service, but in no case shall the waiver of licensure exceed six years in the case of clinical social workers, marriage and family therapists, or professional clinical counselors, or five years in the case of psychologists.

(B) For the purposes of this paragraph, “qualifying experience” means experience that satisfies the requirements of subdivision (d) of Section 2914 of, or Section 4980.43, 4996.23, or 4999.46 of, the Business and Professions Code.

(4) The durational limitation upon waivers pursuant to paragraph (3) shall not apply to any of the following:

(A) Active candidates for a doctoral degree in social work, social welfare, or social science, who are enrolled at an accredited university, college, or professional school, but these limitations shall apply following completion of this training.

(B) Active candidates for a doctoral degree in marriage and family therapy who are enrolled at a school, college, or university, specified in subdivision (b) of Section 4980.36 of, or subdivision (b) of Section 4980.37 of, the Business and Professions Code, but the limitations shall apply following completion of the training.

(C) Active candidates for a doctoral degree in professional clinical counseling who are enrolled at a school, college, or university, specified in subdivision (b) of Section 4999.32 of, or subdivision (b) of Section 4999.33 of, the Business and Professions Code, but the limitations shall apply following the completion of the training.

(5) A waiver pursuant to paragraph (3) shall be granted only to the extent necessary to qualify for licensure, except that personnel recruited for employment from outside this state and whose experience is sufficient to gain admission to a licensing examination shall nevertheless have one year from the date of their employment in California to become licensed, at which time licensure shall have been obtained or the employment shall be terminated, provided that the employee shall take the licensure examination at the earliest possible date after the date of the employee’s employment. If the employee does not pass the examination at that time, the employee shall have a second opportunity to pass the next possible examination, subject to the one-year limit.

(c) A special permit shall be issued by the department when it finds that the staff, both professional and nonprofessional, and the standards of care and services are adequate and appropriate, and that the special services unit is operated in the manner required in this chapter and by the rules and regulations adopted hereunder.

(d) The department shall apply the same standards to state and other governmental health facilities that it licenses as it applies to health facilities in private ownership, including standards specifying the level of training and supervision of all unlicensed practitioners. Except for psychologists, the department may grant an extension of a waiver of licensure for personnel recruited from outside this state for one additional year, based upon extenuating circumstances as determined by the department pursuant to subdivision (e).

(e) The department shall grant a request for an extension of a waiver based on extenuating circumstances, pursuant to subdivision (b) or (d), if any of the following circumstances exist:

(1) The person requesting the extension has experienced a recent catastrophic event that may impair the person’s ability to qualify for and pass the license examination. Those events may include, but are not limited to, significant hardship caused by a natural disaster, serious and prolonged illness of the person, serious and prolonged illness or death of a child, spouse, or parent, or other stressful circumstances.

(2) The person requesting the extension has difficulty speaking or writing the English language, or other cultural and ethnic factors exist that substantially impair the person’s ability to qualify for and pass the license examination.

(3) The person requesting the extension has experienced other personal hardship that the department, in its discretion, determines to warrant the extension.

(Amended by Stats. 2020, Ch. 279, Sec. 1. (AB 2253) Effective January 1, 2021.)

1278. Any officer, employee, or agent of the state department may, upon presentation of proper identification, enter and inspect any building or premises at any reasonable time to secure compliance with, or to prevent a violation of, any provision of this chapter.

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

1278.5. (a) The Legislature finds and declares that it is the public policy of the State of California to encourage patients, nurses, members of the medical staff, and other health care workers to notify government entities of suspected unsafe patient care and conditions. The Legislature encourages this reporting in order to protect patients and in order to assist those accreditation and government entities charged with ensuring that health care is safe. The Legislature finds and declares that whistleblower protections apply primarily to issues relating to the care, services, and conditions of a facility and are not intended to conflict with existing provisions in state and federal law relating to employee and employer relations.

(b) (1) A health facility shall not discriminate or retaliate, in any manner, against a patient, employee, member of the medical staff, or other health care worker of the health facility because that person has done either of the following:

(A) Presented a grievance, complaint, or report to the facility, to an entity or agency responsible for accrediting or evaluating the facility, or the medical staff of the facility, or to any other governmental entity.

(B) Has initiated, participated, or cooperated in an investigation or administrative proceeding related to the quality of care, services, or conditions at the facility that is carried out by an entity or agency responsible for accrediting or evaluating the facility or its medical staff, or governmental entity.

(2) An entity that owns or operates a health facility, or that owns or operates any other health facility, shall not discriminate or retaliate against a person because that person has taken any actions pursuant to this subdivision.

(3) A violation of this section shall be subject to a civil penalty of not more than twenty-five thousand dollars ($25,000). The civil penalty shall be assessed and recovered through the same administrative process set forth in Chapter 2.4 (commencing with Section 1417) for long-term health care facilities.

(c) Any type of discriminatory treatment of a patient by whom, or upon whose behalf, a grievance or complaint has been submitted, directly or indirectly, to a governmental entity or received by a health facility administrator within 180 days of the filing of the grievance or complaint, shall raise a rebuttable presumption that the action was taken by the health facility in retaliation for the filing of the grievance or complaint.

(d) (1) There shall be a rebuttable presumption that discriminatory action was taken by the health facility, or by the entity that owns or operates that health facility, or that owns or operates any other health facility, in retaliation against an employee, member of the medical staff, or any other health care worker of the facility, if responsible staff at the facility or the entity that owns or operates the facility had knowledge of the actions, participation, or cooperation of the person responsible for any acts described in paragraph (1) of subdivision (b), and the discriminatory action occurs within 120 days of the filing of the grievance or complaint by the employee, member of the medical staff or any other health care worker of the facility.

(2) For purposes of this section, discriminatory treatment of an employee, member of the medical staff, or any other health care worker includes, but is not limited to, discharge, demotion, suspension, or any unfavorable changes in, or breach of, the terms or conditions of a contract, employment, or privileges of the employee, member of the medical staff, or any other health care worker of the health care facility, or the threat of any of these actions.

(e) The presumptions in subdivisions (c) and (d) shall be presumptions affecting the burden of producing evidence as provided in Section 603 of the Evidence Code.

(f) A person who willfully violates this section is guilty of a misdemeanor punishable by a fine of not more than seventy-five thousand dollars ($75,000), in addition to the civil penalty provided in paragraph (3) of subdivision (b).

(g) An employee who has been discriminated against in employment pursuant to this section shall be entitled to reinstatement, reimbursement for lost wages and work benefits caused by the acts of the employer, and the legal costs associated with pursuing the case, or to any remedy deemed warranted by the court pursuant to this chapter or any other applicable provision of statutory or common law. A health care worker who has been discriminated against pursuant to this section shall be entitled to reimbursement for lost income and the legal costs associated with pursuing the case, or to any remedy deemed warranted by the court pursuant to this chapter or other applicable provision of statutory or common law. A member of the medical staff who has been discriminated against pursuant to this section shall be entitled to reinstatement, reimbursement for lost income resulting from any change in the terms or conditions of the member’s privileges caused by the acts of the facility or the entity that owns or operates a health facility or any other health facility that is owned or operated by that entity, and the legal costs associated with pursuing the case, or to any remedy deemed warranted by the court pursuant to this chapter or any other applicable provision of statutory or common law.

(h) The medical staff of the health facility may petition the court for an injunction to protect a peer review committee from being required to comply with evidentiary demands on a pending peer review hearing from the member of the medical staff who has filed

an action pursuant to this section, if the evidentiary demands from the complainant would impede the peer review process or endanger the health and safety of patients of the health facility during the peer review process. Prior to granting an injunction, the court shall conduct an in camera review of the evidence sought to be discovered to determine if a peer review hearing, as authorized in Section 805 and Sections 809 to 809.5, inclusive, of the Business and Professions Code, would be impeded. If it is determined that the peer review hearing will be impeded, the injunction shall be granted until the peer review hearing is completed. This section does not preclude the court, on motion of its own or by a party, from issuing an injunction or other order under this subdivision in the interest of justice for the duration of the peer review process to protect the person from irreparable harm.

(i) For purposes of this section, “health facility” means a facility defined under this chapter, including, but not limited to, the facility’s administrative personnel, employees, boards, and committees of the board, and medical staff.

(j) This section does not apply to an inmate of a correctional facility or juvenile facility of the Department of Corrections and Rehabilitation, or to an inmate housed in a local detention facility including a county jail or a juvenile hall, juvenile camp, or other juvenile detention facility.

(k) This section does not apply to a health facility that is a long-term health care facility, as defined in Section 1418. A health facility that is a long-term health care facility shall remain subject to Section 1432.

(l) This section does not limit the ability of the medical staff to carry out its legitimate peer review activities in accordance with Sections 809 to 809.5, inclusive, of the Business and Professions Code.

(m) This section does not abrogate or limit any other theory of liability or remedy otherwise available at law.

(n) An employee or the employee’s representative shall have the right to discuss possible regulatory violations or patient safety concerns with the inspector privately during the course of an investigation or inspection by the department.

(Amended by Stats. 2019, Ch. 72, Sec. 1. (SB 322) Effective January 1, 2020.)

1279. (a) Every health facility for which a license or special permit has been issued shall be periodically inspected by the department, or by another governmental entity under contract with the department. The frequency of inspections shall vary, depending upon the type and complexity of the health facility or special service to be inspected, unless otherwise specified by state or federal law or regulation. The inspection shall include participation by the California Medical Association consistent with the manner in which it participated in inspections, as provided in Section 1282 prior to September 15, 1992.

(b) Except as provided in subdivision (c) and Section 1422, inspections shall be conducted no less than once every two years and as often as necessary to ensure the quality of care being provided.

(c) For a health facility specified in subdivision (a), (b), or (f) of Section 1250, inspections shall be conducted no less than once every three years, and as often as necessary to ensure the quality of care being provided.

(d) During the inspection, the representative or representatives shall offer such advice and assistance to the health facility as they deem appropriate.

(e) For acute care hospitals of 100 beds or more, the inspection team shall include at least a physician, registered nurse, and persons experienced in hospital administration and sanitary inspections. During the inspection, the team shall offer advice and assistance to the hospital as it deems appropriate.

(f) The department shall ensure that a periodic inspection conducted pursuant to this section is not announced in advance of the date of inspection. An inspection may be conducted jointly with inspections by entities specified in Section 1282. However, if the department conducts an inspection jointly with an entity specified in Section 1282 that provides notice in advance of the periodic inspection, the department shall conduct an additional periodic inspection that is not announced or noticed to the health facility. The department shall conduct a periodic inspection to inspect compliance with this section and regulations adopted pursuant to Section 1276.4 that is not announced in advance of the date of inspection.

(g) Notwithstanding any other law, the department shall inspect the facility for compliance with provisions of state law and regulations during a state periodic inspection or at the same time as a federal periodic inspection, including, but not limited to, an inspection required under this section. If the department inspects for compliance with state law and regulations at the same time as a federal periodic inspection, the inspection shall be done consistent with the guidance of the federal Centers for Medicare and Medicaid Services for the federal portion of the inspection.

(h) The department shall emphasize consistency across the state and its district offices when conducting licensing and certification surveys and complaint investigations, including the selection of state or federal enforcement remedies in accordance with Section 1423. The department may issue federal deficiencies and recommend federal enforcement actions in those circumstances where they provide more rigorous enforcement action.

(Amended by Stats. 2022, Ch. 277, Sec. 1. (AB 1907) Effective January 1, 2023.)

1279.1. (a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent

threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law.

(b) For purposes of this section, “adverse event” includes any of the following:

(1) Surgical events, including the following:

(A) Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.

(B) Surgery performed on the wrong patient.

(C) The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.

(D) Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

(E) Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

(2) Product or device events, including the following:

(A) Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

(B) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, “device” includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

(C) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

(3) Patient protection events, including the following:

(A) An infant discharged to the wrong person.

(B) Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decisionmaking capacity.

(C) A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.

(4) Care management events, including the following:

(A) A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

(B) A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

(C) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

(D) Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.

(E) Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, “hyperbilirubinemia” means bilirubin levels greater than 30

milligrams per deciliter.

(F) A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

(G) A patient death or serious disability due to spinal manipulative therapy performed at the health facility.

(5) Environmental events, including the following:

(A) A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.

(B) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.

(C) A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.

(D) A patient death associated with a fall while being cared for in a health facility.

(E) A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

(6) Criminal events, including the following:

(A) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

(B) The abduction of a patient of any age.

(C) The sexual assault on a patient within or on the grounds of a health facility.

(D) The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

(7) An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

(c) The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made.

(d) “Serious disability” means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

(e) Nothing in this section shall be interpreted to change or otherwise affect hospital reporting requirements regarding reportable diseases or unusual occurrences, as provided in Section 70737 of Title 22 of the California Code of Regulations. The department shall review Section 70737 of Title 22 of the California Code of Regulations requiring hospitals to report “unusual occurrences” and consider amending the section to enhance the clarity and specificity of this hospital reporting requirement.

(Amended by Stats. 2007, Ch. 130, Sec. 156. Effective January 1, 2008.)

1279.2. (a) (1) In any case in which the department receives a report from a facility pursuant to Section 1279.1, or a written or oral complaint involving a health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250, that indicates an ongoing threat of imminent danger of death or serious bodily harm, the department shall make an onsite inspection or investigation within 48 hours or two business days, whichever is greater, of the receipt of the report or complaint and shall complete that investigation within 45 days.

(2) Until the department has determined by onsite inspection that the adverse event has been resolved, the department shall, not less than once a year, conduct an unannounced inspection of any health facility that has reported an adverse event pursuant to Section 1279.1.

(b) In any case in which the department is able to determine from the information available to it that there is no threat of imminent danger of death or serious bodily harm to that patient or other patients, the department shall complete an investigation of the report within 45 days.

(c) If the department does not meet the timeframes established in subdivision (a), the department shall document the extenuating circumstances explaining why it could not meet the timeframes. The department shall provide written notice to the facility and the complainant, if any, of the basis for the extenuating circumstances and the anticipated completion date.

(d) The department shall notify the complainant and licensee in writing of the department’s determination as a result of an inspection or report.

(e) For purposes of this section, “complaint” means any oral or written notice to the department, other than a report from the health facility, of an alleged violation of applicable requirements of state or federal law or an allegation of facts that might constitute a violation of applicable requirements of state or federal law.

(f) The costs of administering and implementing this section shall be paid from funds derived from existing licensing fees paid by general acute care hospitals, acute psychiatric hospitals, and special hospitals.

(g) In enforcing this section and Sections 1279 and 1279.1, the department shall take into account the special circumstances of small and rural hospitals, as defined in Section 124840, in order to protect the quality of patient care in those hospitals.

(h) In preparing the staffing and systems analysis required pursuant to Section 1266, the department shall also report regarding the number and timeliness of investigations of adverse events initiated in response to reports of adverse events.

(Amended by Stats. 2015, Ch. 18, Sec. 6. (SB 75) Effective June 24, 2015.)

1279.3. (a) By January 1, 2015, the department shall provide information regarding reports of substantiated adverse events pursuant to Section 1279.1 and the outcomes of inspections and investigations conducted pursuant to Section 1279.1, on the department’s Internet Web site and in written form in a manner that is readily accessible to consumers in all parts of California, and that protects patient confidentiality.

(b) By January 1, 2009, and until January 1, 2015, the department shall make information regarding reports of substantiated adverse events pursuant to Section 1279.1, and outcomes of inspections and investigations conducted pursuant to Section 1279.1, readily accessible to consumers throughout California. The department shall also compile and make available, to entities deemed appropriate by the department, data regarding these reports of substantiated adverse events pursuant to Section 1279.1 and outcomes of inspections and investigations conducted pursuant to Section 1279.1, in order that these entities may post this data on their Internet Web sites. Entities deemed appropriate by the department shall enter into a memorandum of understanding with the department that requires the inclusion of all data and all hospital information provided by the department. These entities may include universities, consumer organizations, or health care quality organizations.

(c) The information required pursuant to this section shall include, but not be limited to, information regarding each substantiated adverse event, as defined in Section 1279.1, reported to the department, and may include compliance information history. The names of the health care professionals and health care workers shall not be included in the information released by the department to the public.

(Added by Stats. 2006, Ch. 647, Sec. 3. Effective January 1, 2007. Operative July 1, 2007, by Sec. 5 of Ch. 647.)

1279.6. (a) A health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, shall develop, implement, and comply with a patient safety plan for the purpose of improving the health and safety of patients and reducing preventable patient safety events. The patient safety plan shall be developed by the facility, in consultation with the facility’s various health care professionals.

(b) The patient safety plan required pursuant to subdivision (a) shall, at a minimum, provide for the establishment of all of the following:

(1) A patient safety committee or equivalent committee in composition and function. The committee shall be composed of the facility’s various health care professionals, including, but not limited to, physicians, nurses, pharmacists, and administrators. The committee shall do all of the following:

(A) Review and approve the patient safety plan.

(B) Receive and review reports of patient safety events as defined in subdivision (c).

(C) Monitor implementation of corrective actions for patient safety events.

(D) Make recommendations to eliminate future patient safety events.

(E) Review and revise the patient safety plan, at least once a year, but more often if necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices.

(2) A reporting system for patient safety events that allows anyone involved, including, but not limited to, health care practitioners, facility employees, patients, and visitors, to make a report of a patient safety event to the health facility, including anonymous reporting options.

(3) A process for a team of facility staff to conduct analyses, including, but not limited to, root cause analyses of patient safety events. The team shall be composed of the facility’s various categories of health care professionals, with the appropriate

competencies to conduct the required analyses. The process shall also include analyses of patient safety events, including the following sociodemographic factors, to identify disparities in these events:

(A) Age.

(B) Race.

(C) Ethnicity.

(D) Gender identity.

(E) Sexual orientation.

(F) Preferred language spoken.

(G) Disability status.

(H) Payor.

(I) Sex.

(4) For the purposes of paragraph (3), it is the intent of the Legislature that a health facility use the same stratification categories as developed and defined by the Department of Health Care Access and Information for purposes of Section 127372, which is part of the Medical Equity Disclosure Act (Article 3 (commencing with Section 127370) of Chapter 2 of Part 2 of Division 107). With respect to the information set forth in subparagraphs (D) and (E) of paragraph (3), a health facility shall only be required to disclose information that is voluntarily provided by the patient or client.

(5) A reporting process that supports and encourages a culture of safety and reporting patient safety events.

(6) A process for providing ongoing patient safety training for facility personnel and health care practitioners.

(7) A process for addressing racism and discrimination, and its impacts on patient health and safety, that includes, but is not limited to:

(A) Monitoring sociodemographic disparities in patient safety events and developing interventions to remedy known disparities.

(B) Encouraging facility staff to report suspected instances of racism and discrimination.

(c) Commencing January 1, 2026, and biannually thereafter, health facilities shall submit patient safety plans to the department's licensing and certification division.

(1) The department may impose a fine not to exceed five thousand dollars ($5,000) on health facilities for failure to adopt, update, or submit patient safety plans.

(2) The department may grant a health facility an automatic 60-day extension for submitting biannual patient safety plans.

(d) The department shall make all patient safety plans submitted by health facilities available to the public on its internet website.

(e) For the purposes of this section, patient safety events shall be defined by the patient safety plan and shall include, but not be limited to, all adverse events or potential adverse events as described in Section 1279.1 that are determined to be preventable, and health-care-associated infections (HAI), as defined in the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor, unless the department accepts the recommendation of the Healthcare Associated Infection Advisory Committee, or its successor, that are determined to be preventable.

(Amended by Stats. 2024, Ch. 757, Sec. 1. (AB 3161) Effective January 1, 2025.)

1279.7. (a) A health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, shall implement a facilitywide hand hygiene program.

(b) Commencing January 1, 2017, a health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, is prohibited from using an epidural connector that would fit into a connector other than the type it was intended for, unless an emergency or urgent situation exists and the prohibition would impair the ability to provide health care.

(c) Commencing January 1, 2016, a health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, is prohibited from using an intravenous connector that would fit into a connector other than the type it was intended for, unless an emergency or urgent situation exists and the prohibition would impair the ability to provide health care.

(d) Commencing July 1, 2016, a health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, is prohibited from using an enteral feeding connector that would fit into a connector other than the type it was intended for, unless an emergency or urgent

situation exists and the prohibition would impair the ability to provide health care.

(e) The Advanced Medical Technology Association shall, on January 1 of each year until the standards are developed, provide the Legislature with a report on the progress of the International Organization for Standardization in developing new design standards for connectors for intravenous, epidural, or enteral applications.

(f) A health facility that is required to develop a patient safety plan pursuant to Section 1279.6 shall include in the patient safety plan measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines. This subdivision shall become inoperative as to epidural connectors upon the operative date of subdivision (b), and as to intravenous connectors upon the operative date of subdivision (c), and as to enteral feeding connectors upon the operative date of subdivision (d).

(Amended by Stats. 2016, Ch. 86, Sec. 174. (SB 1171) Effective January 1, 2017.)

1279.8. (a) Every health facility, as defined in subdivision (c), (d), (e), (g), (h), (i), or (m) of Section 1250, shall, for the purpose of addressing issues that arise when a patient is missing from the facility, develop and comply with an absentee notification plan as part of the written plans and procedures that are required pursuant to federal or state law. The plan shall include and be limited to the following: a requirement that an administrator of the facility, or his or her designee, inform the patient's authorized representative when that patient is missing from the facility and the circumstances in which an administrator of the facility, or his or her designee, shall notify local law enforcement when a patient is missing from the facility.

(b) This section shall not apply to state hospitals under the jurisdiction of the State Department of State Hospitals when the executive director of the state hospital, or his or her designee, determines that informing the patient's authorized representative that a patient is missing will create a risk to the safety and security of the state hospital.

(Added by Stats. 2013, Ch. 674, Sec. 1. (AB 620) Effective January 1, 2014.)

1280. (a) The state department may provide consulting services upon request to any health facility to assist in the identification or correction of deficiencies or the upgrading of the quality of care provided by the health facility.

(b) The state department shall notify the health facility of all deficiencies in its compliance with this chapter and the rules and regulations adopted hereunder, and the health facility shall agree with the state department upon a plan of correction that shall give the health facility a reasonable time to correct these deficiencies. If at the end of the allotted time, as revealed by inspection, the health facility has failed to correct the deficiencies, the director may take action to revoke or suspend the license.

(c) (1) In addition to subdivision (a), if the health facility is licensed under subdivision (a), (b), or (f) of Section 1250, and if the facility fails to implement a plan of correction that has been agreed upon by both the facility and the state department within a reasonable time, the state department may order implementation of the plan of correction previously agreed upon by the facility and the state department. If the facility and the state department fail to agree upon a plan of correction within a reasonable time and if the deficiency poses an immediate and substantial hazard to the health or safety of patients, then the director may take action to order implementation of a plan of correction devised by the state department. The order shall be in writing and shall contain a statement of the reasons for the order. If the facility does not agree that the deficiency poses an immediate and substantial hazard to the health or safety of patients or if the facility believes that the plan of correction will not correct the hazard, or if the facility proposes a more efficient or effective means of remedying the deficiency, the facility may, within 10 days of receiving the plan of correction from the department, appeal the order to the director. The director shall review information provided by the facility, the department, and other affected parties and within a reasonable time render a decision in writing that shall include a statement of reasons for the order. During the period which the director is reviewing the appeal, the order to implement the plan of correction shall be stayed. The opportunity for appeal provided pursuant to this subdivision shall not be deemed to be an adjudicative hearing and is not required to comply with Section 100171.

(2) If any condition within a health facility licensed under subdivision (a), (b), or (f) of Section 1250 poses an immediate and substantial hazard to the health or safety of patients, the state department may order either of the following until the hazardous condition is corrected:

(A) Reduction in the number of patients.

(B) Closure of the unit or units within the facility that pose the risk. If the unit to be closed is an emergency room in a designated facility, as defined in Section 1797.67, the state department shall notify and coordinate with the local emergency medical services agency.

(3) The facility may appeal an order pursuant to paragraph (2) by appealing to the superior court of the county in which the facility is located.

(4) Paragraph (2) shall not apply to a deficiency for which the facility was cited prior to January 1, 1994.

(d) Reports on the results of each inspection of a health facility shall be prepared by the inspector or inspector team and shall be kept on file in the state department along with the plan of correction and health facility comments. The inspection report may include a recommendation for reinspection. Inspection reports of an intermediate care facility/developmentally disabled habilitative or an intermediate care facility/developmentally disabled—nursing shall be provided by the state department to the appropriate regional center pursuant to Chapter 5 (commencing with Section 4620) of Division 4.5 of the Welfare and Institutions Code.

(e) All inspection reports and lists of deficiencies shall be open to public inspection when the state department has received verification that the health facility has received the report from the state department. All plans of correction shall be open to public inspection upon receipt by the state department.

(f) In no event shall the act of providing a plan of correction, the content of the plan of correction, or the execution of a plan of correction, be used in any legal action or administrative proceeding as an admission within the meaning of Sections 1220 to 1227, inclusive, of the Evidence Code against the health facility, its licensee, or its personnel.

(Amended by Stats. 1997, Ch. 220, Sec. 10. Effective August 4, 1997.)

1280.1. (a) Subject to subdivision (d), prior to the effective date of regulations adopted to implement Section 1280.3, if a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars ($25,000) per violation.

(b) If the licensee disputes a determination by the department regarding the alleged deficiency or the alleged failure to correct a deficiency, or regarding the reasonableness of the proposed deadline for correction or the amount of the penalty, the licensee may, within 10 days, request a hearing pursuant to Section 131071. Penalties shall be paid when appeals have been exhausted and the department's position has been upheld.

(c) For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.

(d) This section shall apply only to incidents occurring on or after January 1, 2007. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to one hundred thousand dollars ($100,000) per violation. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to fifty thousand dollars ($50,000) for the first administrative penalty, up to seventy-five thousand dollars ($75,000) for the second subsequent administrative penalty, and up to one hundred thousand dollars ($100,000) for the third and every subsequent violation. An administrative penalty issued after three years from the date of the last issued immediate jeopardy violation shall be considered a first administrative penalty so long as the facility has not received additional immediate jeopardy violations and is found by the department to be in substantial compliance with all state and federal licensing laws and regulations. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section.

(e) No new regulations are required or authorized for implementation of this section.

(f) This section shall become inoperative on the effective date of regulations promulgated by the department pursuant to Section 1280.3.

(g) In enforcing this section, the department shall take into consideration the special circumstances of small and rural hospitals, as defined in Section 124840, in order to protect access to quality care in those hospitals.

(Amended by Stats. 2008, Ch. 605, Sec. 1. Effective January 1, 2009. Inoperative on date prescribed in subd. (f).)

1280.2. (a) No deficiency cited pursuant to paragraph (2) of subdivision (b) of Section 1280 or Section 1280.1 shall be for the failure of a facility to meet the requirements of the California Building Standards Code if, as of January 1, 1994, the hospital building was approved under Chapter 12.5 (commencing with Section 15000) of Division 12.5, or if the hospital building was exempt from that approval under any other provision of law in effect on that date.

(b) It is the intent of the Legislature that neither the amendments made to Section 1280 by the act that added this section, nor Section 1280.1 shall be construed to require the retrofitting of hospital buildings built prior to January 1, 1994, to meet seismic standards in effect on that date.

(Added by Stats. 1993, Ch. 1152, Sec. 3. Effective January 1, 1994.)

1280.3. (a) Commencing on the effective date of the regulations adopted pursuant to this section, the director may assess an administrative penalty against a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 for a deficiency constituting an immediate jeopardy violation as determined by the department up to a maximum of seventy-five thousand dollars ($75,000) for the first administrative penalty, up to one hundred thousand dollars ($100,000) for the second subsequent administrative penalty, and up to one hundred twenty-five thousand dollars ($125,000) for the third and every subsequent violation. An administrative penalty issued after three years from the date of the last issued immediate jeopardy violation shall be considered a

first administrative penalty so long as the facility has not received additional immediate jeopardy violations and is found by the department to be in substantial compliance with all state and federal licensing laws and regulations. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section.

(b) Except as provided in subdivision (c), for a violation of this chapter or the rules and regulations promulgated thereunder that does not constitute a violation of subdivision (a), the department may assess an administrative penalty in an amount of up to twenty-five thousand dollars ($25,000) per violation. This subdivision shall also apply to violation of regulations set forth in Article 1 (commencing with Section 127400) of Chapter 2.5 of Part 2 of Division 107 or the rules and regulations promulgated thereunder.

The department shall promulgate regulations establishing the criteria to assess an administrative penalty against a health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250. The criteria shall include, but need not be limited to, the following:

(1) The patient's physical and mental condition.

(2) The probability and severity of the risk that the violation presents to the patient.

(3) The actual financial harm to patients, if any.

(4) The nature, scope, and severity of the violation.

(5) The facility's history of compliance with related state and federal statutes and regulations.

(6) Factors beyond the facility's control that restrict the facility's ability to comply with this chapter or the rules and regulations promulgated thereunder.

(7) The demonstrated willfulness of the violation.

(8) The extent to which the facility detected the violation and took steps to immediately correct the violation and prevent the violation from recurring.

(c) The department shall not assess an administrative penalty for minor violations.

(d) The regulations shall not change the definition of immediate jeopardy as established in this section.

(e) The regulations shall apply only to incidents occurring on or after the effective date of the regulations.

(f) (1) Notwithstanding subdivision (a), if the department determines that a health facility licensed under subdivision (a), (b), or (f) of Section 1250 has violated a regulation adopted pursuant to Section 1276.4, the department shall assess an administrative penalty of fifteen thousand dollars ($15,000) for the first violation and thirty thousand dollars ($30,000) for the second and each subsequent violation. For purposes of this subdivision, multiple violations found on the same inspection survey shall constitute a single violation for purposes of determining whether the violation was a first, second, or subsequent violation.

(2) A violation occurring more than three years after the date of the last violation shall be treated as a first violation.

(3) 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 subdivision by means of an All Facilities Letter (AFL) or similar instruction.

(4) (A) Notwithstanding paragraph (1), a general acute care hospital shall not be subject to an administrative penalty under that paragraph if the hospital demonstrates to the satisfaction of the department all of the following:

(i) That any fluctuation in required staffing levels was unpredictable and uncontrollable.

(ii) Prompt efforts were made to maintain required staffing levels.

(iii) In making those efforts, the hospital immediately used and subsequently exhausted the hospital's on-call list of nurses and the charge nurse.

(B) Nothing in this paragraph shall be construed to affect the obligation of a general acute care hospital to maintain proper staffing levels as prescribed in Section 70217 of Title 22 of the California Code of Regulations.

(5) Nothing in this section prohibits the department from issuing an administrative penalty for a staffing violation pursuant to this section and an administrative penalty for any resulting harm pursuant to subdivision (a).

(g) If the licensee disputes a determination by the department regarding the alleged deficiency or alleged failure to correct a deficiency, or regarding the reasonableness of the proposed deadline for correction or the amount of the penalty, the licensee may, within 10 working days, request a hearing pursuant to Section 131071. Penalties shall be paid when all appeals have been exhausted and the department's position has been upheld.

(h) For purposes of this section, “immediate jeopardy” means a situation in which the licensee’s noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.

(i) In enforcing subdivision (a) and paragraph (1) of subdivision (f), the department shall take into consideration the special circumstances of small and rural hospitals, as defined in Section 124840, in order to protect access to quality care in those hospitals.

(Amended by Stats. 2019, Ch. 843, Sec. 2. (SB 227) Effective January 1, 2020.)

1280.4. (a) If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 fails to report an adverse event pursuant to Section 1279.1, the department may assess the licensee a civil penalty in an amount not to exceed one hundred dollars ($100) for each day that the adverse event is not reported following the initial five-day period or 24-hour period, as applicable, pursuant to subdivision (a) of Section 1279.1.

(b) If a licensee of a health facility licensed under subdivision (a) or (b) of Section 1250 is required to, and fails to, immediately report an incident under subdivision (a) of Section 4427.5 of the Welfare and Institutions Code, the department may assess the licensee a civil penalty in the amount not to exceed one hundred dollars ($100) for each day that the incident was not reported to law enforcement.

(c) If a licensee disputes a determination by the department regarding an alleged failure to report as described in this section, the licensee may, within 10 days, request a hearing pursuant to Section 131071. Penalties shall be paid when appeals pursuant to those provisions have been exhausted.

(Amended by Stats. 2013, Ch. 724, Sec. 1. (SB 651) Effective January 1, 2014.)

1280.5. The state department shall accept, consider, and resolve written appeals by a licensee or health facility administrator of findings made upon the inspection of a health facility.

(Added by Stats. 1988, Ch. 595, Sec. 1.)

1280.6. In assessing an administrative penalty pursuant to Section 1280.1 or Section 1280.3 against a licensee of a health facility licensed under subdivision (a) of Section 1250 owned by a nonprofit corporation that shares an identical board of directors with a nonprofit health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340), the director shall consider whether the deficiency arises from an incident that is the subject of investigation of, or has resulted in a fine to, the health care service plan by the Department of Managed Health Care. If the deficiency results from the same incident, the director shall limit the administrative penalty to take into consideration the penalty imposed by the Department of Managed Health Care.

(Added by Stats. 2006, Ch. 895, Sec. 5.5. Effective January 1, 2007.)

1280.15. (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients’ medical information, as defined in Section 56.05 of the Civil Code and consistent with Section 1280.18. For purposes of this section, internal paper records, electronic mail, or facsimile transmissions inadvertently misdirected within the same facility or health care system within the course of coordinating care or delivering services shall not constitute unauthorized access to, or use or disclosure of, a patient’s medical information. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patient’s medical information. For purposes of the investigation, the department shall consider the clinic’s, health facility’s, agency’s, or hospice’s history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility’s ability to comply with this section. The department shall have full discretion to consider all factors when determining whether to investigate and the amount of an administrative penalty, if any, pursuant to this section.

(b) (1) A clinic, health facility, home health agency, or hospice to which subdivision (a) applies shall report any unlawful or unauthorized access to, or use or disclosure of, a patient’s medical information to the department no later than 15 business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, home health agency, or hospice.

(2) Subject to subdivision (c), a clinic, health facility, home health agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient’s medical information to the affected patient or the patient’s representative at the last known address, or by an alternative means or at an alternative location as specified by the patient or the patient’s representative in writing pursuant to Section 164.522(b) of Title 45 of the Code of Federal Regulations, no later than 15 business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, home health agency, or hospice. Notice may be provided by email only if the patient has previously agreed in writing to electronic notice by email.

(c) (1) A clinic, health facility, home health agency, or hospice shall delay the reporting, as required pursuant to paragraph (2) of subdivision (b), of any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information beyond 15 business days if a law enforcement agency or official provides the clinic, health facility, home health agency, or hospice with a written or oral statement that compliance with the reporting requirements of paragraph (2) of subdivision (b) would likely impede the law enforcement agency's investigation that relates to the unlawful or unauthorized access to, and use or disclosure of, a patient's medical information and specifies a date upon which the delay shall end, not to exceed 60 days after a written request is made, or 30 days after an oral request is made. A law enforcement agency or official may request an extension of a delay based upon a written declaration that there exists a bona fide, ongoing, significant criminal investigation of serious wrongdoing relating to the unlawful or unauthorized access to, and use or disclosure of, a patient's medical information, that notification of patients will undermine the law enforcement agency's investigation, and that specifies a date upon which the delay shall end, not to exceed 60 days after the end of the original delay period.

(2) If the statement of the law enforcement agency or official is made orally, then the clinic, health facility, home health agency, or hospice shall do both of the following:

(A) Document the oral statement, including, but not limited to, the identity of the law enforcement agency or official making the oral statement and the date upon which the oral statement was made.

(B) Limit the delay in reporting the unlawful or unauthorized access to, or use or disclosure of, the patient's medical information to the date specified in the oral statement, not to exceed 30 calendar days from the date that the oral statement is made, unless a written statement that complies with the requirements of this subdivision is received during that time.

(3) A clinic, health facility, home health agency, or hospice shall submit a report that is delayed pursuant to this subdivision not later than 15 business days after the date designated as the end of the delay.

(d) If a clinic, health facility, home health agency, or hospice to which subdivision (a) applies violates subdivision (b), the department may assess the licensee a penalty in the amount of one hundred dollars ($100) for each day that the unlawful or unauthorized access, use, or disclosure is not reported to the department or the affected patient, following the initial 15-day period specified in subdivision (b). However, the total combined penalty assessed by the department under subdivision (a) and this subdivision shall not exceed two hundred fifty thousand dollars ($250,000) per reported event. For enforcement purposes, it shall be presumed that the facility did not notify the affected patient if the notification was not documented. This presumption may be rebutted by a licensee only if the licensee demonstrates, by a preponderance of the evidence, that the notification was made.

(e) In enforcing subdivisions (a) and (d), the department shall take into consideration the special circumstances of small and rural hospitals, as defined in Section 124840, and primary care clinics, as defined in subdivision (a) of Section 1204, in order to protect access to quality care in those hospitals and clinics. When assessing a penalty on a skilled nursing facility or other facility subject to Section 1423, 1424, 1424.1, or 1424.5, the department shall issue only the higher of either a penalty for the violation of this section or a penalty for violation of Section 1423, 1424, 1424.1, or 1424.5, not both.

(f) All penalties collected by the department pursuant to this section, Sections 1280.1, 1280.3, 1280.4, and 1280.19, shall be deposited into the Internal Departmental Quality Improvement Account, which is hereby established in the State Treasury. Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys deposited into the account shall be retained in the account. Upon appropriation by the Legislature, moneys in the account shall be expended for internal quality improvement activities in the Licensing and Certification Program.

(g) If the licensee disputes a determination by the department regarding a failure to prevent or failure to timely report unlawful or unauthorized access to, or use or disclosure of, patients' medical information, or the imposition of a penalty under this section, the licensee may, within 10 days of receipt of the penalty assessment, request a hearing pursuant to Section 131071. Penalties shall be paid when appeals have been exhausted and the penalty has been upheld.

(h) In lieu of disputing the determination of the department regarding a failure to prevent or failure to timely report unlawful or unauthorized access to, or use or disclosure of, patients' medical information, transmit to the department 75 percent of the total amount of the administrative penalty, for each violation, within 30 business days of receipt of the administrative penalty.

(i) For purposes of this section, the following definitions shall apply:

(1) "Reported event" means all breaches included in any single report that is made pursuant to subdivision (b), regardless of the number of breach events contained in the report.

(2) "Unauthorized" means the inappropriate access, review, or viewing of patient medical information without a direct need for medical diagnosis, treatment, or other lawful use as permitted by the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) or any other statute or regulation governing the lawful access, use, or disclosure of medical information.

(j) Notwithstanding any other provision of law, the State Controller may use the funds in the Internal Departmental Quality Improvement Account for cash flow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(Amended by Stats. 2025, Ch. 21, Sec. 4. (AB 116) Effective June 30, 2025.)

1280.16. For purposes of Sections 1280.17, 1280.18, 1280.19, and 1280.20, the following definitions apply:

(a) “Department” means the State Department of Public Health.

(b) “Director” means the State Public Health Officer.

(c) “Medical information” means the term as defined in Section 56.05 of the Civil Code.

(d) “Provider of health care” means the term as defined in Sections 56.05 and 56.06 of the Civil Code.

(e) “Unauthorized access” means the inappropriate review or viewing of patient medical information without a direct need for diagnosis, treatment, or other lawful use as permitted by the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) or by other statutes or regulations governing the lawful access, use, or disclosure of medical information.

(Added by renumbering Section 130201 by Stats. 2014, Ch. 31, Sec. 24. (SB 857) Effective June 20, 2014.)

1280.17. (a) (1) The department may assess an administrative fine against any person or any provider of health care, whether licensed or unlicensed, for any violation of Section 1280.18 of this code or Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code in an amount as provided in Section 56.36 of the Civil Code. Proceedings against any person or entity for a violation of this section shall be held in accordance with administrative adjudication provisions of Chapter 4.5 (commencing with Section 11400) and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Paragraph (1) shall not apply to a clinic, health facility, agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745.

(b) The department shall adopt, amend, or repeal, in accordance with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, rules and regulations as may be reasonable and proper to carry out the purposes and intent of Sections 1280.18, 1280.19, and 1280.20, and to enable the authority to exercise the powers and perform the duties conferred upon it by those sections not inconsistent with any other provision of law.

(Added by renumbering Section 130202 by Stats. 2014, Ch. 31, Sec. 25. (SB 857) Effective June 20, 2014.)

1280.18. (a) Every provider of health care shall establish and implement appropriate administrative, technical, and physical safeguards to protect the privacy of a patient’s medical information. Every provider of health care shall reasonably safeguard confidential medical information from any unauthorized access or unlawful access, use, or disclosure.

(b) In exercising its duties pursuant to Section 1280.17, the department shall consider the provider’s capability, complexity, size, and history of compliance with this section and other related state and federal statutes and regulations, the extent to which the provider detected violations and took steps to immediately correct and prevent past violations from reoccurring, and factors beyond the provider’s immediate control that restricted the facility’s ability to comply with this section.

(c) The department may conduct joint investigations of individuals and health facilities for violations of this section and Section 1280.15, respectively.

(Added by renumbering Section 130203 by Stats. 2014, Ch. 31, Sec. 26. (SB 857) Effective June 20, 2014.)

1280.19. (a) Effective July 1, 2025, the Internal Health Information Integrity Quality Improvement Account is hereby abolished. All moneys in the fund shall be transferred to the Internal Departmental Quality Improvement Account created pursuant to subdivision (f) of Section 1280.15. Any remaining balance, assets, liabilities, and encumbrances of the Internal Health Information Integrity Quality Improvement Account as of July 1, 2025, shall be transferred to, and become part of, the Internal Departmental Quality Improvement Account. All administrative fines assessed by the department pursuant to Section 56.36 of the Civil Code shall be deposited into the Internal Departmental Quality Improvement Account. Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys deposited in the account shall be retained in the account. Upon appropriation by the Legislature, moneys in the account shall be used for the purpose of supporting quality improvement activities in the Licensing and Certification Program.

(b) Notwithstanding any other provision of law, the State Controller may use the funds in the Internal Departmental Quality Improvement Account for cash flow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(Amended by Stats. 2025, Ch. 21, Sec. 5. (AB 116) Effective June 30, 2025.)

1280.20. Notwithstanding any other law, the director may send a recommendation for further investigation of, or discipline for, a potential violation of the licensee’s relevant licensing authority. The recommendation shall include all documentary evidence collected by the director in evaluating whether or not to make that recommendation. The recommendation and accompanying evidence shall be deemed in the nature of an investigative communication and be protected by the provisions listed in Section

7920.505 of the Government Code. The licensing authority of the provider of health care shall review all evidence submitted by the director and may take action for further investigation or discipline of the licensee.

(Amended by Stats. 2021, Ch. 615, Sec. 221. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

1281. All public and private general acute care hospitals either shall comply with the standards for the examination and treatment of victims of sexual assault and attempted sexual assault, including child sexual abuse, and the collection and preservation of evidence therefrom, specified in Section 13823.11 of the Penal Code, and the protocol and guidelines therefor established pursuant to Section 13823.5 of the Penal Code, or they shall adopt a protocol for the immediate referral of these victims to a local hospital that so complies, and shall notify local law enforcement agencies, the district attorney, and local victim assistance agencies of the adoption of the referral protocol.

(Amended by Stats. 2019, Ch. 714, Sec. 1. (AB 538) Effective January 1, 2020.)

1281.5. (a) All general acute care hospitals with an emergency department shall adopt and implement policies and procedures to facilitate the self-identification of an emergency department patient as a victim of human trafficking or domestic violence to hospital personnel.

(b) The policies and procedures adopted and implemented pursuant to subdivision (a) shall meet all of the following minimum requirements:

(1) Provide for patient confidentiality in accordance with the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

(2) Provide an emergency department patient with a safe and discreet means of informing hospital personnel that they are a victim of human trafficking or domestic violence.

(3) (A) Facilitate a reasonably prompt and private interview of the patient by medical personnel for purposes of providing information to the patient described in paragraph (4). This paragraph does not require a patient to participate in a private interview if the patient declines.

(B) For purposes of this paragraph, “medical personnel” includes any health care professional licensed under Article 1 (commencing with Section 500) of Chapter 1 of Division 2 of the Business and Professions Code.

(4) Provide patients with information to local services and resources for victims of human trafficking or domestic violence, if any.

(5) Incorporate principles of trauma-informed care.

(c) Every general acute care hospital subject to this section may track the use of the self-identification procedure, including the total number, ages, and racial demographics of patients who self-identify as a victim of human trafficking or domestic violence, to the extent that this information is provided by the patient.

(d) (1) A general acute care hospital subject to this section shall not be required to report the identities of any patients who self-identify as a victim of human trafficking or domestic violence to the department or to any law enforcement agency, except as may be required pursuant to Article 2 (commencing with Section 11160) or Article 2.5 (commencing with Section 11164) of Chapter 2 of Title 1 of Part 4 of the Penal Code, or Chapter 11 (commencing with Section 15600) of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) (A) A general acute care hospital, including its directors, officers, employees, medical staff, contracted health care providers, agents, and all persons licensed under Article 1 (commencing with Section 500) of Chapter 1 of Division 2 of the Business and Professions Code, acting in compliance with this section shall not be liable for any injuries or damages arising from, or related to, a patient who is offered or receives the information described in paragraph (4) of subdivision (b) or who self-identifies, including any injuries inflicted by a trafficker or abuser based on acts or omissions taken pursuant to the policies and procedures established under this section, so long as the hospital has acted in good faith.

(B) The liability limitations described in subparagraph (A) shall not be construed to limit a person’s liability for any act or omission that constitutes gross negligence or willful or wanton misconduct.

(e) For purposes of this section, the following definitions shall apply:

(1) “Human trafficking” has the same meaning as that term is defined in Section 236.1 of the Penal Code.

(2) “Domestic violence” has the same meaning as that term is defined in Section 6211 of the Family Code or Section 13700 of the Penal Code.

(Added by Stats. 2024, Ch. 616, Sec. 1. (SB 963) Effective January 1, 2025.)

1282. (a) The state department shall have the authority to contract for outside personnel to perform inspections of health facilities as the need arises. The state department, when feasible, shall contract with nonprofit, professional organizations which have demonstrated the ability to carry out the provisions of this chapter. The organizations shall include, but not be limited to, the California Medical Association Committee on Medical Staff Surveys and participants in the Consolidated Hospital Survey Program.

Quality of care inspections have been performed in recent years by the California Medical Association Committee on Staff Surveys and other organizations which have combined their efforts in the Consolidated Hospital Survey Program. It is the intent of the Legislature that these organizations or comparable organizations shall continue to perform these inspections by contract when sufficient manpower is available from the organizations to do so, unless the state department demonstrates that the inspections fail to assure compliance with the quality of care standards set by this chapter.

(b) If, pursuant to this section, the state department contracts with the Joint Commission on Accreditation of Hospitals to perform all or any part of a quality of care inspection for a health facility specified in subdivision (a) of Section 1250, and if that health facility contracts with the Joint Commission on Accreditation of Hospitals to perform an accreditation inspection and survey at the same time as the quality of care inspection, the health facility shall transmit to the state department, within 30 days of receipt, a copy of the final accreditation report of the Joint Commission on the Accreditation of Hospitals. However, if the Joint Commission on Accreditation of Hospitals conducts an accreditation inspection and survey at a health facility at a time other than the time at which, pursuant to this section, it participates in a quality of care inspection at that facility, then the health facility shall not be required to transmit a copy of the final accreditation report to the state department.

(Amended by Stats. 1983, Ch. 992, Sec. 3.)

1283. (a) No health facility shall surrender the physical custody of a minor under 16 years of age to any person unless such surrender is authorized in writing by the child’s parent, the person having legal custody of the child, or the caregiver of the child who is a relative of the child and who may authorize medical care and dental care under Section 6550 of the Family Code.

(b) A health facility shall report to the State Department of Health Services, on forms supplied by the department, the name and address of any person and, in the case of a person acting as an agent for an organization, the name and address of the organization, into whose physical custody a minor under the age of 16 is surrendered, other than a parent, relative by blood or marriage, or person having legal custody. This report shall be transmitted to the department within 48 hours of the surrendering of custody. No report to the department is required if a minor under the age of 16 is transferred to another health facility for further care or if this minor comes within Section 300, 601, or 602 of the Welfare and Institutions Code and is released to an agent of a public welfare, probation, or law enforcement agency.

(Amended by Stats. 1996, Ch. 563, Sec. 4. Effective January 1, 1997.)

1284. A licensed inpatient mental health facility shall be subject to the provisions of Section 5622 of the Welfare and Institutions Code.

(Amended by Stats. 1987, Ch. 835, Sec. 1.)

1285. (a) No patient shall be detained in a health facility solely for the nonpayment of a bill.

(b) For the purposes of this section, “detained” means the intentional confinement of a patient in a health facility without authorization of the patient or any other person who may be authorized to provide consent to care on behalf of the patient.

(c) Any person who is detained in a health facility solely for the nonpayment of a bill has a cause of action against the health facility for the detention, which may be brought by that person or that person’s parent, guardian, conservator, or other legal representative.

The cause of action may be brought against the health facility, proprietor, lessee or their agents, or against any person, corporation, association, or directors thereof. Any person who has been detained in a health facility, solely for the nonpayment of a bill, who has brought an action for the detention, may recover general and punitive damages, court costs, and reasonable attorney’s fees actually incurred and any other relief which the court in its discretion may allow.

(d) Violation of subdivision (a) is a misdemeanor punishable as prescribed in Section 1290.

(Amended by Stats. 1981, Ch. 714.)

1286. (a) Smoking a tobacco product shall be prohibited in patient care areas, waiting rooms, and visiting rooms of a health facility, except those areas specifically designated as smoking areas, and in patient rooms as specified in subdivision (b).

(b) Smoking a tobacco product shall not be permitted in a patient room unless all persons assigned to the room have requested a room where smoking is permitted. In the event that the health facility occupancy has reached capacity, the health facility shall have reasonable time to reassign patients to appropriate rooms.

(c) Clearly legible signs shall either:

(1) State that smoking is unlawful and be conspicuously posted by, or on behalf of, the owner or manager of the health facility, in all areas of a health facility where smoking is unlawful, or

(2) Identify “smoking permitted” areas, and be posted by, or on behalf of, the owner or manager of the health facility, only in areas of the health facility where smoking is lawfully permitted.

If “smoking permitted” signs are posted, there shall also be conspicuously posted, near all major entrances, clearly legible signs stating that smoking is unlawful except in areas designated “smoking permitted.”

(d) No signs pertaining to smoking are required to be posted in patient rooms.

(e) This section shall not apply to skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the developmentally disabled.

(f) For purposes of this section, “smoking” has the same meaning as in subdivision (c) of Section 22950.5 of the Business and Professions Code.

(g) For purposes of this section, “tobacco product” means a product or device as defined in subdivision (d) of Section 22950.5 of the Business and Professions Code.

(Amended by Stats. 2016, 2nd Ex. Sess., Ch. 7, Sec. 12. (SB 5 2x) Effective June 9, 2016.)

1288. (a) Except as provided in subdivision (b), the licensee of each skilled nursing or intermediate care facility shall notify, in writing, all patients for whom the facility’s services are not reimbursed pursuant to the provisions of Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code, or such patient’s responsible agent, of any scheduled room rate increase at least 30 calendar days in advance of the increase.

(b) The licensee need not delay rate increases in order to provide the notice prescribed by subdivision (a) during any period when such delay would result in a loss to the facility of Medi-Cal reimbursement revenues available to it under Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code due to increases in allowable Medi-Cal reimbursement rates (1) implemented by emergency regulation or (2) made retroactive. In such cases, the licensee shall provide the notice as many days in advance as is possible without loss of Medi-Cal revenues or, if not possible without Medi-Cal revenue losses, at the time of effectuating the rate increase. Nothing contained in this subdivision shall be construed as authorizing retroactive room rate increases for facility services to patients that are not reimbursed under Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

(Added by Stats. 1980, Ch. 891.)

1288.4. A health facility licensed under subdivision (a), (b), or (f) of Section 1250 shall post conspicuously, in a prominent location within the premises and accessible to public view, a notice providing the telephone number of the state department’s regional licensing office where complaints regarding the facility may be reported. The state department shall inform the health facility of the telephone number to be included in the notice.

(Added by Stats. 1993, Ch. 1152, Sec. 4. Effective January 1, 1994.)

1289. (a) No owner, employee, agent, or consultant of a long-term health care facility, as defined in Section 1418, or member of his or her immediate family, or representative of a public agency or organization operating within the long-term health care facility with state, county, or city authority, or member of his or her immediate family, shall purchase or receive any item or property with a fair market value of more than one hundred dollars ($100) from a resident in the long-term health care facility, unless the purchase or receipt is made or conducted in the presence of a representative of the Office of the State Long-Term Care Ombudsman, as defined in subdivision (c) of Section 9701 of the Welfare and Institutions Code. The role of the ombudsman is to witness the transaction and to question the resident and others as appropriate, about the transaction. The ombudsman may submit written comments pertaining to the transaction into the health records of the resident. The Office of the State Long-Term Care Ombudsman shall establish guidelines concerning activities of ombudsmen pursuant to this section. Additionally, the transaction described in this subdivision shall be recorded by the facility in the health records of the resident. The record of the transaction shall include the name and address of the purchaser, date and location of the transaction, description of property sold, and purchase price. The instrument shall include signatures of the resident, the purchaser, and the witnessing ombudsman.

(b) Any owner, employee, agent, or consultant of a long-term health care facility, or member of his or her immediate family, or representative of a public agency or organization operating within the long-term health care facility with state, county, or city authority, or member of his or her immediate family, who violates subdivision (a) shall be required to return the item or property he or

she purchased to the person from whom it was purchased, if he or she still possesses it. If the employee no longer possesses the item or property, he or she shall pay the person who sold the item or property the fair market value at the time he or she would otherwise be required to return the property.

(c) Craft items, which are those items made by residents of a long-term health care facility, are exempt from the provisions of this section.

(d) Any violation of this section shall be subject to a civil penalty not to exceed one thousand dollars ($1,000) which shall be enforced by the Department of Aging. The Department of Aging may bring a cause of action in a court of competent jurisdiction to enforce the provisions of this subdivision.

(e) Notwithstanding Section 1290, any person who violates this section is guilty of an infraction and shall be punished by a fine of not more than one hundred dollars ($100).

(Added by Stats. 1984, Ch. 1182, Sec. 1.)

1289.3. (a) A long-term health care facility, as defined in Section 1418, which fails to make reasonable efforts to safeguard patient property shall reimburse a patient for or replace stolen or lost patient property at its then current value. The facility shall be presumed to have made reasonable efforts to safeguard patient property if the facility has shown clear and convincing evidence of its efforts to meet each of the requirements specified in Section 1289.4. The presumption shall be a rebuttable presumption, and the resident or the resident's representative may pursue this matter in any court of competent jurisdiction.

(b) A citation shall be issued if the long-term health care facility has no program in place or if the facility has not shown clear and convincing evidence of its efforts to meet all of the requirements set forth in Section 1289.4. The department shall issue a deficiency in the event that the manner in which the policies have been implemented is inadequate or the individual facility situation warrants additional theft and loss protections.

(c) The department shall not determine that a long-term health care facility's program is inadequate based solely on the occasional occurrence of theft or loss in a facility.

(Added by Stats. 1987, Ch. 1235, Sec. 2.)

1289.4. A theft and loss program shall be implemented by the long-term health care facilities within 90 days after January 1, 1988. The program shall include all of the following:

(a) Establishment and posting of the facility's policy regarding theft and investigative procedures.

(b) Orientation to the policies and procedures for all employees within 90 days of employment.

(c) Documentation of lost and stolen patient property with a value of twenty-five dollars ($25) or more and, upon request, the documented theft and loss record for the past 12 months shall be made available to the State Department of Public Health, the county health department or law enforcement agencies, and to the office of the State Long-Term Care Ombudsman in response to a specific complaint. The documentation shall include, but not be limited to, the following:

(1) A description of the article.

(2) Its estimated value.

(3) The date and time the theft or loss was discovered.

(4) If determinable, the date and time the loss or theft occurred.

(5) The action taken.

(d) A written patient personal property inventory is established upon admission and retained during the resident's stay in the long-term health care facility. A copy of the written inventory shall be provided to the resident or the person acting on the resident's behalf. Subsequent items brought into or removed from the facility shall be added to or deleted from the personal property inventory by the facility at the written request of the resident, the resident's family, a responsible party, or a person acting on behalf of a resident. The facility shall not be liable for items which have not been requested to be included in the inventory or for items which have been deleted from the inventory. A copy of a current inventory shall be made available upon request to the resident, responsible party, or other authorized representative. The resident, resident's family, or a responsible party may list those items that are not subject to addition or deletion from the inventory, such as personal clothing or laundry, that are subject to frequent removal from the facility.

(e) Inventory and surrender of the resident's personal effects and valuables upon discharge to the resident or authorized representative in exchange for a signed receipt.

(f) Inventory and surrender of personal effects and valuables following the death of a resident to the authorized representative in exchange for a signed receipt. Immediate notice to the public administrator of the county upon the death of a resident without known

next of kin as provided in Section 7600.5 of the Probate Code.

(g) Documentation, at least semiannually, of the facility's efforts to control theft and loss, including the review of theft and loss documentation and investigative procedures and results of the investigation by the administrator and, when feasible, the resident council.

(h) Establishment of a method of marking, to the extent feasible, personal property items for identification purposes upon admission and, as added to the property inventory list, including engraving of dentures and tagging of other prosthetic devices.

(i) Reports to the local law enforcement agency within 36 hours when the administrator of the facility has reason to believe patient property with a then-current value of one hundred dollars ($100) or more has been stolen. Copies of those reports for the preceding 12 months shall be made available to the State Department of Public Health and law enforcement agencies.

(j) Maintenance of a secured area for patients' property which is available for safekeeping of patient property upon the request of the patient or the patient's responsible party. Provide a lock for the resident's bedside drawer or cabinet upon request of and at the expense of the resident, the resident's family, or authorized representative. The facility administrator shall have access to the locked areas upon request.

(k) A copy of this section and Sections 1289.3 and 1289.5 is provided by a facility to all of the residents and their responsible parties, and, available upon request, to all of the facility's prospective residents and their responsible parties.

(l) Notification to all current residents and all new residents, upon admission, of the facility's policies and procedures relating to the facility's theft and loss prevention program.

(Amended by Stats. 2010, Ch. 328, Sec. 112. (SB 1330) Effective January 1, 2011.)

1289.5. No provision of a contract of admission, which includes all documents which a resident or his or her representative is required to sign at the time of, or as a condition of, admission to a long-term health care facility, shall require or imply a lesser standard of responsibility for the personal property of residents than is required by law.

(Added by Stats. 1987, Ch. 1235, Sec. 4.)