HOUSE BILL NO. 1446

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Health, Welfare and Institutions

on _____)

(Patron Prior to Substitute--Delegate Orrock)

A BILL to amend and reenact §§ 32.1-27.1 and 32.1-127 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-27.2, relating to minimum staffing standards for certified nursing facilities; administrative sanctions.

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-27.1 and 32.1-127 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-27.2 as follows:

§ 32.1-27.1. Additional civil penalty or appointment of a receiver.

A. In addition to the remedies provided in ~~§~~ §§ 32.1-27 and 32.1-27.2, the civil penalties set forth in this section may be imposed by the circuit court for the city or county in which the facility is located as follows:

1. A civil penalty for a Class I violation shall not exceed the lesser of $25 per licensed or certified bed or $1,000 for each day the facility is in violation, beginning on the date the facility was first notified of the violation.

2. A civil penalty for a Class II violation shall not exceed the lesser of $5 per licensed or certified bed or $250 per day for each day the facility is in violation, beginning on the date the facility was first notified of the violation.

In the event federal law or regulations require a civil penalty in excess of the amounts set forth above for Class I or Class II violations, then the lowest amounts required by such federal law or regulations shall become the maximum civil penalties under this section. The date of notification under this section shall be deemed to be the date of receipt by the facility of written notice of the alleged Class I or Class II

violation, which notice shall include specifics of the violation charged and which notice shall be hand delivered or sent by overnight express mail or by registered or certified mail, return receipt requested.

All civil penalties received pursuant to this subsection shall be paid into a special fund of the Department for the cost of implementation of this section, to be applied to the protection of the health or property of residents or patients of facilities that the Commissioner or the United States Secretary of Health and Human Services finds in violation, including payment for the costs for relocation of patients, maintenance of temporary management or receivership to operate a facility pending correction of a violation, and for reimbursement to residents or patients of lost personal funds.

B. In addition to the remedies provided in ~~§~~ §§ 32.1-27 and 32.1-27.2 and the civil penalties set forth in subsection A ~~of this section~~, the Commissioner may petition the circuit court for the jurisdiction in which any nursing home or certified nursing facility as defined in § 32.1-123 is located for the appointment of a receiver in accordance with the provisions of this subsection whenever such nursing home or certified nursing facility shall (i) receive official notice from the Commissioner that its license has been or will be revoked or suspended, or that its Medicare or Medicaid certification has been or will be cancelled or revoked; or (ii) receive official notice from the United States Department of Health and Human Services or the Department of Medical Assistance Services that its provider agreement has been or will be revoked, cancelled, terminated or not renewed; or (iii) advise the Department of its intention to close or not to renew its license or Medicare or Medicaid provider agreement less than ninety days in advance; or (iv) operate at any time under conditions which present a major and continuing threat to the health, safety, security, rights or welfare of the patients, including the threat of imminent abandonment by the owner or operator, or a pattern of failure to meet ongoing financial obligations such as the inability to pay for essential food, pharmaceuticals, personnel, or required insurance; and (v) the Department is unable to make adequate and timely arrangements for relocating all patients who are receiving medical assistance under this chapter and Title XIX of the Social Security Act in order to ensure their continued safety and health care.

Upon the filing of a petition for appointment of a receiver, the court shall hold a hearing within ten days, at which time the Department and the owner or operator of the facility may participate and

present evidence. The court may grant the petition if it finds any one of the conditions identified in (i) through (iv) ~~above~~ to exist in combination with the condition identified in (v) and the court further finds that such conditions will not be remedied and that the patients will not be protected unless the petition is granted.

No receivership established under this subsection shall continue in effect for more than 180 days without further order of the court, nor shall the receivership continue in effect following the revocation of the nursing home's license or the termination of the certified nursing facility's Medicare or Medicaid provider agreement, except to enforce any post-termination duties of the provider as required by the provisions of the Medicare or Medicaid provider agreement.

The appointed receiver shall be a person licensed as nursing home administrator in the Commonwealth pursuant to Title 54.1 or, if not so licensed, shall employ and supervise a person so licensed to administer the day-to-day business of the nursing home or certified nursing facility.

The receiver shall have (i) such powers and duties to manage the nursing home or certified nursing facility as the court may grant and direct, including but not limited to the duty to accomplish the orderly relocation of all patients and the right to refuse to admit new patients during the receivership, (ii) the power to receive, conserve, protect and disburse funds, including Medicare and Medicaid payments on behalf of the owner or operator of the nursing home or certified nursing facility, (iii) the power to execute and avoid executory contracts, (iv) the power to hire and discharge employees, and (v) the power to do all other acts, including the filing of such reports as the court may direct, subject to accounting to the court therefor and otherwise consistent with state and federal law, necessary to protect the patients from the threat or threats set forth in the original petitions, as well as such other threats arising thereafter or out of the same conditions.

The court may grant injunctive relief as it deems appropriate to the Department or to its receiver either in conjunction with or subsequent to the granting of a petition for appointment of a receiver under this section.

The court may terminate the receivership on the motion of the Department, the receiver, or the owner or operator, upon finding, after a hearing, that either (i) the conditions described in the petition have

been substantially eliminated or remedied~~,~~ or (ii) all patients in the nursing home or certified nursing facility have been relocated. Within ~~thirty~~ 30 days after such termination, the receiver shall file a complete report of his activities with the court, including an accounting for all property of which he has taken possession and all funds collected.

All costs of administration of a receivership hereunder shall be paid by the receiver out of reimbursement to the nursing home or certified nursing facility from Medicare, Medicaid and other patient care collections. The court, after terminating such receivership, shall enter appropriate orders to ensure such payments upon its approval of the receiver's reports.

A receiver appointed under this section shall be an officer of the court, shall not be liable for conditions at the nursing home or certified nursing facility which existed or originated prior to his appointment and shall not be personally liable, except for his own gross negligence and intentional acts which result in injuries to persons or damage to property at the nursing home or certified nursing facility during his receivership.

The provisions of this subsection shall not be construed to relieve any owner, operator or other party of any duty imposed by law or of any civil or criminal liability incurred by reason of any act or omission of such owner, operator, or other party.

§ 32.1-27.2. Administrative sanctions.

A. Notwithstanding any other provision of law, the Commissioner may impose administrative sanctions in accordance with this section on any certified nursing facility, if that certified nursing facility does not comply with the provisions of regulations promulgated pursuant to subdivision B 32 of § 32.1-127. The Commissioner shall not impose any administrative sanctions authorized under this section until regulations are promulgated pursuant to subsection G.

B. No sanction for noncompliance with the provisions of regulations promulgated pursuant to subdivision B 32 of § 32.1-127 shall be issued if the Commissioner determines that the certified nursing facility:

1. Was affected by a declared emergency, or an act of God, that had an impact on the ability to hire or retain staff at levels required under subdivision B 32 of § 32.1-127. To the extent necessary, the

Commissioner may review trended employment data for direct care staff, as provided by the certified nursing facility, to determine the effect of such emergencies or acts of God in assessing this criterion. Failure to provide adequate data may remove this criterion from the Commissioner's consideration;

2. Has made a concerted effort to recruit and retain direct care staff as evidenced through position advertisements, interviews, offers, financial incentives, and nonfinancial incentives. The certified nursing facility shall provide such evidence upon request of the Commissioner for consideration. Failure to provide adequate evidence may remove this criterion from the Commissioner's consideration; or

3. Was located in a health professional shortage area as designated by the Health Resources and Services Administration (HRSA) or was located in a medically underserved area as designated by the Department and such location severely limited the ability of the certified nursing facility to recruit and retain direct care staff despite a concerted effort to recruit and retain direct care staff. The certified nursing facility shall provide evidence upon request of the Commissioner for consideration. Failure to provide adequate evidence may remove this criterion from the Commissioner's consideration.

C. Prior to restricting or prohibiting new admissions to a certified nursing facility, suspending or refusing to renew or reinstate any nursing home license, or revoking any nursing home license issued pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5, the Commissioner shall first impose the following iterative administrative sanctions:

1. When a certified nursing facility is not in compliance with subdivision B 32 of § 32.1-127 and the conditions under subsection B do not exist, the Commissioner shall require the submission of an annual corrective action plan by a certified nursing facility and, upon approval of such plan by the Commissioner, compliance with such plan. A corrective action plan shall only articulate strategies to be utilized to increase direct care staffing with the goal of compliance with subdivision B 32 of § 32.1-127 or improvement on the total nurse staffing hours metric, as defined by the Virginia Medicaid Nursing Facility Value-Based Purchasing (VBP) program. The Commissioner shall consider evidence of direct care staff hours provided in addition to the payroll based journal report, if requested by a certified nursing facility, and may or may not impose a corrective action plan under this section. The Commissioner shall consider the following:

a. If the annual measurement immediately subsequent to issuance of the corrective action plan shows compliance with subdivision B 32 of § 32.1-127, no additional administrative sanctions are warranted, and the corrective action plan is deemed inactive but shall be retained by the Commissioner pursuant to the Virginia Public Records Act (§ 42.1-76 et seq.); or

b. If the annual measurement immediately subsequent to issuance of the corrective action plan still shows noncompliance with subdivision B 32 of § 32.1-127, but the VBP program, as administered by the Department of Medical Assistance Services, indicates defined improvement on the total nurse staffing hours metric, the Commissioner shall repeat the provisions of subdivision 1; or

c. If the annual measurement immediately subsequent to issuance of the corrective action plan still shows noncompliance with subdivision B 32 of § 32.1-127, and the VBP program, as administered by the Department of Medical Assistance Services, does not indicate defined improvement on the total nurse staffing hours metric, the Commissioner shall repeat the provisions of subdivision 1 and may, under circumstances described, provide additional sanctions under subdivisions 2 and 3;

2. To the extent that any consecutive annual corrective action plan is required and results articulated in subdivision 1 c are obtained a second consecutive time, the Commissioner may impose a monetary penalty of up to $50,000 for each subsequent consecutive annual period in which compliance with subdivision B 32 of § 32.1-127 or defined improvement on the total nurse staffing hours metric under the VBP program is not attained; and

3. To the extent that a certified nursing facility is out of compliance with subdivision B 32 of § 32.1-127 or fails to show defined improvement on the total nurse staffing hours metric under the VBP program after four consecutive corrective action plans, the Commissioner may place the nursing home or certified nursing facility on probation.

D. A certified nursing facility sanctioned by the Commissioner shall retain responsibility for the health, safety, and welfare of any person under its care, including the timely transfer or relocation of such persons as may be deemed necessary by the Commissioner in compliance with state and federal discharge rights and protections for nursing home residents.

E. After deduction of the administrative costs of the Commissioner and the Department in furtherance of this section, any penalties collected under this section shall be paid to the special fund as set forth in § 32.1-27.1.

F. Prior to imposing administrative sanctions, the Commissioner shall provide the facility with reasonable notice. To the extent that sanctions are imposed, the facility shall be entitled to all rights under the Administrative Process Act (§ 2.2-4000 et seq.) and to a de novo appeal to circuit court.

G. The Board shall promulgate regulations to implement the provisions of this section consistent with the Administrative Process Act (§ 2.2-4000 et seq.).

§ 32.1-127. Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities;

2. Shall provide that at least one physician who is licensed to practice medicine in this Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each hospital which operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS regulations for routine contact, whereby the provider's designated organ procurement organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer

of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the other parent of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and Medicaid Services;

9. Shall establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national or state-developed evaluation system. Such standards may be differentiated for various levels or categories of care and may include, but need not be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

10. Shall require that each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report;

11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital policies and procedures, by the person giving the order, or, when such person is not available within the period of time specified, co-signed by another physician or other person authorized to give the order;

12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of the vaccination, that each certified nursing facility and nursing home provide or arrange for the administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal vaccination, in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

13. Shall require that each nursing home and certified nursing facility register with the Department of State Police to receive notice of the registration, reregistration, or verification of registration information of any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 within the same or a contiguous zip code area in which the home or facility is located, pursuant to § 9.1-914;

14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission, whether a potential patient is required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the potential patient will have a length of stay greater than three days or in fact stays longer than three days;

15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult patient to receive visits from any individual from whom the patient desires to receive visits,

subject to other restrictions contained in the visitation policy including, but not limited to, those related to the patient's medical condition and the number of visitors permitted in the patient's room simultaneously;

16. Shall require that each nursing home and certified nursing facility shall, upon the request of the facility's family council, send notices and information about the family council mutually developed by the family council and the administration of the nursing home or certified nursing facility, and provided to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times per year. Such notices may be included together with a monthly billing statement or other regular communication. Notices and information shall also be posted in a designated location within the nursing home or certified nursing facility. No family member of a resident or other resident representative shall be restricted from participating in meetings in the facility with the families or resident representatives of other residents in the facility;

17. Shall require that each nursing home and certified nursing facility maintain liability insurance coverage in a minimum amount of $1 million, and professional liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15, to compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the facility. Failure to maintain such minimum insurance shall result in revocation of the facility's license;

18. Shall require each hospital that provides obstetrical services to establish policies to follow when a stillbirth, as defined in § 32.1-69.1, occurs that meet the guidelines pertaining to counseling patients and their families and other aspects of managing stillbirths as may be specified by the Board in its regulations;

19. Shall require each nursing home to provide a full refund of any unexpended patient funds on deposit with the facility following the discharge or death of a patient, other than entrance-related fees paid to a continuing care provider as defined in § 38.2-4900, within 30 days of a written request for such funds by the discharged patient or, in the case of the death of a patient, the person administering the person's estate in accordance with the Virginia Small Estates Act (§ 64.2-600 et seq.);

20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct

verbal communication between the on-call physician in the psychiatric unit and the referring physician, if requested by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for such direct verbal communication by a referring physician and (ii) a patient for whom there is a question regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which the patient is sought to be transferred to participate in direct verbal communication, either in person or via telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information employed by a poison control center that is accredited by the American Association of Poison Control Centers to review the results of the toxicology screen and determine whether a medical reason for refusing admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the referring physician;

21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a policy governing determination of the medical and ethical appropriateness of proposed medical care, which shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care; and (iii) requirements for a written explanation of the decision reached by the interdisciplinary medical review committee, which shall be included in the patient's medical record. Such policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other remedies available at law, including seeking court review, provided that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-

2986, or legal counsel provides written notice to the chief executive officer of the hospital within 14 days of the date on which the physician's determination that proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical record;

22. Shall require every hospital with an emergency department to establish protocols to ensure that security personnel of the emergency department, if any, receive training appropriate to the populations served by the emergency department, which may include training based on a trauma-informed approach in identifying and safely addressing situations involving patients or other persons who pose a risk of harm to themselves or others due to mental illness or substance abuse or who are experiencing a mental health crisis;

23. Shall require that each hospital establish a protocol requiring that, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan;

24. Shall establish an exemption from the requirement to obtain a license to add temporary beds in an existing hospital or nursing home, including beds located in a temporary structure or satellite location operated by the hospital or nursing home, provided that the ability remains to safely staff services across the existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the emergency order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of

suppressing a nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to the public life and health;

25. Shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up treatment after discharge is informed that he (i) is expected to require outpatient physical therapy as a follow-up treatment and (ii) will be required to select a physical therapy provider prior to being discharged from the hospital;

26. Shall permit nursing home staff members who are authorized to possess, distribute, or administer medications to residents to store, dispense, or administer cannabis oil to a resident who has been issued a valid written certification for the use of cannabis oil in accordance with subsection B of § 54.1-3408.3 and has registered with the Board of Pharmacy;

27. Shall require each hospital with an emergency department to establish a protocol for the treatment and discharge of individuals experiencing a substance use-related emergency, which shall include provisions for (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to identify medical interventions necessary for the treatment of the individual in the emergency department and (ii) recommendations for follow-up care following discharge for any patient identified as having a substance use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a) the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection X of § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or other opioid antagonist used for overdose reversal, including information about accessing naloxone or other opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing order. Such protocols may also provide for referrals of individuals experiencing a substance use-related emergency to peer recovery

specialists and community-based providers of behavioral health services, or to providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

28. During a public health emergency related to COVID-19, shall require each nursing home and certified nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid Services and the Board. Such protocol shall include provisions describing (i) the conditions, including conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be required to comply to protect the health and safety of the patients and staff of the nursing home or certified nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing home or certified nursing facility will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subdivision. Such protocol shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided that such waiver or limitation is included in the patient's health record; and (c) a requirement that each nursing home and certified nursing facility publish on its website or communicate to each patient or the patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing facility's plan for providing visits to patients as required by this subdivision;

29. Shall require each hospital, nursing home, and certified nursing facility to establish and implement policies to ensure the permissible access to and use of an intelligent personal assistant provided by a patient, in accordance with such regulations, while receiving inpatient services. Such policies shall ensure protection of health information in accordance with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the purposes of this subdivision, "intelligent personal assistant" means a combination of an electronic device

and a specialized software application designed to assist users with basic tasks using a combination of natural language processing and artificial intelligence, including such combinations known as "digital assistants" or "virtual assistants";

30. During a declared public health emergency related to a communicable disease of public health threat, shall require each hospital, nursing home, and certified nursing facility to establish a protocol to allow patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services and subject to compliance with any executive order, order of public health, Department guidance, or any other applicable federal or state guidance having the effect of limiting visitation. Such protocol may restrict the frequency and duration of visits and may require visits to be conducted virtually using interactive audio or video technology. Any such protocol may require the person visiting a patient pursuant to this subdivision to comply with all reasonable requirements of the hospital, nursing home, or certified nursing facility adopted to protect the health and safety of the person, patients, and staff of the hospital, nursing home, or certified nursing facility; ~~and~~

31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients who are minors available to such patients through a secure website shall make such health records available to such patient's parent or guardian through such secure website, unless the hospital cannot make such health record available in a manner that prevents disclosure of information, the disclosure of which has been denied pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of § 54.1-2969 has not been provided; and

32. Shall require each certified nursing facility to provide at least 3.08 hours of case mix-adjusted total nurse staffing hours per resident per day on average as determined annually by the Department of Medical Assistance Services (DMAS) for use in the Virginia Medicaid Nursing Facility Value-Based Purchasing (VBP) program, as referenced in Chapter 2 of the Acts of Assembly of 2022, Special Session I, utilizing job codes for the calculation of total nurse staffing hours per resident per day following the Centers for Medicare and Medicaid Services (CMS) definitions as of January 1, 2022 used for similar

purposes and including certified nursing assistants, licensed practical nurses, and registered nurses. No additional reporting shall be required by a certified nursing facility under this subdivision.

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day care centers.

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot that is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.

E. Hospitals in the Commonwealth may enter into agreements with the Department of Health for the provision to uninsured patients of naloxone or other opioid antagonists used for overdose reversal.

2. That without initial and ongoing funding for the state share of the cost to implement the provisions of this act, as built in to the calculation and application of the base Medicaid rates, the State Health Commissioner shall not impose administrative sanctions in accordance with § 32.1-27.2 of the Code of Virginia, as created by this act, on any certified nursing home that does not comply with the provisions of regulations promulgated pursuant to subdivision B 32 of § 32.1-127 of the Code of Virginia, as amended by this act. In any period in which the calculated Medicaid Virginia Nursing Home Inflation Index is not fully implemented, administrative sanctions in accordance with § 32.1-27.2 of the Code of Virginia, as created by this act, shall be suspended.

3. That if the funding of the Value-Based Purchasing program is reduced or suspended below levels established in the 2022 Appropriation Act (Chapter 2 of the Acts of Assembly of 2022, Special Session I), as adjusted by the Medicaid Virginia Nursing Home Inflation Index annually thereafter, the State Health Commissioner shall not impose administrative sanctions in accordance with § 32.1-

27.2 of the Code of Virginia, as created by this act, on any certified nursing home that does not comply with the provisions of regulations promulgated pursuant to subdivision B 32 of § 32.1-127 of the Code of Virginia, as amended by this act.

4. That in the event that a federal staffing ratio or similar mandate is established, the staffing ratio established pursuant to subdivision B 32 of § 32.1-127 of the Code of Virginia, as amended by this act, shall be repealed. In such an event, authority for administrative sanctions in accordance with § 32.1-27.2 of the Code of Virginia, as created by this act, shall be revoked, with deferral to federal authority to enforce the staffing ratio or similar mandate under federal law.

5. That annually the Department of Medical Assistance Services shall communicate to the State Board of Health the information required by the provisions of subdivision B 32 of § 32.1-127 of the Code of Virginia, as amended by this act, and the State Board of Health shall not include the provisions of subdivision B 32 of § 32.1-127 of the Code of Virginia, as amended by this act, in the state licensure requirements.

6. That in the event that the Centers for Medicare and Medicaid Services amends, revises, or deletes the payroll base journal reporting requirements, forms, and processes after January 1, 2022, to such an extent that it impacts the ability of the Commissioner to determine compliance, the Department of Medical Assistance Services shall convene a stakeholder workgroup to make recommendations to the Chairman of the House Committee on Health, Welfare and Institutions and the Chairman of the Senate Committee on Education and Health on what process will be used for determining the equivalent staffing ratio to that designated under subdivision B 32 of § 32.1-127 of the Code of Virginia, as amended by this act, relative to the federal methodology changes or reporting to support the ratio established under the previous federal methodology.

7. That the provisions of the first enactment of this act shall become effective on July 1, 2025.

8. That the State Health Commissioner, in collaboration with the Department of Medical Assistance Services, shall, in consultation with relevant stakeholder groups, review and consider modifications to the minimum nurse staffing standard articulated in subdivision B 32 of § 32.1-127 of the Code of Virginia, as amended by this act, every four years from the effective date of the first enactment of

this act. Upon completion of each required review, the State Health Commissioner shall submit his findings and recommendations regarding modification of the minimum nurse staffing standard to the Governor and the Chairmen of the House Committees on Health, Welfare and Institutions and Appropriations and the Senate Committees on Education and Health and Finance and Appropriations prior to the next regular session of the General Assembly.

9. That the Department shall promulgate regulations consistent with the provisions of the first enactment of this act consistent with its passage.

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