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SENATE BILL NO. 1260

Offered January 8, 2025

Prefiled January 8, 2025

A BILL to amend and reenact § 32.1-127, as it shall become effective, of the Code of Virginia, relating to hospitals; reports of threats or acts of violence against health care providers.

Patrons—Aird and Srinivasan; Delegates: Bennett-Parker and Price

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-127, as it shall become effective, of the Code of Virginia is amended and reenacted as follows:

§ 32.1-127. (Effective July 1, 2025) 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 the Commonwealth and is primarily responsible for the emergency department shall be on duty and physically present at all times at each hospital that 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

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- 59 transfer of any pregnant woman who presents herself while in labor;
- 60 6. Shall also require that each licensed hospital develop and implement a protocol requiring written  
61 discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall  
62 require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and  
63 the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment  
64 services, comprehensive early intervention services for infants and toddlers with disabilities and their families  
65 pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and  
66 family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the  
67 other parent of the infant and any members of the patient's extended family who may participate in the  
68 follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of  
69 any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the  
70 community services board of the jurisdiction in which the woman resides to appoint a discharge plan  
71 manager. The community services board shall implement and manage the discharge plan;
- 72 7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for  
73 admission the home's or facility's admissions policies, including any preferences given;
- 74 8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of  
75 patients which shall include a process reasonably designed to inform patients of such rights and  
76 responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on  
77 admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and  
78 Medicaid Services;
- 79 9. Shall establish standards and maintain a process for designation of levels or categories of care in  
80 neonatal services according to an applicable national or state-developed evaluation system. Such standards  
81 may be differentiated for various levels or categories of care and may include, but need not be limited to,  
82 requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;
- 83 10. Shall require that each nursing home and certified nursing facility train all employees who are  
84 mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures  
85 and the consequences for failing to make a required report;
- 86 11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or  
87 hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or  
88 treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give  
89 patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time  
90 not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital  
91 policies and procedures, by the person giving the order, or, when such person is not available within the  
92 period of time specified, co-signed by another physician or other person authorized to give the order;
- 93 12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of  
94 the vaccination, that each certified nursing facility and nursing home provide or arrange for the  
95 administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal  
96 vaccination, in accordance with the most recent recommendations of the Advisory Committee on  
97 Immunization Practices of the Centers for Disease Control and Prevention;
- 98 13. Shall require that each nursing home and certified nursing facility register with the Department of  
99 State Police to receive notice of the registration, reregistration, or verification of registration information of  
100 any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to  
101 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  
102 facility is located, pursuant to § 9.1-914;
- 103 14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission,  
104 whether a potential patient is required to register with the Sex Offender and Crimes Against Minors Registry  
105 pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the potential patient  
106 will have a length of stay greater than three days or in fact stays longer than three days;
- 107 15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult  
108 patient to receive visits from any individual from whom the patient desires to receive visits, subject to other  
109 restrictions contained in the visitation policy including, but not limited to, those related to the patient's  
110 medical condition and the number of visitors permitted in the patient's room simultaneously;
- 111 16. Shall require that each nursing home and certified nursing facility shall, upon the request of the  
112 facility's family council, send notices and information about the family council mutually developed by the  
113 family council and the administration of the nursing home or certified nursing facility, and provided to the  
114 facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six  
115 times per year. Such notices may be included together with a monthly billing statement or other regular  
116 communication. Notices and information shall also be posted in a designated location within the nursing  
117 home or certified nursing facility. No family member of a resident or other resident representative shall be  
118 restricted from participating in meetings in the facility with the families or resident representatives of other  
119 residents in the facility;
- 120 17. Shall require that each nursing home and certified nursing facility maintain liability insurance

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

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

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

133 20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that  
134 requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct verbal  
135 communication between the on-call physician in the psychiatric unit and the referring physician, if requested  
136 by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for  
137 such direct verbal communication by a referring physician and (ii) a patient for whom there is a question  
138 regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due  
139 to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which  
140 the patient is sought to be transferred to participate in direct verbal communication, either in person or via  
141 telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information  
142 employed by a poison control center that is accredited by the American Association of Poison Control  
143 Centers to review the results of the toxicology screen and determine whether a medical reason for refusing  
144 admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the  
145 referring physician;

146 21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a  
147 policy governing determination of the medical and ethical appropriateness of proposed medical care, which  
148 shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of  
149 proposed medical care in cases in which a physician has determined proposed care to be medically or  
150 ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is  
151 medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by  
152 the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the  
153 proposed health care; and (iii) requirements for a written explanation of the decision reached by the  
154 interdisciplinary medical review committee, which shall be included in the patient's medical record. Such  
155 policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to  
156 § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent  
157 medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee  
158 meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical  
159 decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other  
160 remedies available at law, including seeking court review, provided that the patient, his agent, or the person  
161 authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the  
162 chief executive officer of the hospital within 14 days of the date on which the physician's determination that  
163 proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical  
164 record;

165 22. Shall require every hospital with an emergency department to establish a security plan. Such security  
166 plan shall be developed using standards established by the International Association for Healthcare Security  
167 and Safety or other industry standard and shall be based on the results of a security risk assessment of each  
168 emergency department location of the hospital and shall include the presence of at least one off-duty  
169 law-enforcement officer or trained security personnel who is present in the emergency department at all times  
170 as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based  
171 on identified risks for the emergency department, including trauma level designation, overall volume, volume  
172 of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from  
173 such violence, and prevalence of crime in the community, in consultation with the emergency department  
174 medical director and nurse director. The security plan shall also outline training requirements for security  
175 personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques,  
176 appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches.  
177 Such training shall also include instruction on safely addressing situations involving patients, family  
178 members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance  
179 abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through  
180 completion of the Department of Criminal Justice Services minimum training standards for auxiliary police  
181 officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at

182 least one off-duty law-enforcement officer or trained security personnel be present at all times in the  
183 emergency department if the hospital demonstrates that a different level of security is necessary and  
184 appropriate for any of its emergency departments based upon findings in the security risk assessment;

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

193 24. Shall establish an exemption from the requirement to obtain a license to add temporary beds in an  
194 existing hospital or nursing home, including beds located in a temporary structure or satellite location  
195 operated by the hospital or nursing home, provided that the ability remains to safely staff services across the  
196 existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's  
197 determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has  
198 caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a  
199 shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the emergency  
200 order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the  
201 Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of suppressing a  
202 nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to  
203 the public life and health;

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

209 26. Shall permit nursing home staff members who are authorized to possess, distribute, or administer  
210 medications to residents to store, dispense, or administer cannabis oil to a resident who has been issued a  
211 valid written certification for the use of cannabis oil in accordance with § 4.1-1601;

212 27. Shall require each hospital with an emergency department to establish a protocol for the treatment and  
213 discharge of individuals experiencing a substance use-related emergency, which shall include provisions for  
214 (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to  
215 identify medical interventions necessary for the treatment of the individual in the emergency department and  
216 (ii) recommendations for follow-up care following discharge for any patient identified as having a substance  
217 use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have  
218 been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a)  
219 the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection X of  
220 § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or  
221 other opioid antagonist used for overdose reversal, including information about accessing naloxone or other  
222 opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy  
223 operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or  
224 other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing  
225 order. Such protocols may also provide for referrals of individuals experiencing a substance use-related  
226 emergency to peer recovery specialists and community-based providers of behavioral health services, or to  
227 providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

228 28. During a public health emergency related to COVID-19, shall require each nursing home and certified  
229 nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from  
230 the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid  
231 Services and the Board. Such protocol shall include provisions describing (i) the conditions, including  
232 conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and  
233 community, under which in-person visits will be allowed and under which in-person visits will not be  
234 allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be  
235 required to comply to protect the health and safety of the patients and staff of the nursing home or certified  
236 nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff  
237 support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing  
238 home or certified nursing facility will take in the event of a technology failure, service interruption, or  
239 documented emergency that prevents visits from occurring as required by this subdivision. Such protocol  
240 shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where  
241 appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a  
242 provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided

243 that such waiver or limitation is included in the patient's health record; and (c) a requirement that each  
244 nursing home and certified nursing facility publish on its website or communicate to each patient or the  
245 patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing  
246 facility's plan for providing visits to patients as required by this subdivision;

247 29. Shall require each hospital, nursing home, and certified nursing facility to establish and implement  
248 policies to ensure the permissible access to and use of an intelligent personal assistant provided by a patient,  
249 in accordance with such regulations, while receiving inpatient services. Such policies shall ensure protection  
250 of health information in accordance with the requirements of the federal Health Insurance Portability and  
251 Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the purposes of this subdivision,  
252 "intelligent personal assistant" means a combination of an electronic device and a specialized software  
253 application designed to assist users with basic tasks using a combination of natural language processing and  
254 artificial intelligence, including such combinations known as "digital assistants" or "virtual assistants";

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

266 31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients  
267 who are minors available to such patients through a secure website shall make such health records available  
268 to such patient's parent or guardian through such secure website, unless the hospital cannot make such health  
269 record available in a manner that prevents disclosure of information, the disclosure of which has been denied  
270 pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of  
271 § 54.1-2969 has not been provided; and

272 32. Shall require that every hospital where surgical procedures are performed adopt a policy requiring the  
273 use of a smoke evacuation system for all planned surgical procedures that are likely to generate surgical  
274 smoke. For the purposes of this subdivision, "smoke evacuation system" means smoke evacuation equipment  
275 and technologies designed to capture, filter, and remove surgical smoke at the site of origin and to prevent  
276 surgical smoke from making ocular contact or contact with a person's respiratory tract.

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

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

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

289 *F. Hospitals in the Commonwealth shall report any threat, as described in clause (ii) of subsection B of §*  
290 *18.2-60, or battery, as described in subsection E of § 18.2-57, against a health care provider while on the*  
291 *premises and engaged in the performance of his duties to the Department. Each hospital shall provide the*  
292 *following data to the Department quarterly: (i) the number of health care providers who reported a threat or*  
293 *battery; (ii) whether the perpetrator of the threat or battery was a coworker, a patient, a member of the*  
294 *patient's family, a visitor, or another person; and (iii) the locality where the threat or battery took place. The*  
295 *Department shall ensure the privacy of any identifiable information received pursuant to this subsection. The*  
296 *Department shall publish on its website, on an annual basis, aggregate numbers for the data collected*  
297 *pursuant to this subsection. The Department may incorporate the reported findings on the Injury and*  
298 *Violence Data Dashboard. The Department shall promulgate regulations to implement the provisions of this*  
299 *subsection that shall include the establishment of reporting dates and the appropriate format for the data*  
300 *reported by hospitals.*

301 **2. That the Department of Health's initial adoption of regulations necessary to implement the**  
302 **provisions of this act shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq. of the**  
303 **Code of Virginia).**