SENATE BILL NO. 1152
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the Senate Committee on Education and Health
on January 30, 2025)
(Patron Prior to Substitute—Senator Obenshain)

A BILL to amend and reenact § 32.1-127, as it is currently effective and as it shall become effective, of the Code of Virginia, relating to nursing homes and certified nursing facilities; professional liability insurance.

Be it enacted by the General Assembly of Virginia:

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

§ 32.1-127. (Effective until 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 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

31 hospitals and nursing homes by bed capacity and by type of specialty or service;

32 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal
33 law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. §
34 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS
35 regulations for routine contact, whereby the provider's designated organ procurement organization certified
36 by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii)
37 is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a
38 similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of
39 America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The
40 hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in
41 the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable
42 tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The
43 protocol shall ensure that the hospital collaborates with the designated organ procurement organization to
44 inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to
45 donate. The individual making contact with the family shall have completed a course in the methodology for
46 approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved
47 by the organ procurement organization and designed in conjunction with the tissue and eye bank community
48 and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of
49 the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement
50 organization in educating the staff responsible for contacting the organ procurement organization's personnel
51 on donation issues, the proper review of death records to improve identification of potential donors, and the
52 proper procedures for maintaining potential donors while necessary testing and placement of potential
53 donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the
54 family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative
55 officer of the hospital or his designee knows of such opposition, and no donor card or other relevant
56 document, such as an advance directive, can be found;

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

59 6. Shall also require that each licensed hospital develop and implement a protocol requiring written

60 discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall
61 require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and
62 the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment
63 services, comprehensive early intervention services for infants and toddlers with disabilities and their families
64 pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and
65 family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the
66 other parent of the infant and any members of the patient's extended family who may participate in the
67 follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of
68 any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the
69 community services board of the jurisdiction in which the woman resides to appoint a discharge plan
70 manager. The community services board shall implement and manage the discharge plan;
71 7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for
72 admission the home's or facility's admissions policies, including any preferences given;
73 8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of
74 patients which shall include a process reasonably designed to inform patients of such rights and
75 responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on
76 admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and
77 Medicaid Services;
78 9. Shall establish standards and maintain a process for designation of levels or categories of care in
79 neonatal services according to an applicable national or state-developed evaluation system. Such standards
80 may be differentiated for various levels or categories of care and may include, but need not be limited to,
81 requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;
82 10. Shall require that each nursing home and certified nursing facility train all employees who are
83 mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures
84 and the consequences for failing to make a required report;
85 11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or
86 hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or
87 treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give
88 patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time

89 not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital
90 policies and procedures, by the person giving the order, or, when such person is not available within the
91 period of time specified, co-signed by another physician or other person authorized to give the order;
92 12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of
93 the vaccination, that each certified nursing facility and nursing home provide or arrange for the
94 administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal
95 vaccination, in accordance with the most recent recommendations of the Advisory Committee on
96 Immunization Practices of the Centers for Disease Control and Prevention;
97 13. Shall require that each nursing home and certified nursing facility register with the Department of
98 State Police to receive notice of the registration, reregistration, or verification of registration information of
99 any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to
100 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
101 facility is located, pursuant to § 9.1-914;
102 14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission,
103 whether a potential patient is required to register with the Sex Offender and Crimes Against Minors Registry
104 pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the potential patient
105 will have a length of stay greater than three days or in fact stays longer than three days;
106 15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult
107 patient to receive visits from any individual from whom the patient desires to receive visits, subject to other
108 restrictions contained in the visitation policy including, but not limited to, those related to the patient's
109 medical condition and the number of visitors permitted in the patient's room simultaneously;
110 16. Shall require that each nursing home and certified nursing facility shall, upon the request of the
111 facility's family council, send notices and information about the family council mutually developed by the
112 family council and the administration of the nursing home or certified nursing facility, and provided to the
113 facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six
114 times per year. Such notices may be included together with a monthly billing statement or other regular
115 communication. Notices and information shall also be posted in a designated location within the nursing
116 home or certified nursing facility. No family member of a resident or other resident representative shall be
117 restricted from participating in meetings in the facility with the families or resident representatives of other

118 residents in the facility;

119 17. Shall require that each nursing home and certified nursing facility maintain*, per facility, general*
120 liability insurance coverage in a minimum amount of $1 million *per occurrence*, and professional liability
121 coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15 *per patient occurrence*, to
122 compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the
123 facility. *Minimum combined general and professional liability aggregate policy limits shall be equal to a $3*
124 *million aggregate policy limit for each facility insured under the insurance policy. No insurance policy under*
125 *this section shall have limits that are reduced or eroded by the cost of litigation that exceed $50,000 per*
126 *patient occurrence per insurance policy. Occurrence or claims-made insurance coverage policies are*
127 *permissible to meet the requirements of this section.* Failure to maintain such minimum insurance *limits*
128 *under this section* shall result in revocation of the facility's license *if not cured within 10 business days of*
129 *being notified of such failure by any person. Each nursing home and certified nursing facility shall provide at*
130 *licensure renewal or have available to the Board proof of the insurance coverages as required by this section*
131 ;

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

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

140 20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that
141 requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct verbal
142 communication between the on-call physician in the psychiatric unit and the referring physician, if requested
143 by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for
144 such direct verbal communication by a referring physician and (ii) a patient for whom there is a question
145 regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due
146 to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which

147 the patient is sought to be transferred to participate in direct verbal communication, either in person or via
148 telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information
149 employed by a poison control center that is accredited by the American Association of Poison Control
150 Centers to review the results of the toxicology screen and determine whether a medical reason for refusing
151 admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the
152 referring physician;

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

172 22. Shall require every hospital with an emergency department to establish a security plan. Such security
173 plan shall be developed using standards established by the International Association for Healthcare Security
174 and Safety or other industry standard and shall be based on the results of a security risk assessment of each
175 emergency department location of the hospital and shall include the presence of at least one off-duty

176 law-enforcement officer or trained security personnel who is present in the emergency department at all times
177 as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based
178 on identified risks for the emergency department, including trauma level designation, overall volume, volume
179 of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from
180 such violence, and prevalence of crime in the community, in consultation with the emergency department
181 medical director and nurse director. The security plan shall also outline training requirements for security
182 personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques,
183 appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches.
184 Such training shall also include instruction on safely addressing situations involving patients, family
185 members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance
186 abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through
187 completion of the Department of Criminal Justice Services minimum training standards for auxiliary police
188 officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at
189 least one off-duty law-enforcement officer or trained security personnel be present at all times in the
190 emergency department if the hospital demonstrates that a different level of security is necessary and
191 appropriate for any of its emergency departments based upon findings in the security risk assessment;
192 23. Shall require that each hospital establish a protocol requiring that, before a health care provider
193 arranges for air medical transportation services for a patient who does not have an emergency medical
194 condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized
195 representative with written or electronic notice that the patient (i) may have a choice of transportation by an
196 air medical transportation provider or medically appropriate ground transportation by an emergency medical
197 services provider and (ii) will be responsible for charges incurred for such transportation in the event that the
198 provider is not a contracted network provider of the patient's health insurance carrier or such charges are not
199 otherwise covered in full or in part by the patient's health insurance plan;
200 24. Shall establish an exemption from the requirement to obtain a license to add temporary beds in an
201 existing hospital or nursing home, including beds located in a temporary structure or satellite location
202 operated by the hospital or nursing home, provided that the ability remains to safely staff services across the
203 existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's
204 determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has

205 caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a
206 shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the emergency
207 order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the
208 Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of suppressing a
209 nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to
210 the public life and health;

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

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

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

234 providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;
235 28. During a public health emergency related to COVID-19, shall require each nursing home and certified
236 nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from
237 the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid
238 Services and the Board. Such protocol shall include provisions describing (i) the conditions, including
239 conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and
240 community, under which in-person visits will be allowed and under which in-person visits will not be
241 allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be
242 required to comply to protect the health and safety of the patients and staff of the nursing home or certified
243 nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff
244 support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing
245 home or certified nursing facility will take in the event of a technology failure, service interruption, or
246 documented emergency that prevents visits from occurring as required by this subdivision. Such protocol
247 shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where
248 appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a
249 provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided
250 that such waiver or limitation is included in the patient's health record; and (c) a requirement that each
251 nursing home and certified nursing facility publish on its website or communicate to each patient or the
252 patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing
253 facility's plan for providing visits to patients as required by this subdivision;
254 29. Shall require each hospital, nursing home, and certified nursing facility to establish and implement
255 policies to ensure the permissible access to and use of an intelligent personal assistant provided by a patient,
256 in accordance with such regulations, while receiving inpatient services. Such policies shall ensure protection
257 of health information in accordance with the requirements of the federal Health Insurance Portability and
258 Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the purposes of this subdivision,
259 "intelligent personal assistant" means a combination of an electronic device and a specialized software
260 application designed to assist users with basic tasks using a combination of natural language processing and
261 artificial intelligence, including such combinations known as "digital assistants" or "virtual assistants";
262 30. During a declared public health emergency related to a communicable disease of public health threat,

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

273 31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients
274 who are minors available to such patients through a secure website shall make such health records available
275 to such patient's parent or guardian through such secure website, unless the hospital cannot make such health
276 record available in a manner that prevents disclosure of information, the disclosure of which has been denied
277 pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of
278 § 54.1-2969 has not been provided.

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

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

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

291 **§ 32.1-127. (Effective July 1, 2025) Regulations.**

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

297 B. Such regulations:

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

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

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

311 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal
312 law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. §
313 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS
314 regulations for routine contact, whereby the provider's designated organ procurement organization certified
315 by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii)
316 is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a
317 similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of
318 America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The
319 hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in
320 the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable

321 tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The
322 protocol shall ensure that the hospital collaborates with the designated organ procurement organization to
323 inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to
324 donate. The individual making contact with the family shall have completed a course in the methodology for
325 approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved
326 by the organ procurement organization and designed in conjunction with the tissue and eye bank community
327 and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of
328 the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement
329 organization in educating the staff responsible for contacting the organ procurement organization's personnel
330 on donation issues, the proper review of death records to improve identification of potential donors, and the
331 proper procedures for maintaining potential donors while necessary testing and placement of potential
332 donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the
333 family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative
334 officer of the hospital or his designee knows of such opposition, and no donor card or other relevant
335 document, such as an advance directive, can be found;

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

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

350 7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for
351 admission the home's or facility's admissions policies, including any preferences given;
352 8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of
353 patients which shall include a process reasonably designed to inform patients of such rights and
354 responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on
355 admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and
356 Medicaid Services;
357 9. Shall establish standards and maintain a process for designation of levels or categories of care in
358 neonatal services according to an applicable national or state-developed evaluation system. Such standards
359 may be differentiated for various levels or categories of care and may include, but need not be limited to,
360 requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;
361 10. Shall require that each nursing home and certified nursing facility train all employees who are
362 mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures
363 and the consequences for failing to make a required report;
364 11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or
365 hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or
366 treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give
367 patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time
368 not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital
369 policies and procedures, by the person giving the order, or, when such person is not available within the
370 period of time specified, co-signed by another physician or other person authorized to give the order;
371 12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of
372 the vaccination, that each certified nursing facility and nursing home provide or arrange for the
373 administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal
374 vaccination, in accordance with the most recent recommendations of the Advisory Committee on
375 Immunization Practices of the Centers for Disease Control and Prevention;
376 13. Shall require that each nursing home and certified nursing facility register with the Department of
377 State Police to receive notice of the registration, reregistration, or verification of registration information of
378 any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to

379 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
380 facility is located, pursuant to § 9.1-914;
381 14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission,
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383 pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the potential patient
384 will have a length of stay greater than three days or in fact stays longer than three days;
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386 patient to receive visits from any individual from whom the patient desires to receive visits, subject to other
387 restrictions contained in the visitation policy including, but not limited to, those related to the patient's
388 medical condition and the number of visitors permitted in the patient's room simultaneously;
389 16. Shall require that each nursing home and certified nursing facility shall, upon the request of the
390 facility's family council, send notices and information about the family council mutually developed by the
391 family council and the administration of the nursing home or certified nursing facility, and provided to the
392 facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six
393 times per year. Such notices may be included together with a monthly billing statement or other regular
394 communication. Notices and information shall also be posted in a designated location within the nursing
395 home or certified nursing facility. No family member of a resident or other resident representative shall be
396 restricted from participating in meetings in the facility with the families or resident representatives of other
397 residents in the facility;
398 17. Shall require that each nursing home and certified nursing facility maintain*, per facility, general*
399 liability insurance coverage in a minimum amount of $1 million *per occurrence*, and professional liability
400 coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15 *per patient occurrence*, to
401 compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the
402 facility. *Minimum combined general and professional liability aggregate policy limits shall be equal to a $3*
403 *million aggregate policy limit for each facility insured under the insurance policy. No insurance policy under*
404 *this section shall have limits that are reduced or eroded by the cost of litigation that exceed $50,000 per*
405 *patient occurrence per insurance policy. Occurrence or claims-made insurance coverage policies are*
406 *permissible to meet the requirements of this section.* Failure to maintain such minimum insurance *limits*
407 *under this section* shall result in revocation of the facility's license *if not cured within 10 business days of*

408 *being notified of such failure by any person. Each nursing home and certified nursing facility shall provide at*
409 *licensure renewal or have available to the Board proof of the insurance coverages as required by this section*
410 ;

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

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

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

432 21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a
433 policy governing determination of the medical and ethical appropriateness of proposed medical care, which
434 shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of
435 proposed medical care in cases in which a physician has determined proposed care to be medically or
436 ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is

437 medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by
438 the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the
439 proposed health care; and (iii) requirements for a written explanation of the decision reached by the
440 interdisciplinary medical review committee, which shall be included in the patient's medical record. Such
441 policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to
442 § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent
443 medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee
444 meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical
445 decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other
446 remedies available at law, including seeking court review, provided that the patient, his agent, or the person
447 authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the
448 chief executive officer of the hospital within 14 days of the date on which the physician's determination that
449 proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical
450 record;
451 22. Shall require every hospital with an emergency department to establish a security plan. Such security
452 plan shall be developed using standards established by the International Association for Healthcare Security
453 and Safety or other industry standard and shall be based on the results of a security risk assessment of each
454 emergency department location of the hospital and shall include the presence of at least one off-duty
455 law-enforcement officer or trained security personnel who is present in the emergency department at all times
456 as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based
457 on identified risks for the emergency department, including trauma level designation, overall volume, volume
458 of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from
459 such violence, and prevalence of crime in the community, in consultation with the emergency department
460 medical director and nurse director. The security plan shall also outline training requirements for security
461 personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques,
462 appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches.
463 Such training shall also include instruction on safely addressing situations involving patients, family
464 members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance
465 abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through

466 completion of the Department of Criminal Justice Services minimum training standards for auxiliary police
467 officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at
468 least one off-duty law-enforcement officer or trained security personnel be present at all times in the
469 emergency department if the hospital demonstrates that a different level of security is necessary and
470 appropriate for any of its emergency departments based upon findings in the security risk assessment;
471 23. Shall require that each hospital establish a protocol requiring that, before a health care provider
472 arranges for air medical transportation services for a patient who does not have an emergency medical
473 condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized
474 representative with written or electronic notice that the patient (i) may have a choice of transportation by an
475 air medical transportation provider or medically appropriate ground transportation by an emergency medical
476 services provider and (ii) will be responsible for charges incurred for such transportation in the event that the
477 provider is not a contracted network provider of the patient's health insurance carrier or such charges are not
478 otherwise covered in full or in part by the patient's health insurance plan;
479 24. Shall establish an exemption from the requirement to obtain a license to add temporary beds in an
480 existing hospital or nursing home, including beds located in a temporary structure or satellite location
481 operated by the hospital or nursing home, provided that the ability remains to safely staff services across the
482 existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's
483 determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has
484 caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a
485 shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the emergency
486 order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the
487 Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of suppressing a
488 nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to
489 the public life and health;
490 25. Shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure
491 for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up
492 treatment after discharge is informed that he (i) is expected to require outpatient physical therapy as a follow-
493 up treatment and (ii) will be required to select a physical therapy provider prior to being discharged from the
494 hospital;

495 26. Shall permit nursing home staff members who are authorized to possess, distribute, or administer
496 medications to residents to store, dispense, or administer cannabis oil to a resident who has been issued a
497 valid written certification for the use of cannabis oil in accordance with § 4.1-1601;
498 27. Shall require each hospital with an emergency department to establish a protocol for the treatment and
499 discharge of individuals experiencing a substance use-related emergency, which shall include provisions for
500 (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to
501 identify medical interventions necessary for the treatment of the individual in the emergency department and
502 (ii) recommendations for follow-up care following discharge for any patient identified as having a substance
503 use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have
504 been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a)
505 the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection X of
506 § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or
507 other opioid antagonist used for overdose reversal, including information about accessing naloxone or other
508 opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy
509 operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or
510 other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing
511 order. Such protocols may also provide for referrals of individuals experiencing a substance use-related
512 emergency to peer recovery specialists and community-based providers of behavioral health services, or to
513 providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;
514 28. During a public health emergency related to COVID-19, shall require each nursing home and certified
515 nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from
516 the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid
517 Services and the Board. Such protocol shall include provisions describing (i) the conditions, including
518 conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and
519 community, under which in-person visits will be allowed and under which in-person visits will not be
520 allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be
521 required to comply to protect the health and safety of the patients and staff of the nursing home or certified
522 nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff
523 support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing

524 home or certified nursing facility will take in the event of a technology failure, service interruption, or
525 documented emergency that prevents visits from occurring as required by this subdivision. Such protocol
526 shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where
527 appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a
528 provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided
529 that such waiver or limitation is included in the patient's health record; and (c) a requirement that each
530 nursing home and certified nursing facility publish on its website or communicate to each patient or the
531 patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing
532 facility's plan for providing visits to patients as required by this subdivision;

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

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

552 31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients

553 who are minors available to such patients through a secure website shall make such health records available
554 to such patient's parent or guardian through such secure website, unless the hospital cannot make such health
555 record available in a manner that prevents disclosure of information, the disclosure of which has been denied
556 pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of
557 § 54.1-2969 has not been provided; and

558 32. Shall require each certified nursing facility eligible to participate in the Virginia Medicaid Nursing
559 Facility Value-Based Purchasing (VBP) program, as referenced in Chapter 2 of the Acts of Assembly of
560 2022, Special Session I, to provide at least 3.08 hours of case mix-adjusted total nurse staffing hours per
561 resident per day on average as determined annually by the Department of Medical Assistance Services for use
562 in the VBP program, utilizing job codes for the calculation of total nurse staffing hours per resident per day
563 following the Centers for Medicare and Medicaid Services (CMS) definitions as of January 1, 2022, used for
564 similar purposes and including certified nursing assistants, licensed practical nurses, and registered nurses.
565 No additional reporting shall be required by a certified nursing facility under this subdivision.

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

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

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