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SENATE BILL NO. 1484**AMENDMENT IN THE NATURE OF A SUBSTITUTE**(Proposed by the House Committee on Health and Human Services
on February 11, 2025)

(Patron Prior to Substitute—Senator Srinivasan)

A *BILL to amend and reenact §§ 2.2-4006, 32.1-127, as it is currently effective and as it shall become effective, and 32.1-130 of the Code of Virginia, relating to hospitals and nursing homes; licensure and inspection fees; Hospital and Nursing Home Licensure and Inspection Program Fund established.*

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-4006 and 32.1-127, as it is currently effective and as it shall become effective, of the Code of Virginia are amended and reenacted as follows:

§ 2.2-4006. Exemptions from requirements of this article.

A. The following agency actions otherwise subject to this chapter and § 2.2-4103 of the Virginia Register Act shall be exempted from the operation of this article:

1. Agency orders or regulations fixing rates or prices.

2. Regulations that establish or prescribe agency organization, internal practice or procedures, including delegations of authority.

3. Regulations that consist only of changes in style or form or corrections of technical errors. Each promulgating agency shall review all references to sections of the Code of Virginia within their regulations each time a new supplement or replacement volume to the Code of Virginia is published to ensure the accuracy of each section or section subdivision identification listed.

4. Regulations that are:

a. Necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. However, such regulations shall be filed with the Registrar within 90 days of the law's effective date;

b. Required by order of any state or federal court of competent jurisdiction where no agency discretion is involved; or

c. Necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and the Registrar has so determined in writing. Notice of the proposed adoption of these regulations and the Registrar's determination shall be published in the Virginia Register not less than 30 days prior to the effective date of the regulation.

5. Regulations of the Board of Agriculture and Consumer Services adopted pursuant to subsection B of § 3.2-3929 or clause (v) or (vi) of subsection C of § 3.2-3931 after having been considered at two or more Board meetings and one public hearing.

6. Regulations of (i) the regulatory boards served by the Department of Labor and Industry pursuant to Title 40.1 and the Department of Professional and Occupational Regulation or the Department of Health Professions pursuant to Title 54.1 ~~and~~, (ii) the Board of Accountancy, and (iii) the State Board of Health that are limited to reducing fees charged to regulants and applicants.

7. The development and issuance of procedural policy relating to risk-based mine inspections by the Department of Energy authorized pursuant to §§ 45.2-560 and 45.2-1149.

8. General permits issued by the (a) State Air Pollution Control Board pursuant to Chapter 13 (§ 10.1-1300 et seq.) of Title 10.1 or (b) State Water Control Board pursuant to the State Water Control Law (§ 62.1-44.2 et seq.), Chapter 24 (§ 62.1-242 et seq.) of Title 62.1 and Chapter 25 (§ 62.1-254 et seq.) of Title 62.1, (c) Virginia Soil and Water Conservation Board pursuant to the Dam Safety Act (§ 10.1-604 et seq.), and (d) the development and issuance of general wetlands permits by the Marine Resources Commission pursuant to subsection B of § 28.2-1307, if the respective Board or Commission (i) provides a Notice of Intended Regulatory Action in conformance with the provisions of § 2.2-4007.01, (ii) following the passage of 30 days from the publication of the Notice of Intended Regulatory Action forms a technical advisory committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the development of the general permit, (iii) provides notice and receives oral and written comment as provided in § 2.2-4007.03, and (iv) conducts at least one public hearing on the proposed general permit.

9. The development and issuance by the Board of Education of guidelines on constitutional rights and restrictions relating to the recitation of the pledge of allegiance to the American flag in public schools pursuant to § 22.1-202.

10. Regulations of the Board of the Commonwealth Savers Plan adopted pursuant to § 23.1-704.

11. Regulations of the Marine Resources Commission.

12. Regulations adopted by the Board of Housing and Community Development pursuant to (i) Statewide Fire Prevention Code (§ 27-94 et seq.), (ii) the Industrialized Building Safety Law (§ 36-70 et seq.), (iii) the Uniform Statewide Building Code (§ 36-97 et seq.), and (iv) § 36-98.3, provided the Board (a) provides a

60 Notice of Intended Regulatory Action in conformance with the provisions of § 2.2-4007.01, (b) publishes the
61 proposed regulation and provides an opportunity for oral and written comments as provided in § 2.2-4007.03,
62 and (c) conducts at least one public hearing as provided in §§ 2.2-4009 and 36-100 prior to the publishing of
63 the proposed regulations. Notwithstanding the provisions of this subdivision, any regulations promulgated by
64 the Board shall remain subject to the provisions of § 2.2-4007.06 concerning public petitions, and §§
65 2.2-4013 and 2.2-4014 concerning review by the Governor and General Assembly.

66 13. Amendments to regulations of the Board to schedule a substance pursuant to subsection D or E of §
67 54.1-3443.

68 14. Waste load allocations adopted, amended, or repealed by the State Water Control Board pursuant to
69 the State Water Control Law (§ 62.1-44.2 et seq.), including but not limited to Article 4.01 (§ 62.1-44.19:4 et
70 seq.) of the State Water Control Law, if the Board (i) provides public notice in the Virginia Register; (ii) if
71 requested by the public during the initial public notice 30-day comment period, forms an advisory group
72 composed of relevant stakeholders; (iii) receives and provides summary response to written comments; and
73 (iv) conducts at least one public meeting. Notwithstanding the provisions of this subdivision, any such waste
74 load allocations adopted, amended, or repealed by the Board shall be subject to the provisions of §§ 2.2-4013
75 and 2.2-4014 concerning review by the Governor and General Assembly.

76 15. Regulations of the Workers' Compensation Commission adopted pursuant to § 65.2-605, including
77 regulations that adopt, amend, adjust, or repeal Virginia fee schedules for medical services, provided the
78 Workers' Compensation Commission (i) utilizes a regulatory advisory panel constituted as provided in
79 subdivision F 2 of § 65.2-605 to assist in the development of such regulations and (ii) provides an opportunity
80 for public comment on the regulations prior to adoption.

81 16. Amendments to the State Health Services Plan adopted by the Board of Health following receipt of
82 recommendations by the State Health Services Task Force pursuant to § 32.1-102.2:1 if the Board (i)
83 provides a Notice of Intended Regulatory Action in accordance with the requirements of § 2.2-4007.01, (ii)
84 provides notice and receives comments as provided in § 2.2-4007.03, and (iii) conducts at least one public
85 hearing on the proposed amendments.

86 17. Rules of the Workers' Compensation Commission adopted pursuant to subsection A of § 65.2-201 and
87 subsection B of § 65.2-703, provided the Workers' Compensation Commission provides an opportunity for
88 public comment on the rules prior to adoption.

89 B. Whenever regulations are adopted under this section, the agency shall state as part thereof that it will
90 receive, consider and respond to petitions by any interested person at any time with respect to reconsideration
91 or revision. The effective date of regulations adopted under this section shall be in accordance with the
92 provisions of § 2.2-4015, except in the case of emergency regulations, which shall become effective as
93 provided in subsection B of § 2.2-4012.

94 C. A regulation for which an exemption is claimed under this section or § 2.2-4002 or 2.2-4011 and that is
95 placed before a board or commission for consideration shall be provided at least two days in advance of the
96 board or commission meeting to members of the public that request a copy of that regulation. A copy of that
97 regulation shall be made available to the public attending such meeting.

98 **§ 32.1-127. (Effective until July 1, 2025) Regulations.**

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

104 B. Such regulations:

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

113 2. Shall provide that at least one physician who is licensed to practice medicine in the Commonwealth and
114 is primarily responsible for the emergency department shall be on duty and physically present at all times at
115 each hospital that operates or holds itself out as operating an emergency service;

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

118 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal
119 law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. §
120 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS

121 regulations for routine contact, whereby the provider's designated organ procurement organization certified
 122 by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii)
 123 is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a
 124 similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of
 125 America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The
 126 hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in
 127 the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable
 128 tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The
 129 protocol shall ensure that the hospital collaborates with the designated organ procurement organization to
 130 inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to
 131 donate. The individual making contact with the family shall have completed a course in the methodology for
 132 approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved
 133 by the organ procurement organization and designed in conjunction with the tissue and eye bank community
 134 and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of
 135 the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement
 136 organization in educating the staff responsible for contacting the organ procurement organization's personnel
 137 on donation issues, the proper review of death records to improve identification of potential donors, and the
 138 proper procedures for maintaining potential donors while necessary testing and placement of potential
 139 donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the
 140 family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative
 141 officer of the hospital or his designee knows of such opposition, and no donor card or other relevant
 142 document, such as an advance directive, can be found;

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

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

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

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

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

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

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

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

182 Immunization Practices of the Centers for Disease Control and Prevention;

183 13. Shall require that each nursing home and certified nursing facility register with the Department of
184 State Police to receive notice of the registration, reregistration, or verification of registration information of
185 any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to
186 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
187 facility is located, pursuant to § 9.1-914;

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

192 15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult
193 patient to receive visits from any individual from whom the patient desires to receive visits, subject to other
194 restrictions contained in the visitation policy including, but not limited to, those related to the patient's
195 medical condition and the number of visitors permitted in the patient's room simultaneously;

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

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

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

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

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

231 21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a
232 policy governing determination of the medical and ethical appropriateness of proposed medical care, which
233 shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of
234 proposed medical care in cases in which a physician has determined proposed care to be medically or
235 ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is
236 medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by
237 the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the
238 proposed health care; and (iii) requirements for a written explanation of the decision reached by the
239 interdisciplinary medical review committee, which shall be included in the patient's medical record. Such
240 policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to
241 § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent
242 medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee

243 meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical
 244 decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other
 245 remedies available at law, including seeking court review, provided that the patient, his agent, or the person
 246 authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the
 247 chief executive officer of the hospital within 14 days of the date on which the physician's determination that
 248 proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical
 249 record;

250 22. Shall require every hospital with an emergency department to establish a security plan. Such security
 251 plan shall be developed using standards established by the International Association for Healthcare Security
 252 and Safety or other industry standard and shall be based on the results of a security risk assessment of each
 253 emergency department location of the hospital and shall include the presence of at least one off-duty
 254 law-enforcement officer or trained security personnel who is present in the emergency department at all times
 255 as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based
 256 on identified risks for the emergency department, including trauma level designation, overall volume, volume
 257 of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from
 258 such violence, and prevalence of crime in the community, in consultation with the emergency department
 259 medical director and nurse director. The security plan shall also outline training requirements for security
 260 personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques,
 261 appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches.
 262 Such training shall also include instruction on safely addressing situations involving patients, family
 263 members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance
 264 abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through
 265 completion of the Department of Criminal Justice Services minimum training standards for auxiliary police
 266 officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at
 267 least one off-duty law-enforcement officer or trained security personnel be present at all times in the
 268 emergency department if the hospital demonstrates that a different level of security is necessary and
 269 appropriate for any of its emergency departments based upon findings in the security risk assessment;

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

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

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

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

297 27. Shall require each hospital with an emergency department to establish a protocol for the treatment and
 298 discharge of individuals experiencing a substance use-related emergency, which shall include provisions for
 299 (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to
 300 identify medical interventions necessary for the treatment of the individual in the emergency department and
 301 (ii) recommendations for follow-up care following discharge for any patient identified as having a substance
 302 use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have
 303 been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a)

304 the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection X of
305 § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or
306 other opioid antagonist used for overdose reversal, including information about accessing naloxone or other
307 opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy
308 operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or
309 other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing
310 order. Such protocols may also provide for referrals of individuals experiencing a substance use-related
311 emergency to peer recovery specialists and community-based providers of behavioral health services, or to
312 providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

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

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

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

351 31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients
352 who are minors available to such patients through a secure website shall make such health records available
353 to such patient's parent or guardian through such secure website, unless the hospital cannot make such health
354 record available in a manner that prevents disclosure of information, the disclosure of which has been denied
355 pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of
356 § 54.1-2969 has not been provided; *and*

357 32. *Shall establish fees for the issuance, change, or renewal of a hospital or nursing home license to cover*
358 *the costs of operating the hospital and nursing home licensure and inspection program in a manner that*
359 *ensures timely completion of inspections as set forth in § 32.1-126. In establishing such fees, the Board shall*
360 *distribute the costs of operating the hospital and nursing home licensure and inspection program in an*
361 *equitable manner across all hospitals or nursing homes and ensure that the amount of such fees shall change*
362 *no more frequently than annually. Fee changes under this section shall only be initiated if the expenses*
363 *allocated to the Hospital and Nursing Home Licensure and Inspection Program Fund established under §*
364 *32.1-130, plus any state or other funding sources appropriated for the hospital and nursing home licensure*

365 *and inspection program, are shown to be more than 10 percent greater or less than the annual costs of*
366 *operating the hospital and nursing home licensure and inspection program in a manner that ensures timely*
367 *completion of inspections. This analysis shall be conducted separately for hospital fees and nursing home*
368 *fees, and resulting fee changes shall be established such that fees are sufficient to cover unfunded expenses*
369 *but not excessive.*

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

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

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

382 **§ 32.1-127. (Effective July 1, 2025) Regulations.**

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

388 B. Such regulations:

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

397 2. Shall provide that at least one physician who is licensed to practice medicine in the Commonwealth and
398 is primarily responsible for the emergency department shall be on duty and physically present at all times at
399 each hospital that operates or holds itself out as operating an emergency service;

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

402 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal
403 law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. §
404 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS
405 regulations for routine contact, whereby the provider's designated organ procurement organization certified
406 by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii)
407 is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a
408 similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of
409 America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The
410 hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in
411 the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable
412 tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The
413 protocol shall ensure that the hospital collaborates with the designated organ procurement organization to
414 inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to
415 donate. The individual making contact with the family shall have completed a course in the methodology for
416 approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved
417 by the organ procurement organization and designed in conjunction with the tissue and eye bank community
418 and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of
419 the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement
420 organization in educating the staff responsible for contacting the organ procurement organization's personnel
421 on donation issues, the proper review of death records to improve identification of potential donors, and the
422 proper procedures for maintaining potential donors while necessary testing and placement of potential
423 donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the
424 family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative
425 officer of the hospital or his designee knows of such opposition, and no donor card or other relevant

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426 document, such as an advance directive, can be found;

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

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

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

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

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

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

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

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

467 13. Shall require that each nursing home and certified nursing facility register with the Department of
468 State Police to receive notice of the registration, reregistration, or verification of registration information of
469 any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to
470 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
471 facility is located, pursuant to § 9.1-914;

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

476 15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult
477 patient to receive visits from any individual from whom the patient desires to receive visits, subject to other
478 restrictions contained in the visitation policy including, but not limited to, those related to the patient's
479 medical condition and the number of visitors permitted in the patient's room simultaneously;

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

487 restricted from participating in meetings in the facility with the families or resident representatives of other
488 residents in the facility;

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

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

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

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

515 21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a
516 policy governing determination of the medical and ethical appropriateness of proposed medical care, which
517 shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of
518 proposed medical care in cases in which a physician has determined proposed care to be medically or
519 ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is
520 medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by
521 the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the
522 proposed health care; and (iii) requirements for a written explanation of the decision reached by the
523 interdisciplinary medical review committee, which shall be included in the patient's medical record. Such
524 policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to
525 § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent
526 medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee
527 meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical
528 decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other
529 remedies available at law, including seeking court review, provided that the patient, his agent, or the person
530 authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the
531 chief executive officer of the hospital within 14 days of the date on which the physician's determination that
532 proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical
533 record;

534 22. Shall require every hospital with an emergency department to establish a security plan. Such security
535 plan shall be developed using standards established by the International Association for Healthcare Security
536 and Safety or other industry standard and shall be based on the results of a security risk assessment of each
537 emergency department location of the hospital and shall include the presence of at least one off-duty
538 law-enforcement officer or trained security personnel who is present in the emergency department at all times
539 as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based
540 on identified risks for the emergency department, including trauma level designation, overall volume, volume
541 of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from
542 such violence, and prevalence of crime in the community, in consultation with the emergency department
543 medical director and nurse director. The security plan shall also outline training requirements for security
544 personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques,
545 appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches.
546 Such training shall also include instruction on safely addressing situations involving patients, family
547 members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance

548 abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through
549 completion of the Department of Criminal Justice Services minimum training standards for auxiliary police
550 officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at
551 least one off-duty law-enforcement officer or trained security personnel be present at all times in the
552 emergency department if the hospital demonstrates that a different level of security is necessary and
553 appropriate for any of its emergency departments based upon findings in the security risk assessment;

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

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

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

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

581 27. Shall require each hospital with an emergency department to establish a protocol for the treatment and
582 discharge of individuals experiencing a substance use-related emergency, which shall include provisions for
583 (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to
584 identify medical interventions necessary for the treatment of the individual in the emergency department and
585 (ii) recommendations for follow-up care following discharge for any patient identified as having a substance
586 use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have
587 been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a)
588 the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection X of
589 § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or
590 other opioid antagonist used for overdose reversal, including information about accessing naloxone or other
591 opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy
592 operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or
593 other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing
594 order. Such protocols may also provide for referrals of individuals experiencing a substance use-related
595 emergency to peer recovery specialists and community-based providers of behavioral health services, or to
596 providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

597 28. During a public health emergency related to COVID-19, shall require each nursing home and certified
598 nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from
599 the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid
600 Services and the Board. Such protocol shall include provisions describing (i) the conditions, including
601 conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and
602 community, under which in-person visits will be allowed and under which in-person visits will not be
603 allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be
604 required to comply to protect the health and safety of the patients and staff of the nursing home or certified
605 nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff
606 support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing
607 home or certified nursing facility will take in the event of a technology failure, service interruption, or
608 documented emergency that prevents visits from occurring as required by this subdivision. Such protocol

609 shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where
 610 appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a
 611 provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided
 612 that such waiver or limitation is included in the patient's health record; and (c) a requirement that each
 613 nursing home and certified nursing facility publish on its website or communicate to each patient or the
 614 patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing
 615 facility's plan for providing visits to patients as required by this subdivision;

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

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

635 31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients
 636 who are minors available to such patients through a secure website shall make such health records available
 637 to such patient's parent or guardian through such secure website, unless the hospital cannot make such health
 638 record available in a manner that prevents disclosure of information, the disclosure of which has been denied
 639 pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of
 640 § 54.1-2969 has not been provided; ~~and~~

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

646 33. *Shall establish fees for the issuance, change, or renewal of a hospital or nursing home license to cover
 647 the costs of operating the hospital and nursing home licensure and inspection program in a manner that
 648 ensures timely completion of inspections as set forth in § 32.1-126. In establishing such fees, the Board shall
 649 distribute the costs of operating the hospital and nursing home licensure and inspection program in an
 650 equitable manner across all hospitals or nursing homes and ensure that the amount of such fees shall change
 651 no more frequently than annually. Fee changes under this section shall only be initiated if the expenses
 652 allocated to the Hospital and Nursing Home Licensure and Inspection Program Fund established under §
 653 32.1-130, plus any state or other funding sources appropriated for the hospital and nursing home licensure
 654 and inspection program, are shown to be more than 10 percent greater or less than the annual costs of
 655 operating the hospital and nursing home licensure and inspection program in a manner that ensures timely
 656 completion of inspections. This analysis shall be conducted separately for hospital fees and nursing home
 657 fees, and resulting fee changes shall be established such that fees are sufficient to cover unfunded expenses
 658 but not excessive.*

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

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

669 E. Hospitals in the Commonwealth may enter into agreements with the Department of Health for the

670 provision to uninsured patients of naloxone or other opioid antagonists used for overdose reversal.

671 **2. That § 32.1-130 of the Code of Virginia is amended and reenacted as follows:**

672 **§ 32.1-130. Fees; Hospital and Nursing Home Licensure and Inspection Program Fund.**

673 A. A service charge of \$1.50 per patient bed for which the hospital or nursing home is licensed, but not
674 less than \$75 nor more than \$500, shall be paid for each license upon issuance and renewal. The service
675 charge for a license for a hospital or nursing home which does not provide overnight inpatient care shall be
676 \$75.

677 B. All service charges fees received under the provisions of this article shall be paid into a special fund of
678 the Department the Hospital and Nursing Home Licensure and Inspection Program Fund established in
679 subsection B and are appropriated to the Department solely for the operation of the hospital and nursing home
680 licensure and inspection program.

681 B. There is hereby created in the state treasury a special nonreverting fund to be known as the Hospital
682 and Nursing Home Licensure and Inspection Program Fund, referred to in this section as "the Fund." The
683 Fund shall be established on the books of the Comptroller. All fees collected pursuant to subsection A shall
684 be paid into the state treasury and credited to the Fund accounting separately for hospital fee revenue and
685 nursing home fee revenue. Interest earned on moneys in the Fund shall remain in the Fund and be credited to
686 it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not
687 revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for operating
688 the hospital and nursing home licensure and inspection program administered pursuant to this article.
689 Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by
690 the Comptroller upon written request signed by Commissioner.

691 **3. That the Board of Health shall promulgate regulations to implement the provisions of the first**

692 **enactment of this act to be effective within 280 days of its enactment.**

693 **4. That the provisions of the second enactment of this act shall not become effective until the Board of**
694 **Health promulgates regulations to implement the provisions of the first enactment of this act. The**
695 **Board of Health shall certify in writing to the Code Commission the date upon which such regulations**
696 **become effective.**