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1 SENATE BILL NO. 548

2 Offered January 14, 2026

3 Prefiled January 14, 2026

4 A BILL to amend and reenact §§ 32.1-127, as it is currently effective and as it shall become effective, and
5 54.1-2915 of the Code of Virginia and to amend the Code of Virginia by adding in Article 9 of Chapter 4
6 of Title 18.2 a section numbered 18.2-76.3, relating to abortion; born alive infant; treatment and care;
7 penalty.
8

9 Patron—Sturtevant

10 Referred to Committee on Education and Health

11 Be it enacted by the General Assembly of Virginia:

12 1. That §§ 32.1-127, as it is currently effective and as it shall become effective, and 54.1-2915 of the
13 Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in
14 Article 9 of Chapter 4 of Title 18.2 a section numbered 18.2-76.3 as follows:15 § 18.2-76.3. *Failure to provide treatment and care to a human infant born alive; penalty.*16 A. Every health care provider licensed by the Board of Medicine who attempts or assists in the attempt to
17 perform an abortion or cause a miscarriage for the purpose of terminating a pregnancy and who is present at
18 the time such abortion is attempted or such miscarriage is attempted to be caused shall, in the case of a
19 human infant who has been born alive, as defined in § 18.2-71.1, following performance of such attempted
20 abortion or causing of a miscarriage, (i) exercise the same degree of professional skill, care, and diligence to
21 preserve the life and health of the human infant who has been born alive as a reasonably diligent and
22 conscientious health care practitioner would render to any other child born alive at the same gestational age
23 and (ii) take all reasonable steps to ensure the immediate transfer of the human infant who has been born
24 alive to a hospital for further medical care.25 B. Any health care provider licensed by the Board of Medicine who fails to comply with the provisions of
26 subsection A is guilty of a Class 4 felony.27 C. The mother of a human infant who has been born alive shall not be subject to prosecution for any
28 criminal offense pursuant to this section.

29 § 32.1-127. (Effective until January 1, 2026) Regulations.

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

35 B. Such regulations:

36 1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes,
37 and certified nursing facilities to ensure the environmental protection and the life safety of its patients,
38 employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified
39 nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing
40 facilities, except those professionals licensed or certified by the Department of Health Professions; (iv)
41 conditions under which a hospital or nursing home may provide medical and nursing services to patients in
42 their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility
43 security of hospitals, nursing homes, and certified nursing facilities;44 2. Shall provide that at least one physician who is licensed to practice medicine in the Commonwealth and
45 is primarily responsible for the emergency department shall be on duty and physically present at all times at
46 each hospital that operates or holds itself out as operating an emergency service;47 3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing
48 hospitals and nursing homes by bed capacity and by type of specialty or service;49 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal
50 law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. §
51 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS
52 regulations for routine contact, whereby the provider's designated organ procurement organization certified
53 by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii)
54 is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a
55 similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of
56 America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The
57 hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in
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59 the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable
60 tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The
61 protocol shall ensure that the hospital collaborates with the designated organ procurement organization to
62 inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to
63 donate. The individual making contact with the family shall have completed a course in the methodology for
64 approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved
65 by the organ procurement organization and designed in conjunction with the tissue and eye bank community
66 and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of
67 the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement
68 organization in educating the staff responsible for contacting the organ procurement organization's personnel
69 on donation issues, the proper review of death records to improve identification of potential donors, and the
70 proper procedures for maintaining potential donors while necessary testing and placement of potential
71 donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the
72 family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative
73 officer of the hospital or his designee knows of such opposition, and no donor card or other relevant
74 document, such as an advance directive, can be found;

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

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

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

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

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

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

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

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

115 13. Shall require that each nursing home and certified nursing facility register with the Department of
116 State Police to receive notice of the registration, reregistration, or verification of registration information of
117 any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to
118 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
119 facility is located, pursuant to § 9.1-914;

120 14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission,

121 whether a potential patient is required to register with the Sex Offender and Crimes Against Minors Registry
 122 pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the potential patient
 123 will have a length of stay greater than three days or in fact stays longer than three days;

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

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

137 17. Shall require that each nursing home and certified nursing facility maintain, per facility, non-eroding
 138 general liability insurance coverage in a minimum amount of \$1 million per occurrence, and professional
 139 liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15 per patient
 140 occurrence, to compensate patients or individuals for injuries and losses resulting from the negligent acts of
 141 the facility. Failure to maintain such minimum insurance limits under this section shall result in revocation of
 142 the facility's license. Each nursing home and certified nursing facility shall provide at licensure renewal or
 143 have available to the Board proof of the insurance coverages as required by this section;

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

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

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

165 21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a
 166 policy governing determination of the medical and ethical appropriateness of proposed medical care, which
 167 shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of
 168 proposed medical care in cases in which a physician has determined proposed care to be medically or
 169 ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is
 170 medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by
 171 the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the
 172 proposed health care; and (iii) requirements for a written explanation of the decision reached by the
 173 interdisciplinary medical review committee, which shall be included in the patient's medical record. Such
 174 policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to
 175 § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent
 176 medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee
 177 meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical
 178 decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other
 179 remedies available at law, including seeking court review, provided that the patient, his agent, or the person
 180 authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the
 181 chief executive officer of the hospital within 14 days of the date on which the physician's determination that
 182 proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical

183 record;

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

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

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

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

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

231 27. Shall require each hospital with an emergency department to establish a protocol for the treatment and
232 discharge of individuals experiencing a substance use-related emergency, which shall include provisions for
233 (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to
234 identify medical interventions necessary for the treatment of the individual in the emergency department and
235 (ii) recommendations for follow-up care following discharge for any patient identified as having a substance
236 use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have
237 been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a)
238 the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection Y of
239 § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or
240 other opioid antagonist used for overdose reversal, including information about accessing naloxone or other
241 opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy
242 operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or
243 other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing
244 order. Such protocols may also provide for referrals of individuals experiencing a substance use-related

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

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

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

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

285 31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients
 286 who are minors available to such patients through a secure website shall make such health records available
 287 to such patient's parent or guardian through such secure website, unless the hospital cannot make such health
 288 record available in a manner that prevents disclosure of information, the disclosure of which has been denied
 289 pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of
 290 § 54.1-2969 has not been provided;

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

296 33. Shall establish fees for the issuance, change, or renewal of a hospital or nursing home license to cover
 297 the costs of operating the hospital and nursing home licensure and inspection program in a manner that
 298 ensures timely completion of inspections as set forth in § 32.1-126. In establishing such fees, the Board shall
 299 distribute the costs of operating the hospital and nursing home licensure and inspection program in an
 300 equitable manner across all hospitals or nursing homes and ensure that the amount of such fees shall change
 301 no more frequently than annually. Fee changes under this section shall only be initiated if the expenses
 302 allocated to the Hospital and Nursing Home Licensure and Inspection Program Fund established under
 303 § 32.1-130, plus any state or other funding sources appropriated for the hospital and nursing home licensure
 304 and inspection program, are shown to be more than 10 percent greater or less than the annual costs of
 305 operating the hospital and nursing home licensure and inspection program in a manner that ensures timely
 306 completion of inspections. This analysis shall be conducted separately for hospital fees and nursing home

307 fees, and resulting fee changes shall be established such that fees are sufficient to cover unfunded expenses
308 but not excessive; and

309 *34. Shall require every hospital to establish a protocol for (i) the treatment and care of a human infant
310 who has been born alive, as that term is defined in § 18.2-71.1, and (ii) requiring the immediate reporting to
311 law enforcement of any failure of any health care provider required to provide treatment and care to a
312 human infant who has been born alive in accordance with the provisions of clause (i) or § 18.2-76.3.*

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

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

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

325 F. Hospitals in the Commonwealth shall:

326 1. Establish a workplace violence incident reporting system, through which each hospital shall document,
327 track, and analyze any incident of workplace violence reported. The results of such analysis shall be used to
328 make improvements in preventing workplace violence, including improvements achieved through continuing
329 education in targeted areas, including de-escalation training, risk identification, and violence prevention
330 planning. Such reporting system shall (i) be clearly communicated to all employees, including to any new
331 employees at the employee orientation, and (ii) include guidelines on when and how to report incidents of
332 workplace violence to the employer, security agencies, and appropriate law-enforcement authorities;

333 2. Record all reported incidents of workplace violence as voluntarily reported by an employee; and

334 3. Adopt a policy that prohibits any person from discriminating or retaliating against any employee of the
335 hospital for reporting to, or seeking assistance or intervention from, the employer, security agencies,
336 law-enforcement authorities, local emergency services organizations, government agencies, or others
337 participating in any incident investigation. Such policy shall comply with the provisions of § 40.1-27.3.

338 G. Each hospital in the Commonwealth shall maintain the record of reported incidents of workplace
339 violence made pursuant to subsection F for at least two years and shall include in such record, at a minimum:

340 1. The date and time of the incident;
341 2. A description of the incident, including the job titles of the affected employee;
342 3. Whether the perpetrator was a patient, visitor, employee, or other person;
343 4. A description of where the incident occurred;
344 5. Information relating the type of incident, including whether the incident involved (i) a physical attack
345 without a weapon; (ii) an attack with a weapon or object; (iii) a threat of physical force or use of a weapon or
346 other object with the intent to cause bodily harm; (iv) sexual assault or the threat of sexual assault; or (v)
347 anything else not listed in subdivisions (i) through (iv);

348 6. The response to and any consequences of the incident, including (i) whether security or law
349 enforcement was contacted and, if so, their response and (ii) whether the incident resulted in any change to
350 hospital policy; and

351 7. Information about the individual who completed the report, including such individual's name, job title,
352 and the date of completion.

353 H. Each hospital shall:

354 1. Report the data collected and reported pursuant to subsection G to the chief medical officer and the
355 chief nursing officer of such hospital on, at a minimum, a quarterly basis; and

356 2. Send a report to the Department on an annual basis that includes, at a minimum, the number of
357 incidents of workplace violence voluntarily reported by an employee pursuant to subsection F. Any report
358 made to the Department pursuant to this subdivision shall be aggregated to remove any personally
359 identifiable information.

360 I. As used in this section:

361 "Employee of the hospital" or "employee" means an employee of the hospital or any health care provider
362 credentialed by the hospital or engaged by the hospital to perform health care services on the premises of the
363 hospital.

364 "Workplace violence" means any act of violence or threat of violence, without regard to the intent of the
365 perpetrator, that occurs against an employee of the hospital while on the premises of such hospital and
366 engaged in the performance of his duties. "Workplace violence" includes (i) the threat or use of physical force
367 against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or
368 stress, regardless of whether physical injury is sustained, and (ii) any incident involving the threat of using

369 dangerous weapons or using common objects as weapons or to cause physical harm, regardless of whether
 370 physical injury is sustained.

371 **§ 32.1-127. (Effective January 1, 2026) Regulations.**

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

377 B. Such regulations:

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

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

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

391 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal
 392 law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. §
 393 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS
 394 regulations for routine contact, whereby the provider's designated organ procurement organization certified
 395 by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii)
 396 is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a
 397 similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of
 398 America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The
 399 hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in
 400 the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable
 401 tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The
 402 protocol shall ensure that the hospital collaborates with the designated organ procurement organization to
 403 inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to
 404 donate. The individual making contact with the family shall have completed a course in the methodology for
 405 approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved
 406 by the organ procurement organization and designed in conjunction with the tissue and eye bank community
 407 and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of
 408 the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement
 409 organization in educating the staff responsible for contacting the organ procurement organization's personnel
 410 on donation issues, the proper review of death records to improve identification of potential donors, and the
 411 proper procedures for maintaining potential donors while necessary testing and placement of potential
 412 donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the
 413 family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative
 414 officer of the hospital or his designee knows of such opposition, and no donor card or other relevant
 415 document, such as an advance directive, can be found;

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

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

430 7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for

431 admission the home's or facility's admissions policies, including any preferences given;

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

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

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

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

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

456 13. Shall require that each nursing home and certified nursing facility register with the Department of
457 State Police to receive notice of the registration, reregistration, or verification of registration information of
458 any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to
459 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
460 facility is located, pursuant to § 9.1-914;

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

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

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

478 17. Shall require that each nursing home and certified nursing facility maintain, per facility, non-eroding
479 general liability insurance coverage in a minimum amount of \$1 million per occurrence, and professional
480 liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15 per patient
481 occurrence, to compensate patients or individuals for injuries and losses resulting from the negligent acts of
482 the facility. Failure to maintain such minimum insurance limits under this section shall result in revocation of
483 the facility's license. Each nursing home and certified nursing facility shall provide at licensure renewal or
484 have available to the Board proof of the insurance coverages as required by this section;

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

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

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

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

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

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

553 24. Shall establish an exemption from the requirement to obtain a license to add temporary beds in an
 554 existing hospital or nursing home, including beds located in a temporary structure or satellite location

555 operated by the hospital or nursing home, provided that the ability remains to safely staff services across the
556 existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's
557 determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has
558 caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a
559 shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the emergency
560 order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the
561 Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of suppressing a
562 nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to
563 the public life and health;

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

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

572 27. Shall require each hospital with an emergency department to establish a protocol for the treatment and
573 discharge of individuals experiencing a substance use-related emergency, which shall include provisions for
574 (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to
575 identify medical interventions necessary for the treatment of the individual in the emergency department and
576 (ii) recommendations for follow-up care following discharge for any patient identified as having a substance
577 use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have
578 been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a)
579 the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection Y of
580 § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or
581 other opioid antagonist used for overdose reversal, including information about accessing naloxone or other
582 opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy
583 operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or
584 other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing
585 order. Such protocols may also provide for referrals of individuals experiencing a substance use-related
586 emergency to peer recovery specialists and community-based providers of behavioral health services, or to
587 providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

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

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

615 30. During a declared public health emergency related to a communicable disease of public health threat,
616 shall require each hospital, nursing home, and certified nursing facility to establish a protocol to allow

617 patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect
 618 consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare
 619 and Medicaid Services and subject to compliance with any executive order, order of public health,
 620 Department guidance, or any other applicable federal or state guidance having the effect of limiting visitation.
 621 Such protocol may restrict the frequency and duration of visits and may require visits to be conducted
 622 virtually using interactive audio or video technology. Any such protocol may require the person visiting a
 623 patient pursuant to this subdivision to comply with all reasonable requirements of the hospital, nursing home,
 624 or certified nursing facility adopted to protect the health and safety of the person, patients, and staff of the
 625 hospital, nursing home, or certified nursing facility;

626 31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients
 627 who are minors available to such patients through a secure website shall make such health records available
 628 to such patient's parent or guardian through such secure website, unless the hospital cannot make such health
 629 record available in a manner that prevents disclosure of information, the disclosure of which has been denied
 630 pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of
 631 § 54.1-2969 has not been provided;

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

637 33. Shall require every hospital with an emergency department, when conducting a urine drug screening
 638 to assist in diagnosing a patient's condition, to include testing for fentanyl in such urine drug screening; **and**

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

652 35. *Shall require every hospital to establish a protocol for (i) the treatment and care of a human infant
 653 who has been born alive, as that term is defined in § 18.2-71.1, and (ii) requiring the immediate reporting to
 654 law enforcement of any failure of any health care provider required to provide treatment and care to a
 655 human infant who has been born alive in accordance with the provisions of clause (i) or § 18.2-76.3.*

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

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

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

668 F. Hospitals in the Commonwealth shall:

669 1. Establish a workplace violence incident reporting system, through which each hospital shall document,
 670 track, and analyze any incident of workplace violence reported. The results of such analysis shall be used to
 671 make improvements in preventing workplace violence, including improvements achieved through continuing
 672 education in targeted areas, including de-escalation training, risk identification, and violence prevention
 673 planning. Such reporting system shall (i) be clearly communicated to all employees, including to any new
 674 employees at the employee orientation, and (ii) include guidelines on when and how to report incidents of
 675 workplace violence to the employer, security agencies, and appropriate law-enforcement authorities;

676 2. Record all reported incidents of workplace violence as voluntarily reported by an employee; **and**

677 3. Adopt a policy that prohibits any person from discriminating or retaliating against any employee of the
 678 hospital for reporting to, or seeking assistance or intervention from, the employer, security agencies,

679 law-enforcement authorities, local emergency services organizations, government agencies, or others
680 participating in any incident investigation. Such policy shall comply with the provisions of § 40.1-27.3.

681 G. Each hospital in the Commonwealth shall maintain the record of reported incidents of workplace
682 violence made pursuant to subsection F for at least two years and shall include in such record, at a minimum:

- 683 1. The date and time of the incident;
- 684 2. A description of the incident, including the job titles of the affected employee;
- 685 3. Whether the perpetrator was a patient, visitor, employee, or other person;
- 686 4. A description of where the incident occurred;
- 687 5. Information relating the type of incident, including whether the incident involved (i) a physical attack
688 without a weapon; (ii) an attack with a weapon or object; (iii) a threat of physical force or use of a weapon or
689 other object with the intent to cause bodily harm; (iv) sexual assault or the threat of sexual assault; or (v)
690 anything else not listed in subdivisions (i) through (iv);

691 6. The response to and any consequences of the incident, including (i) whether security or law
692 enforcement was contacted and, if so, their response and (ii) whether the incident resulted in any change to
693 hospital policy; and

694 7. Information about the individual who completed the report, including such individual's name, job title,
695 and the date of completion.

696 H. Each hospital shall:

697 1. Report the data collected and reported pursuant to subsection G to the chief medical officer and the
698 chief nursing officer of such hospital on, at a minimum, a quarterly basis; and

699 2. Send a report to the Department on an annual basis that includes, at a minimum, the number of
700 incidents of workplace violence voluntarily reported by an employee pursuant to subsection F. Any report
701 made to the Department pursuant to this subdivision shall be aggregated to remove any personally
702 identifiable information.

703 I. As used in this section:

704 "Employee of the hospital" or "employee" means an employee of the hospital or any health care provider
705 credentialed by the hospital or engaged by the hospital to perform health care services on the premises of the
706 hospital.

707 "Workplace violence" means any act of violence or threat of violence, without regard to the intent of the
708 perpetrator, that occurs against an employee of the hospital while on the premises of such hospital and
709 engaged in the performance of his duties. "Workplace violence" includes (i) the threat or use of physical force
710 against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or
711 stress, regardless of whether physical injury is sustained, and (ii) any incident involving the threat of using
712 dangerous weapons or using common objects as weapons or to cause physical harm, regardless of whether
713 physical injury is sustained.

714 **§ 54.1-2915. Unprofessional conduct; grounds for refusal or disciplinary action.**

715 A. The Board may refuse to issue a certificate or license to any applicant; reprimand any person; place
716 any person on probation for such time as it may designate; impose a monetary penalty or terms as it may
717 designate on any person; suspend any license for a stated period of time or indefinitely; or revoke any license
718 for any of the following acts of unprofessional conduct:

719 1. False statements or representations or fraud or deceit in obtaining admission to the practice, or fraud or
720 deceit in the practice of any branch of the healing arts;

721 2. Substance abuse rendering him unfit for the performance of his professional obligations and duties;

722 3. Intentional or negligent conduct in the practice of any branch of the healing arts that causes or is likely
723 to cause injury to a patient or patients;

724 4. Mental or physical incapacity or incompetence to practice his profession with safety to his patients and
725 the public;

726 5. Restriction of a license to practice a branch of the healing arts in another state, the District of Columbia,
727 a United States possession or territory, or a foreign jurisdiction, or for an entity of the federal government;

728 6. Undertaking in any manner or by any means whatsoever to procure or perform or aid or abet in
729 procuring or performing a criminal abortion;

730 7. Engaging in the practice of any of the healing arts under a false or assumed name, or impersonating
731 another practitioner of a like, similar, or different name;

732 8. Prescribing or dispensing any controlled substance with intent or knowledge that it will be used
733 otherwise than medicinally, or for accepted therapeutic purposes, or with intent to evade any law with respect
734 to the sale, use, or disposition of such drug;

735 9. Violating provisions of this chapter on division of fees or practicing any branch of the healing arts in
736 violation of the provisions of this chapter;

737 10. Knowingly and willfully committing an act that is a felony under the laws of the Commonwealth or
738 the United States, or any act that is a misdemeanor under such laws and involves moral turpitude;

739 11. Aiding or abetting, having professional connection with, or lending his name to any person known to

740 him to be practicing illegally any of the healing arts;

741 12. Conducting his practice in a manner contrary to the standards of ethics of his branch of the healing

742 arts;

743 13. Conducting his practice in such a manner as to be a danger to the health and welfare of his patients or

744 to the public;

745 14. Inability to practice with reasonable skill or safety because of illness or substance abuse;

746 15. Publishing in any manner an advertisement relating to his professional practice that contains a claim

747 of superiority or violates Board regulations governing advertising;

748 16. Performing any act likely to deceive, defraud, or harm the public;

749 17. Violating any provision of statute or regulation, state or federal, relating to the manufacture,

750 distribution, dispensing, or administration of drugs;

751 18. Violating or cooperating with others in violating any of the provisions of Chapters 1 (§ 54.1-100 et

752 seq.), 24 (§ 54.1-2400 et seq.) and this chapter or regulations of the Board;

753 19. Engaging in sexual contact with a patient concurrent with and by virtue of the practitioner and patient

754 relationship or otherwise engaging at any time during the course of the practitioner and patient relationship in

755 conduct of a sexual nature that a reasonable patient would consider lewd and offensive;

756 20. Conviction in any state, territory, or country of any felony or of any crime involving moral turpitude;

757 21. Adjudication of legal incompetence or incapacity in any state if such adjudication is in effect and the

758 person has not been declared restored to competence or capacity;

759 22. Performing the services of a medical examiner as defined in 49 C.F.R. § 390.5 if, at the time such

760 services are performed, the person performing such services is not listed on the National Registry of Certified

761 Medical Examiners as provided in 49 C.F.R. § 390.109 or fails to meet the requirements for continuing to be

762 listed on the National Registry of Certified Medical Examiners as provided in 49 C.F.R. § 390.111;

763 23. Failing or refusing to complete and file electronically using the Electronic Death Registration System

764 any medical certification in accordance with the requirements of subsection C of § 32.1-263. However,

765 failure to complete and file a medical certification electronically using the Electronic Death Registration

766 System in accordance with the requirements of subsection C of § 32.1-263 shall not constitute unprofessional

767 conduct if such failure was the result of a temporary technological or electrical failure or other temporary

768 extenuating circumstance that prevented the electronic completion and filing of the medical certification

769 using the Electronic Death Registration System; or

770 24. Engaging in a pattern of violations of § 38.2-3445.01; or

771 25. *Failing to comply with the requirements of § 18.2-76.3.*

772 B. The commission or conviction of an offense in another state, territory, or country, which if committed

773 in Virginia would be a felony, shall be treated as a felony conviction or commission under this section

774 regardless of its designation in the other state, territory, or country.

775 C. The Board shall refuse to issue a certificate or license to any applicant if the candidate or applicant has

776 had his certificate or license to practice a branch of the healing arts revoked or suspended, and has not had his

777 certificate or license to so practice reinstated, in another state, the District of Columbia, a United States

778 possession or territory, or a foreign jurisdiction.

779 **2. That the provisions of this act may result in a net increase in periods of imprisonment or**

780 **commitment. Pursuant to § 30-19.1:4 of the Code of Virginia, the estimated amount of the necessary**

781 **appropriation cannot be determined for periods of imprisonment in state adult correctional facilities;**

782 **therefore, Chapter 725 of the Acts of Assembly of 2025 requires the Virginia Criminal Sentencing**

783 **Commission to assign a minimum fiscal impact of \$50,000. Pursuant to § 30-19.1:4 of the Code of**

784 **Virginia, the estimated amount of the necessary appropriation is \$0 for periods of commitment to the**

785 **custody of the Department of Juvenile Justice.**