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HOUSE BILL NO. 605**AMENDMENT IN THE NATURE OF A SUBSTITUTE**(Proposed by the House Committee on Health and Human Services
on February 12, 2026)

(Patron Prior to Substitute—Delegate Willett)

*A BILL to amend and reenact §§ 32.1-27.2 and 32.1-127 of the Code of Virginia, relating to nursing home staffing; minimum staffing standards; enforcement of administrative sanctions.***Be it enacted by the General Assembly of Virginia:****1. That §§ 32.1-27.2 and 32.1-127 of the Code of Virginia are amended and reenacted as follows:****§ 32.1-27.2. Administrative sanctions.**

A. Notwithstanding any other provision of law, the Commissioner may impose administrative sanctions in accordance with this section on any certified nursing facility, if that certified nursing facility does not comply with the provisions of regulations promulgated pursuant to subdivision B ~~32~~ 35 of § 32.1-127. The Commissioner shall not impose any administrative sanctions authorized under this section until regulations are promulgated pursuant to subsection G.

B. The Commissioner shall have authority to annually determine whether or not to impose any sanctions under subsection C for noncompliance with the provisions of regulations promulgated pursuant to subdivision B ~~32~~ 35 of § 32.1-127, if the certified nursing facility:

1. Was affected by a declared emergency, or an act of God, that had an impact on the ability to hire or retain staff at levels required under subdivision B ~~32~~ 35 of § 32.1-127. To the extent necessary, the Commissioner may review trended employment data for direct care staff, as provided by the certified nursing facility, to determine the effect of such emergencies or acts of God in assessing this criterion. Failure to provide adequate data may remove this criterion from the Commissioner's consideration;

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

3. Was located in a medically underserved area and such location severely limited the ability of the certified nursing facility to recruit and retain direct care staff despite a concerted effort to recruit and retain direct care staff. The certified nursing facility shall provide evidence upon request of the Commissioner for consideration. Failure to provide adequate evidence may remove this criterion from the Commissioner's consideration.

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

1. When a certified nursing facility is not in compliance with subdivision B ~~32~~ 35 of § 32.1-127 and the conditions under subsection B do not exist, the Commissioner shall require the submission of an annual corrective action plan by a certified nursing facility and, upon approval of such plan by the Commissioner, compliance with such plan. A corrective action plan shall only articulate strategies to be utilized to increase direct care staffing with the goal of compliance with subdivision B ~~32~~ 35 of § 32.1-127 or improvement on the total nurse staffing hours metric, as defined by the Virginia Medicaid Nursing Facility Value-Based Purchasing (VBP) program. The Commissioner shall consider evidence of direct care staff hours provided in addition to the payroll based journal report, if requested by a certified nursing facility, and may or may not impose a corrective action plan under this section. The Commissioner shall consider the following:

a. If the annual measurement immediately subsequent to issuance of the corrective action plan shows compliance with subdivision B ~~32~~ 35 of § 32.1-127, no additional administrative sanctions are warranted, and the corrective action plan is deemed inactive but shall be retained by the Commissioner pursuant to the Virginia Public Records Act (§ 42.1-76 et seq.); or

b. If the annual measurement immediately subsequent to issuance of the corrective action plan still shows noncompliance with subdivision B ~~32~~ 35 of § 32.1-127, but the VBP program, as administered by the Department of Medical Assistance Services, indicates defined improvement on the total nurse staffing hours metric, the Commissioner shall repeat the provisions of subdivision 1; or

c. If the annual measurement immediately subsequent to issuance of the corrective action plan still shows noncompliance with subdivision B ~~32~~ 35 of § 32.1-127, and the VBP program, as administered by the Department of Medical Assistance Services, does not indicate defined improvement on the total nurse staffing hours metric, the Commissioner shall repeat the provisions of subdivision 1 and may, under circumstances described, provide additional sanctions under subdivisions 2 and 3;

2. To the extent that any consecutive annual corrective action plan is required and results articulated in

60 subdivision 1 c are obtained a second consecutive time, the Commissioner may impose a monetary penalty of
61 up to \$50,000 for each subsequent consecutive annual period in which compliance with subdivision B ~~32~~ 35
62 of § 32.1-127 or defined improvement on the total nurse staffing hours metric under the VBP program is not
63 attained; and

64 3. To the extent that a certified nursing facility is out of compliance with subdivision B ~~32~~ 35 of
65 § 32.1-127 or fails to show defined improvement on the total nurse staffing hours metric under the VBP
66 program after three consecutive corrective action plans, the Commissioner may place the nursing home or
67 certified nursing facility on probation.

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

72 E. After deduction of the administrative costs of the Commissioner and the Department in furtherance of
73 this section, any penalties collected under this section shall be paid to the special fund as set forth in
74 § 32.1-27.1.

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

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

80 **§ 32.1-127. Regulations.**

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

86 B. Such regulations:

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

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

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

100 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal
101 law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. §
102 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS
103 regulations for routine contact, whereby the provider's designated organ procurement organization certified
104 by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii)
105 is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a
106 similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of
107 America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The
108 hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in
109 the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable
110 tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The
111 protocol shall ensure that the hospital collaborates with the designated organ procurement organization to
112 inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to
113 donate. The individual making contact with the family shall have completed a course in the methodology for
114 approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved
115 by the organ procurement organization and designed in conjunction with the tissue and eye bank community
116 and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of
117 the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement
118 organization in educating the staff responsible for contacting the organ procurement organization's personnel
119 on donation issues, the proper review of death records to improve identification of potential donors, and the
120 proper procedures for maintaining potential donors while necessary testing and placement of potential
121 donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the

122 family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative
123 officer of the hospital or his designee knows of such opposition, and no donor card or other relevant
124 document, such as an advance directive, can be found;

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

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

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

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

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

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

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

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

165 13. Shall require that each nursing home and certified nursing facility register with the Department of
166 State Police to receive notice of the registration, reregistration, or verification of registration information of
167 any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to
168 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
169 facility is located, pursuant to § 9.1-914;

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

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

178 16. Shall require that each nursing home and certified nursing facility shall, upon the request of the
179 facility's family council, send notices and information about the family council mutually developed by the
180 family council and the administration of the nursing home or certified nursing facility, and provided to the
181 facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six
182 times per year. Such notices may be included together with a monthly billing statement or other regular
183 communication. Notices and information shall also be posted in a designated location within the nursing

184 home or certified nursing facility. No family member of a resident or other resident representative shall be
185 restricted from participating in meetings in the facility with the families or resident representatives of other
186 residents in the facility;

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

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

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

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

215 21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a
216 policy governing determination of the medical and ethical appropriateness of proposed medical care, which
217 shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of
218 proposed medical care in cases in which a physician has determined proposed care to be medically or
219 ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is
220 medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by
221 the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the
222 proposed health care; and (iii) requirements for a written explanation of the decision reached by the
223 interdisciplinary medical review committee, which shall be included in the patient's medical record. Such
224 policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to
225 § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent
226 medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee
227 meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical
228 decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other
229 remedies available at law, including seeking court review, provided that the patient, his agent, or the person
230 authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the
231 chief executive officer of the hospital within 14 days of the date on which the physician's determination that
232 proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical
233 record;

234 22. Shall require every hospital with an emergency department to establish a security plan. Such security
235 plan shall be developed using standards established by the International Association for Healthcare Security
236 and Safety or other industry standard and shall be based on the results of a security risk assessment of each
237 emergency department location of the hospital and shall include the presence of at least one off-duty
238 law-enforcement officer or trained security personnel who is present in the emergency department at all times
239 as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based
240 on identified risks for the emergency department, including trauma level designation, overall volume, volume
241 of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from
242 such violence, and prevalence of crime in the community, in consultation with the emergency department
243 medical director and nurse director. The security plan shall also outline training requirements for security
244 personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques,
245 appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches.

246 Such training shall also include instruction on safely addressing situations involving patients, family
247 members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance
248 abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through
249 completion of the Department of Criminal Justice Services minimum training standards for auxiliary police
250 officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at
251 least one off-duty law-enforcement officer or trained security personnel be present at all times in the
252 emergency department if the hospital demonstrates that a different level of security is necessary and
253 appropriate for any of its emergency departments based upon findings in the security risk assessment;

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

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

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

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

281 27. Shall require each hospital with an emergency department to establish a protocol for the treatment and
282 discharge of individuals experiencing a substance use-related emergency, which shall include provisions for
283 (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to
284 identify medical interventions necessary for the treatment of the individual in the emergency department and
285 (ii) recommendations for follow-up care following discharge for any patient identified as having a substance
286 use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have
287 been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a)
288 the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection Y of
289 § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or
290 other opioid antagonist used for overdose reversal, including information about accessing naloxone or other
291 opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy
292 operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or
293 other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing
294 order. Such protocols may also provide for referrals of individuals experiencing a substance use-related
295 emergency to peer recovery specialists and community-based providers of behavioral health services, or to
296 providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

297 28. During a public health emergency related to COVID-19, shall require each nursing home and certified
298 nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from
299 the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid
300 Services and the Board. Such protocol shall include provisions describing (i) the conditions, including
301 conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and
302 community, under which in-person visits will be allowed and under which in-person visits will not be
303 allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be
304 required to comply to protect the health and safety of the patients and staff of the nursing home or certified
305 nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff
306 support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing
307 home or certified nursing facility will take in the event of a technology failure, service interruption, or

308 documented emergency that prevents visits from occurring as required by this subdivision. Such protocol
309 shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where
310 appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a
311 provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided
312 that such waiver or limitation is included in the patient's health record; and (c) a requirement that each
313 nursing home and certified nursing facility publish on its website or communicate to each patient or the
314 patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing
315 facility's plan for providing visits to patients as required by this subdivision;

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

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

335 31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients
336 who are minors available to such patients through a secure website shall make such health records available
337 to such patient's parent or guardian through such secure website, unless the hospital cannot make such health
338 record available in a manner that prevents disclosure of information, the disclosure of which has been denied
339 pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of
340 § 54.1-2969 has not been provided;

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

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

348 34. Shall establish fees for the issuance, change, or renewal of a hospital or nursing home license to cover
349 the costs of operating the hospital and nursing home licensure and inspection program in a manner that
350 ensures timely completion of inspections as set forth in § 32.1-126. In establishing such fees, the Board shall
351 distribute the costs of operating the hospital and nursing home licensure and inspection program in an
352 equitable manner across all hospitals or nursing homes and ensure that the amount of such fees shall change
353 no more frequently than annually. Fee changes under this section shall only be initiated if the expenses
354 allocated to the Hospital and Nursing Home Licensure and Inspection Program Fund established under
355 § 32.1-130, plus any state or other funding sources appropriated for the hospital and nursing home licensure
356 and inspection program, are shown to be more than 10 percent greater or less than the annual costs of
357 operating the hospital and nursing home licensure and inspection program in a manner that ensures timely
358 completion of inspections. This analysis shall be conducted separately for hospital fees and nursing home
359 fees, and resulting fee changes shall be established such that fees are sufficient to cover unfunded expenses
360 but not excessive; *and*

361 35. *Shall require each certified nursing facility eligible to participate in the Virginia Medicaid Nursing*
362 *Facility Value-Based Purchasing (VBP) program, as referenced in Chapter 2 of the Acts of Assembly of*
363 *2022, Special Session I, to provide at least 3.08 hours of case mix-adjusted total nurse staffing hours per*
364 *resident per day on average as determined annually by the Department of Medical Assistance Services for*
365 *use in the VBP program, utilizing job codes for the calculation of total nurse staffing hours per resident per*
366 *day following the Centers for Medicare and Medicaid Services definitions as of January 1, 2022, used for*
367 *similar purposes and including certified nursing assistants, licensed practical nurses, and registered nurses.*
368 *No additional reporting shall be required by a certified nursing facility under this subdivision.*

369 C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified

370 nursing facilities may operate adult day centers.

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

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

381 F. Hospitals in the Commonwealth shall:

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

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

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

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

396 1. The date and time of the incident;

397 2. A description of the incident, including the job titles of the affected employee;

398 3. Whether the perpetrator was a patient, visitor, employee, or other person;

399 4. A description of where the incident occurred;

400 5. Information relating the type of incident, including whether the incident involved (i) a physical attack
 401 without a weapon; (ii) an attack with a weapon or object; (iii) a threat of physical force or use of a weapon or
 402 other object with the intent to cause bodily harm; (iv) sexual assault or the threat of sexual assault; or (v)
 403 anything else not listed in subdivisions (i) through (iv);

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

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

409 H. Each hospital shall:

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

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

416 I. As used in this section:

417 "Employee of the hospital" or "employee" means an employee of the hospital or any health care provider
 418 credentialed by the hospital or engaged by the hospital to perform health care services on the premises of the
 419 hospital.

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

427 **2. That § 32.1-127 of the Code of Virginia is amended and reenacted as follows:**

428 **§ 32.1-127. Regulations.**

429 A. The regulations promulgated by the Board to carry out the provisions of this article shall be in
 430 substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established
 431 and recognized by medical and health care professionals and by specialists in matters of public health and

432 safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the
433 Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

434 B. Such regulations:

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

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

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

448 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal
449 law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. §
450 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS
451 regulations for routine contact, whereby the provider's designated organ procurement organization certified
452 by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii)
453 is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a
454 similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of
455 America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The
456 hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in
457 the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable
458 tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The
459 protocol shall ensure that the hospital collaborates with the designated organ procurement organization to
460 inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to
461 donate. The individual making contact with the family shall have completed a course in the methodology for
462 approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved
463 by the organ procurement organization and designed in conjunction with the tissue and eye bank community
464 and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of
465 the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement
466 organization in educating the staff responsible for contacting the organ procurement organization's personnel
467 on donation issues, the proper review of death records to improve identification of potential donors, and the
468 proper procedures for maintaining potential donors while necessary testing and placement of potential
469 donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the
470 family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative
471 officer of the hospital or his designee knows of such opposition, and no donor card or other relevant
472 document, such as an advance directive, can be found;

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

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

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

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

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

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

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

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

513 13. Shall require that each nursing home and certified nursing facility register with the Department of
514 State Police to receive notice of the registration, reregistration, or verification of registration information of
515 any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to
516 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
517 facility is located, pursuant to § 9.1-914;

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

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

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

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

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

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

550 20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that
551 requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct verbal
552 communication between the on-call physician in the psychiatric unit and the referring physician, if requested
553 by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for
554 such direct verbal communication by a referring physician and (ii) a patient for whom there is a question
555 regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due

556 to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which
557 the patient is sought to be transferred to participate in direct verbal communication, either in person or via
558 telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information
559 employed by a poison control center that is accredited by the American Association of Poison Control
560 Centers to review the results of the toxicology screen and determine whether a medical reason for refusing
561 admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the
562 referring physician;

563 21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a
564 policy governing determination of the medical and ethical appropriateness of proposed medical care, which
565 shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of
566 proposed medical care in cases in which a physician has determined proposed care to be medically or
567 ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is
568 medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by
569 the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the
570 proposed health care; and (iii) requirements for a written explanation of the decision reached by the
571 interdisciplinary medical review committee, which shall be included in the patient's medical record. Such
572 policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to
573 § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent
574 medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee
575 meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical
576 decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other
577 remedies available at law, including seeking court review, provided that the patient, his agent, or the person
578 authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the
579 chief executive officer of the hospital within 14 days of the date on which the physician's determination that
580 proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical
581 record;

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

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

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

618 Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of suppressing a
 619 nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to
 620 the public life and health;

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

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

629 27. Shall require each hospital with an emergency department to establish a protocol for the treatment and
 630 discharge of individuals experiencing a substance use-related emergency, which shall include provisions for
 631 (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to
 632 identify medical interventions necessary for the treatment of the individual in the emergency department and
 633 (ii) recommendations for follow-up care following discharge for any patient identified as having a substance
 634 use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have
 635 been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a)
 636 the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection Y of
 637 § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or
 638 other opioid antagonist used for overdose reversal, including information about accessing naloxone or other
 639 opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy
 640 operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or
 641 other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing
 642 order. Such protocols may also provide for referrals of individuals experiencing a substance use-related
 643 emergency to peer recovery specialists and community-based providers of behavioral health services, or to
 644 providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

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

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

672 30. During a declared public health emergency related to a communicable disease of public health threat,
 673 shall require each hospital, nursing home, and certified nursing facility to establish a protocol to allow
 674 patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect
 675 consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare
 676 and Medicaid Services and subject to compliance with any executive order, order of public health,
 677 Department guidance, or any other applicable federal or state guidance having the effect of limiting visitation.
 678 Such protocol may restrict the frequency and duration of visits and may require visits to be conducted
 679 virtually using interactive audio or video technology. Any such protocol may require the person visiting a

680 patient pursuant to this subdivision to comply with all reasonable requirements of the hospital, nursing home,
681 or certified nursing facility adopted to protect the health and safety of the person, patients, and staff of the
682 hospital, nursing home, or certified nursing facility;

683 31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients
684 who are minors available to such patients through a secure website shall make such health records available
685 to such patient's parent or guardian through such secure website, unless the hospital cannot make such health
686 record available in a manner that prevents disclosure of information, the disclosure of which has been denied
687 pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of
688 § 54.1-2969 has not been provided;

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

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

696 34. Shall establish fees for the issuance, change, or renewal of a hospital or nursing home license to cover
697 the costs of operating the hospital and nursing home licensure and inspection program in a manner that
698 ensures timely completion of inspections as set forth in § 32.1-126. In establishing such fees, the Board shall
699 distribute the costs of operating the hospital and nursing home licensure and inspection program in an
700 equitable manner across all hospitals or nursing homes and ensure that the amount of such fees shall change
701 no more frequently than annually. Fee changes under this section shall only be initiated if the expenses
702 allocated to the Hospital and Nursing Home Licensure and Inspection Program Fund established under
703 § 32.1-130, plus any state or other funding sources appropriated for the hospital and nursing home licensure
704 and inspection program, are shown to be more than 10 percent greater or less than the annual costs of
705 operating the hospital and nursing home licensure and inspection program in a manner that ensures timely
706 completion of inspections. This analysis shall be conducted separately for hospital fees and nursing home
707 fees, and resulting fee changes shall be established such that fees are sufficient to cover unfunded expenses
708 but not excessive; *and*

709 35. *Shall require each certified nursing facility eligible to participate in the Virginia Medicaid Nursing*
710 *Facility Value-Based Purchasing (VBP) program, as referenced in Chapter 2 of the Acts of Assembly of*
711 *2022, Special Session I, to provide at least 3.25 hours of case mix-adjusted total nurse staffing hours per*
712 *resident per day on average as determined annually by the Department of Medical Assistance Services for*
713 *use in the VBP program, utilizing job codes for the calculation of total nurse staffing hours per resident per*
714 *day following the Centers for Medicare and Medicaid Services definitions as of January 1, 2022, used for*
715 *similar purposes and including certified nursing assistants, licensed practical nurses, and registered nurses.*
716 *No additional reporting shall be required by a certified nursing facility under this subdivision.*

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

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

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

729 F. Hospitals in the Commonwealth shall:

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

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

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

742 G. Each hospital in the Commonwealth shall maintain the record of reported incidents of workplace
743 violence made pursuant to subsection F for at least two years and shall include in such record, at a minimum:
744 1. The date and time of the incident;
745 2. A description of the incident, including the job titles of the affected employee;
746 3. Whether the perpetrator was a patient, visitor, employee, or other person;
747 4. A description of where the incident occurred;
748 5. Information relating the type of incident, including whether the incident involved (i) a physical attack
749 without a weapon; (ii) an attack with a weapon or object; (iii) a threat of physical force or use of a weapon or
750 other object with the intent to cause bodily harm; (iv) sexual assault or the threat of sexual assault; or (v)
751 anything else not listed in subdivisions (i) through (iv);
752 6. The response to and any consequences of the incident, including (i) whether security or law
753 enforcement was contacted and, if so, their response and (ii) whether the incident resulted in any change to
754 hospital policy; and
755 7. Information about the individual who completed the report, including such individual's name, job title,
756 and the date of completion.

757 H. Each hospital shall:

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

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

764 I. As used in this section:

765 "Employee of the hospital" or "employee" means an employee of the hospital or any health care provider
766 credentialed by the hospital or engaged by the hospital to perform health care services on the premises of the
767 hospital.

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

775 **3. That the provisions of the first enactment of this act shall become effective on July 1, 2027.**

776 **4. That the provisions of the second enactment of this act shall become effective on July 1, 2031.**

777 **5. That the State Health Commissioner shall have the authority to impose administrative sanctions**
778 **pursuant to § 32.1-27.2 of the Code of Virginia, as amended by this act.**

779 **6. That the State Board of Health (the Board) shall consult with appropriate stakeholders, including**
780 **the Virginia Health Care Association, and promulgate regulations to implement the first enactment of**
781 **this act by December 1, 2026, using the regulatory package currently in process to address Chapters**
782 **482 and 483 of the Acts of Assembly of 2023. If any regulations necessary to implement the second**
783 **enactment of this act cannot be added to such regulatory package, the Board shall promulgate such**
784 **regulations by December 1, 2030.**

785 **7. That without initial and ongoing funding for the state share of the cost to implement the provisions**
786 **of this act, as built in to the calculation and application of the base Medicaid rates, the State Health**
787 **Commissioner shall not impose administrative sanctions in accordance with § 32.1-27.2 of the Code of**
788 **Virginia, as amended by this act, on any certified nursing home that does not comply with the**
789 **provisions of regulations promulgated pursuant to subdivision B 35 of § 32.1-127 of the Code of**
790 **Virginia, as amended by this act. In any period in which the calculated Medicaid Virginia Nursing**
791 **Home Inflation Index is not fully implemented, administrative sanctions in accordance with § 32.1-27.2**
792 **of the Code of Virginia, as amended by this act, shall be suspended.**

793 **8. That if the funding of the Virginia Medicaid Nursing Facility Value-Based Purchasing program is**
794 **reduced or suspended below levels established in Chapter 725 of the Acts of Assembly of 2025 as**
795 **adjusted by the Medicaid Virginia Nursing Home Inflation Index annually thereafter, the State Health**
796 **Commissioner shall not impose administrative sanctions in accordance with § 32.1-27.2 of the Code of**
797 **Virginia, as amended by this act, on any certified nursing home that does not comply with the**
798 **provisions of or regulations promulgated pursuant to subdivision B 35 of § 32.1-127 of the Code of**
799 **Virginia, as amended by this act.**

800 **9. That annually the Department of Medical Assistance Services shall communicate to the State Board**
801 **of Health the information required by the provisions of subdivision B 35 of § 32.1-127 of the Code of**
802 **Virginia, as amended by this act, and the State Board of Health shall not include the provisions of**
803 **subdivision B 35 of § 32.1-127 of the Code of Virginia, as amended by this act, in the state licensure**

804 requirements for nursing homes. The information that the Department of Medical Assistance Services
805 is required to communicate to the State Board of Health under this enactment shall apply to the
806 Virginia Medicaid Nursing Facility Value-Based Purchasing program as referenced in Chapter 2 of the
807 Acts of Assembly of 2022, Special Session I, or its successor programs. Information reported pursuant
808 to this enactment shall not be used to assess a certified nursing facility's compliance with staffing ratios
809 established pursuant to this act until a full 12 months of information has been communicated to the
810 State Board of Health after the respective effective dates for such staffing ratios enumerated in the
811 third and fourth enactments of this act.

812 10. That in the event that the Centers for Medicare and Medicaid Services amends, revises, or deletes
813 the payroll base journal reporting requirements, forms, and processes to such an extent that it impacts
814 the ability of the State Health Commissioner to determine compliance, the Department of Medical
815 Assistance Services shall convene with the State Board of Health a stakeholder work group to make
816 recommendations to the Chairs of the House Committee on Health and Human Services and the Senate
817 Committee on Education and Health on the process to be used for determining the equivalent staffing
818 ratio to that designated under subdivision B 35 of § 32.1-127 of the Code of Virginia, as amended by
819 this act, relative to any changes to federal methodology or reporting.

820 11. That in the event that the Department of Medical Assistance Services stops calculating the staffing
821 standard as referenced in subdivision B 35 of § 32.1-127 of the Code of Virginia, as amended by this
822 act, notice shall be given to the State Board of Health and a work group shall be convened by the
823 Department of Medical Assistance Services along with the State Board of Health and stakeholders to
824 make recommendations to the Chairs of the House Committee on Health and Human Services and the
825 Senate Committee on Education and Health on the process to be used for determining the equivalent
826 staffing ratio to that designated under subdivision B 35 of § 32.1-127 of the Code of Virginia, as
827 amended by this act, relative to how the calculations can be made and what fiscal implications, if any,
828 may result.

829 12. That the State Health Commissioner, in collaboration with the Department of Medical Assistance
830 Services, shall convene a work group of stakeholders to review and consider modifications to the
831 minimum nurse staffing standard articulated in subdivision B 35 of § 32.1-127 of the Code of Virginia,
832 as amended by this act, at least every two years from the effective date of the first enactment of this act.
833 Upon completion of each required review, the State Health Commissioner shall submit his findings and
834 recommendations regarding modification of the minimum nurse staffing standard to the Governor and
835 the Chairs of the House Committees on Health and Human Services and Appropriations and the
836 Senate Committees on Education and Health and Finance and Appropriations prior to the next regular
837 session of the General Assembly.

838 13. That the Joint Commission on Health Care, in collaboration with relevant stakeholders, shall study
839 and develop recommendations on the efficacy of utilizing a measure of registered nurse coverage as an
840 additional component of the minimum staffing requirement. Such study shall examine (i) the potential
841 care benefits of increased registered nurse coverage, (ii) the practical impact of such a measure on
842 staffing availability and costs, (iii) methods for reporting and calculating a measure of registered nurse
843 coverage; and (iv) any other relevant factors necessary to determine compliance with such a measure.
844 Additionally, such study shall consider other aspects of the hours per patient per day component of the
845 staffing standards established pursuant to this act, including use of an adjusted per patient day staffing
846 requirement and the potential inclusion of other direct care professionals in the per patient day
847 calculation. The Joint Commission on Health Care shall report on its findings and recommendations to
848 the Governor and the Chairs of the House Committees on Health and Human Services and
849 Appropriations and the Senate Committees on Education and Health and Finance and Appropriations
850 by December 1, 2026.