

# PATIENT SAFETY LICENSING SURVEY FIELD NOTES

DATE(S) OF SURVEY:

Facility License Number

Facility Name & Address (City, State, Zip)

Type of Survey:

CONCURRENT WITH FEDERAL SURVEY

Not CONCURRENT WITH FEDERAL SURVEY

Name of Team Leader Evaluator & Professional Title

List Additional Evaluators & Titles

List Additional Evaluators & Titles

**SURVEY TEAM COMPOSITION** (indicate the number of Evaluators, according to discipline, who conduct the PSLs) Total # of Evaluators Onsite for the PSLs: \_\_\_\_\_

	HFEN
	HFE
	Dietitian
	Pharmacist
	Physician
	Life Safety Code Surveyor
	Records Administrator

	Infection Control Specialist
	Occupational Therapist
	Consultant

**Note: This is the official field notes document for the survey and may be supplemented by additional documentation on a surveyor notes worksheet.**

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## End of Life Care

442.5.	<p>When a health care provider makes a diagnosis that a patient has a terminal illness, the health care provider shall, upon the patient's request, provide the patient with comprehensive information and counseling regarding legal end-of-life care options pursuant to this section. When a terminally ill patient is in a health facility, as defined in Section 1250, the health care provider, or medical director of the health facility if the patient's health care provider is not available, may refer the patient to a hospice provider or private or public agencies and community-based organizations that specialize in end-of-life care case management and consultation to receive comprehensive information and counseling regarding legal end-of-life care options.</p> <p>(a) If the patient indicates a desire to receive the information and counseling, the comprehensive information shall include, but not be limited to, the following:</p> <ol style="list-style-type: none"> <li>(1) Hospice care at home or in a health care setting.</li> <li>(2) A prognosis with and without the continuation of disease-targeted treatment.</li> <li>(3) The patient's right to refusal of or withdrawal from life-sustaining treatment.</li> <li>(4) The patient's right to continue to pursue disease-targeted treatment, with or without concurrent palliative care.</li> <li>(5) The patient's right to comprehensive pain and symptom management at the end of life, including, but not limited to, adequate pain medication, treatment of nausea, palliative chemotherapy, relief of shortness of breath and fatigue, and other clinical treatments useful when a patient is actively dying.</li> <li>(6) The patient's right to give individual health care instruction pursuant to Section 4670 of the Probate Code, which provides the means by which a patient may provide written health care instruction, such as an advance health care directive, and the patient's right to appoint a legally recognized health care decision maker.</li> </ol> <p>(b) The information described in subdivision (a) may, but is not required to, be in writing. Health care providers may utilize information from organizations specializing in end-of-life care that provide information on factsheets and Internet Web sites to convey the information described in subdivision (a).</p> <p>(c) Counseling may include, but is not limited to, discussions about the outcomes for the patient and his or her family, based on the interest of the patient. Information and counseling, as described in subdivision (a), may occur over a series of meetings with the health care provider or others who may be providing the information and counseling based on the patient's needs.</p>				
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	(d) The information and counseling sessions may include a discussion of treatment options in a manner that the patient and his or her family can easily understand. If the patient requests information on the costs of treatment options, including the availability of insurance and eligibility of the patient for coverage, the patient shall be referred to the appropriate entity for that information.				
442.7.	<p>If a health care provider does not wish to comply with his or her patient's request for information on end-of-life options, the health care provider shall do both of the following:</p> <p>(a) Refer or transfer a patient to another health care provider that shall provide the requested information.</p> <p>(b) Provide the patient with information on procedures to transfer to another health care provider that shall provide the requested information.</p>				

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### Brain Death Policy and Procedures

1254.4.	(a) A general acute care hospital shall adopt a policy for providing family or next of kin with a reasonably brief period of accommodation, as described in subdivision (b), from the time that a patient is declared dead by reason of irreversible cessation of all functions of the entire brain, including the brain stem, in accordance with Section 7180, through discontinuation of cardiopulmonary support for the patient. During this reasonably brief period of accommodation, a hospital is required to continue only previously ordered cardiopulmonary support. No other medical intervention is required.				
	(b) For purposes of this section, a "reasonably brief period" means an amount of time afforded to gather family or next of kin at the patient's bedside.				
	(c) (1) A hospital subject to this section shall provide the patient's legally recognized health care decision maker if any, or the patient's family or next of kin, if available, with a written statement of the policy described in subdivision (a), upon request, but no later than shortly after the treating physician has determined that the potential for brain death is imminent.				
	(2) If the patient's legally recognized health care decision maker, family, or next of kin voices any special religious or cultural practices and concerns of the patient or the patient's family surrounding the issue of death by reason of irreversible cessation of all functions of the entire brain of the patient, the hospital shall make reasonable efforts to accommodate those religious and cultural practices and concerns.				

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### Hospital Services – Closure, Elimination or Relocation

1255.25.	(a) (1) Not less than 30 days prior to closing a health facility, as defined in subdivision (a) or (b) of Section 1250, or eliminating a supplemental service, as defined in Section 70067 of Chapter 1 of Division 5 of Title 22 of the California Code of Regulations, the facility shall provide public notice of the proposed closure or elimination of the supplemental service, including a notice posted at the entrance to all affected facilities and a notice to the department and the board of supervisors of the county in which the health facility is located.				
	(2) Not less than 30 days prior to relocating the provision of supplemental services to a different campus, a health facility, as defined in subdivision (a) or (b) of Section 1250, shall provide public notice of the proposed relocation of supplemental services, including a notice posted at the entrance to all affected facilities and notice to the department and the board of supervisors of the county in which the health facility is located.				
	(b) The notice required by paragraph (1) or (2) of subdivision (a) shall include all of the following: (1) A description of the proposed closure, elimination, or relocation. The description shall be limited to publicly available data, including the number of beds eliminated, if any, the probable decrease in the number of personnel, and a summary of any service that is being eliminated, if applicable.				
	(2) A description of the three nearest available comparable services in the community. If the health facility closing these services serves Medi-Cal or Medicare patients, this health facility shall specify if the providers of the nearest available comparable services serve these patients.				
	(3) A telephone number and address for each of the following, where interested parties may offer comments: (A) The health facility. (B) The parent entity, if any, or contracted company, if any, that acts as the corporate administrator of the health facility. (C) The chief executive officer. (c) Notwithstanding subdivisions (a) and (b), this section shall not apply to county facilities subject to Section 1442.5.				

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## Patient Safety Plan

1279.6.	(a) A health facility, as defined in subdivision (a), (b),(c), or (f) of Section 1250, shall develop, implement, and comply with a patient safety plan for the purpose of improving the health and safety of patients and reducing preventable patient safety events. The patient safety plan shall be developed by the facility, in consultation with the facility's various health care professionals.				
	(b) The patient safety plan required pursuant to subdivision (a) shall, at a minimum, provide for the establishment of all of the following:				
	(1) A patient safety committee or equivalent committee in composition and function. The committee shall be composed of the facility's various health care professionals, including, but not limited to, physicians, nurses, pharmacists, and administrators. The committee shall do all of the following: (A) Review and approve the patient safety plan. (B) Receive and review reports of patient safety events as defined in subdivision (c). (C) Monitor implementation of corrective actions for patient safety events. (D) Make recommendations to eliminate future patient safety events. (E) Review and revise the patient safety plan, at least once a year, but more often if necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices.				
	(2) A reporting system for patient safety events that allows anyone involved, including, but not limited to, health care practitioners, facility employees, patients, and visitors, to make a report of a patient safety event to the health facility.				
	(3) A process for a team of facility staff to conduct analyses, including, but not limited to, root cause analyses of patient safety events. The team shall be composed of the facility's various categories of health care professionals, with the appropriate competencies to conduct the required analyses.				
	(4) A reporting process that supports and encourages a culture of safety and reporting patient safety events.				
	(5) A process for providing ongoing patient safety training for facility personnel and health care practitioners				
	(c) For the purposes of this section, patient safety events shall be defined by the patient safety plan and shall include, but not be limited to, all adverse events or potential adverse events as described in Section 1279.1 that are determined to be preventable, and health-care-associated infections (HAI), as defined in the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor, unless the department accepts the recommendation of the Healthcare Associated Infection Advisory Committee, or its successor, that are determined to be preventable.				
1279.7	(e) A health facility that is required to develop a patient safety plan pursuant to Section 1279.6 shall include in the patient safety plan measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines.				

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### Infection Control

1255.8.	(b) (1) Each patient who is admitted to a health facility shall be tested for MRSA in the following cases, within 24 hours of admission: (B) It has been documented that the patient has been previously discharged from a general acute care hospital within 30 days prior to the current hospital admission. (C) The patient will be admitted to an intensive care unit or burn unit of the hospital. (D) The patient receives inpatient dialysis treatment. (E) The patient is being transferred from a skilled nursing facility.				
	(3) If a patient tests positive for MRSA, the attending physician shall inform the patient or the patient's representative immediately or as soon as practically possible.				
	(4) A patient who tests positive for MRSA infection shall, prior to discharge, receive oral and written instruction regarding aftercare and precautions to prevent the spread of the infection to others.				
	(e) The infection control policy required pursuant to Section 70739 of Title 22 of the California Code of Regulations, at a minimum, shall include all of the following: (1) Procedures to reduce health care associated infections.				
	(2) Regular disinfection of all restrooms, countertops, furniture, televisions, telephones, bedding, office equipment, and surfaces in patient rooms, nursing stations, and storage units.				
	(3) Regular removal of accumulations of bodily fluids and intravenous substances, and cleaning and disinfection of all movable medical equipment, including point-of-care testing devices such as glucometers, and transportable medical devices.				
	(4) Regular cleaning and disinfection of all surfaces in common areas in the facility such as elevators, meeting rooms, and lounges.				
	(f) Each facility shall designate an infection control officer who, in conjunction with the hospital infection control committee, shall ensure implementation of the testing and reporting provisions of this section and other hospital infection control efforts. The reports shall be presented to the appropriate committee within the facility for review. The name of the infection control officer shall be made publicly available, upon request.				
1279.7.	(a) A health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, shall implement a facility-wide hand hygiene program.				

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1288.6.	(a) (1) Each general acute care hospital, in collaboration with infection prevention and control professionals, and with the participation of senior health care facility leadership shall, as a component of its strategic plan, at least once every three years, prepare a written report that examines the hospital's existing resources and evaluates the quality and effectiveness of the hospital's infection surveillance and prevention program.				
	(2) The report shall evaluate and include information on all of the following: (A) The risk and cost of the number of invasive patient procedures performed at the hospital. (B) The number of intensive care beds. (C) The number of emergency department visits to the hospital. (D) The number of outpatient visits by departments. (E) The number of licensed beds. (F) Employee health and occupational health measures implemented at the hospital. (G) Changing demographics of the community being served by the hospital. (H) An estimate of the need and recommendations for additional resources for infection prevention and control programs necessary to address the findings of the plan.				
	(3) The report shall be updated annually, and shall be revised at regular intervals, if necessary, to accommodate technological advances and new information and findings contained in the triennial strategic plan with respect to improving disease surveillance and the prevention of HAI.				
	(b) Each general acute care hospital that uses central venous catheters (CVCs) shall implement policies and procedures to prevent occurrences of health care associated infection, as recommended by the Centers for Disease Control and Prevention intravascular bloodstream infection guidelines or other evidence-based national guidelines, as recommended by the advisory committee. A general acute care hospital that uses CVCs shall internally report CVC associated blood stream infection rates in intensive care units, utilizing device days to calculate the rate for each type of intensive care unit, to the appropriate medical staff committee of the hospital on a regular basis.				
1288.7.	By July 1, 2007, the department shall require that each general acute care hospital, in accordance with the Centers for Disease Control guidelines, take all of the following actions:				
	(a) Annually offer onsite influenza vaccinations, if available, to all hospital employees at no cost to the employee. Each general acute care hospital shall require its employees to be vaccinated, or if the employee elects not to be vaccinated, to declare in writing that he or she has declined the vaccination.				
	(b) Institute respiratory hygiene and cough etiquette protocols, develop and implement procedures for the isolation of patients with influenza, and adopt a seasonal influenza plan.				
	(c) Revise an existing or develop a new disaster plan that includes a pandemic influenza component. The plan shall also document any actual or recommended collaboration with local,				

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1288.8.	<p>regional, and state public health agencies or officials in the event of an influenza pandemic.</p> <p>(a) By January 1, 2008, the department shall take all of the following actions to protect against HAI in general acute care hospitals statewide:</p> <p>(3) Require that general acute care hospitals develop a process for evaluating the judicious use of antibiotics, the results of which shall be monitored jointly by appropriate representatives and committees involved in quality improvement activities.</p>				
	<p>(b) On and after January 1, 2008, each general acute care hospital shall implement and annually report to the department on its implementation of infection surveillance and infection prevention process measures that have been recommended by the federal Centers for Disease Control and Prevention Healthcare Infection Control Practices Advisory Committee, as suitable for a mandatory public reporting program. Initially, these process measures shall include the CDC guidelines for central line insertion practices, surgical antimicrobial prophylaxis, and influenza vaccination of patients and healthcare personnel. In consultation with the advisory committee, the department shall make this information public no later than six months after receiving the data.</p>				
	<p>d) Each general acute care hospital shall also submit data on implemented process measures to the National Healthcare Safety Network of the CDC, or to any other scientifically valid national HAI reporting system based upon the recommendation of the federal Centers for Disease Control and Prevention Healthcare Infection Control Practices Advisory Committee or to another scientifically valid reporting database, as determined by the department based on the recommendations of the HAI-AC. Hospitals shall utilize the federal Centers for Disease Control and Prevention definitions and methodology for surveillance of HAI. Hospitals participating in the California Hospital Assessment and Reporting Task Force (CHART) shall publicly report those HAI measures as agreed to by all CHART hospitals.</p>				
1288.9.	<p>By January 1, 2009, the department shall do all of the following:</p> <p>(a) Require each general acute care hospital to develop, implement, and periodically evaluate compliance with policies and procedures to prevent secondary surgical site infections (SSI). The results of this evaluation shall be monitored by the infection prevention committee and reported to the surgical committee of the hospital.</p> <p>(b) Require each general acute care hospital to develop policies and procedures to implement the current Centers for Disease Control and Prevention guidelines and Institute for Healthcare Improvement (IHI) process measures designed to prevent ventilator associated pneumonia.</p> <p>(c) During surveys, evaluate the facility's compliance with existing policies and procedures to prevent HAI, including any externally or internally reported HAI process and outcome measures.</p>				
1288.95.	<p>(a) No later than January 1, 2010, a physician designated as a hospital epidemiologist or infection surveillance, prevention, and control committee chairperson shall participate in a continuing medical education (CME) training program offered by the federal Centers for Disease Control and</p>				

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	Prevention (CDC) and the Society for Healthcare Epidemiologists of America, or other recognized professional organization. The CME program shall be specific to infection surveillance, prevention, and control. Documentation of attendance shall be placed in the physician's credentialing file.				
	(b) Beginning January 2010, all staff and contract physicians and all other licensed independent contractors, including, but not limited to, nurse practitioners and physician assistants, shall be trained in methods to prevent transmission of HAI, including, but not limited to, MRSA and Clostridium difficile infection.				
	(c) By January 2010, all permanent and temporary hospital employees and contractual staff, including students, shall be trained in hospital-specific infection prevention and control policies, including, but not limited to, hand hygiene, facility-specific isolation procedures, patient hygiene, and environmental sanitation procedures. The training shall be given annually and when new policies have been adopted by the infection surveillance, prevention, and control committee.				
	(d) Environmental services staff shall be trained by the hospital and shall be observed for compliance with hospital sanitation measures. The training shall be given at the start of employment, when new prevention measures have been adopted, and annually thereafter. Cultures of the environment may be randomly obtained by the hospital to determine compliance with hospital sanitation procedures.				

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### Hospital Security Plans

1257.7.	<p>(a) After July 1, 2010, all hospitals licensed pursuant to subdivisions (a), (b), and (f) of Section 1250 shall conduct, not less than annually, a security and safety assessment and, using the assessment, develop, and annually update based on the assessment, a security plan with measures to protect personnel, patients, and visitors from aggressive or violent behavior. The security and safety assessment shall examine trends of aggressive or violent behavior at the facility. These hospitals shall track incidents of aggressive or violent behavior as part of the quality assessment and improvement program and for the purposes of developing a security plan to deter and manage further aggressive or violent acts of a similar nature.</p> <p>The plan may include, but shall not be limited to, security considerations relating to all of the following:</p> <ol style="list-style-type: none"> <li>(1) Physical layout.</li> <li>(2) Staffing.</li> <li>(3) Security personnel availability.</li> <li>(4) Policy and training related to appropriate responses to violent acts.</li> <li>(5) Efforts to cooperate with local law enforcement regarding violent acts in the facility.</li> </ol> <p>In developing this plan, the hospital shall consider guidelines or standards on violence in health care facilities issued by the department, the Division of Occupational Safety and Health, and the federal Occupational Safety and Health Administration. As part of the security plan, a hospital shall adopt security policies including, but not limited to, personnel training policies designed to protect personnel, patients, and visitors from aggressive or violent behavior. In developing the plan and the assessment, the hospital shall consult with affected employees, including the recognized collective bargaining agent or agents, if any, and members of the hospital medical staff organized pursuant to Section 2282 of the Business and Professions Code. This consultation may occur through hospital committees.</p>				
	<p>(b) The individual or members of a hospital committee responsible for developing the security plan shall be familiar with all of the following:</p> <ol style="list-style-type: none"> <li>(1) The role of security in hospital operations.</li> <li>(2) Hospital organization.</li> <li>(3) Protective measures, including alarms and access control.</li> <li>(4) The handling of disturbed patients, visitors, and employees.</li> <li>(5) Identification of aggressive and violent predicting factors.</li> <li>(6) Hospital safety and emergency preparedness.</li> <li>(7) The rudiments of documenting and reporting crimes, including, by way of example, not disturbing a crime scene.</li> </ol>				
	<p>(c) The hospital shall have sufficient personnel to provide security pursuant to the security plan developed pursuant to subdivision (a). Persons regularly assigned to provide security in a hospital</p>				

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	setting shall be trained regarding the role of security in hospital operations, including the identification of aggressive and violent predicting factors and management of violent disturbances.				
	<p>(d) Any act of assault, as defined in Section 240 of the Penal Code, or battery, as defined in Section 242 of the Penal Code, that results in injury or involves the use of a firearm or other dangerous weapon, against any on-duty hospital personnel shall be reported to the local law enforcement agency within 72 hours of the incident. Any other act of assault, as defined in Section 240 of the Penal Code, or battery, as defined in Section 242 of the Penal Code, against any on-duty hospital personnel may be reported to the local law enforcement agency within 72 hours of the incident. No health facility or employee of a health facility who reports a known or suspected instance of assault or battery pursuant to this section shall be civilly or criminally liable for any report required by this section. No health facility or employee of a health facility who reports a known or suspected instance of assault or battery that is authorized, but not required, by this section, shall be civilly or criminally liable for the report authorized by this section unless it can be proven that a false report was made and the health facility or its employee knew that the report was false or was made with reckless disregard of the truth or falsity of the report, and any health facility or employee of a health facility who makes a report known to be false or with reckless disregard of the truth or falsity of the report shall be liable for any damages caused. Any individual knowingly interfering with or obstructing the lawful reporting process shall be guilty of a misdemeanor. "Dangerous weapon," as used in this section, means any weapon the possession or concealed carrying of which is prohibited by Section 12020 of the Penal Code.</p>				

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## Discharge Plans

1262.5.	(a) Each hospital shall have a written discharge planning policy and process.				
	(b) The policy required by subdivision (a) shall require that appropriate arrangements for post hospital care, including, but not limited to, care at home, in a skilled nursing or intermediate care facility, or from a hospice, are made prior to discharge for those patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. If the hospital determines that the patient and family members or interested persons need to be counseled to prepare them for post hospital care, the hospital shall provide for that counseling.				
	(c) The process required by subdivision (a) shall require that the patient be informed, orally or in writing, of the continuing health care requirements following discharge from the hospital. The right to information regarding continuing health care requirements following discharge shall apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient, if the patient is unable to make those decisions for him self or herself. In addition, a patient may request that friends or family members be given this information, even if the patient is able to make his or her own decisions regarding medical care.				
	(d) (1) A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of the hospital. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan, and shall be signed by the physician.				
	(2) A copy of the transfer summary shall be given to the patient and the patient's legal representative, if any, prior to transfer to a skilled nursing or intermediate care facility.				
	(e) A hospital shall establish and implement a written policy to ensure that each patient receives, at the time of discharge, information regarding each medication dispensed, pursuant to Section 4074 of the Business and Professions Code.				
	(f) A hospital shall provide every patient anticipated to be in need of long-term care at the time of discharge with contact information for at least one public or nonprofit agency or organization dedicated to providing information or referral services relating to community-based long-term care options in the patient's county of residence and appropriate to the needs and characteristics of the patient. At a minimum, this information shall include contact information for the area agency on aging serving the patient's county of residence, local independent living centers, or other information appropriate to the needs and characteristics of the patient.				
	(g) A contract between a general acute care hospital and a health care service plan that is issued, amended, renewed, or delivered on or after January 1, 2002, may not contain a provision that prohibits or restricts any health care facility's compliance with the requirements of this section.				

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## Dietitian

1265.4.	<p>(a) A licensed health facility, as defined in subdivision (a), (b), (c), (d), (f), or (k) of Section 1250, shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) To supervise dietetic service operations. The dietetic services supervisor shall receive frequently scheduled consultation from a qualified dietitian.</p> <p>(b) The dietetic services supervisor shall have completed at least one of the following educational requirements:</p> <p>(1) A baccalaureate degree with major studies in food and nutrition, dietetics, or food management and has one year of experience in the dietetic service of a licensed health facility.</p> <p>(2) A graduate of a dietetic technician training program approved by the American Dietetic Association, accredited by the Commission on Accreditation for Dietetics Education, or currently registered by the Commission on Dietetic Registration.</p> <p>(3) A graduate of a dietetic assistant training program approved by the American Dietetic Association.</p> <p>(4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.</p> <p>(5) Is a graduate of a college degree program with major studies in food and nutrition, dietetics, food management, culinary arts, or hotel and restaurant management and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.</p> <p>(6) A graduate of a state approved program that provides 90 or more hours of classroom instruction in dietetic service supervision, or 90 hours or more of combined classroom instruction and instructor led interactive Web-based instruction in dietetic service supervision.</p> <p>(7) Received training experience in food service supervision and management in the military equivalent in content to paragraph (2), (3), or (6).</p>				
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### Immunizations

120392.9.	Pursuant to its standardized procedures and if it has the vaccine in its possession, each year, commencing October 1 to the following April 1, inclusive, a general acute care hospital, as defined in subdivision (a) of Section 1250, shall offer, prior to discharge, immunizations for influenza and pneumococcal disease to inpatients, aged 65 years or older, based upon the adult immunization recommendations of the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention, and the recommendations of appropriate entities for the prevention, detection, and control of influenza outbreaks in California general acute care hospitals.				
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Fair Pricing					
127405.	(a) (1) Each hospital shall maintain an understandable written policy regarding discount payments for financially qualified patients as well as an understandable written charity care policy.				
	Both the charity care policy and the discount payment policy shall state the process used by the hospital to determine whether a patient is eligible for charity care or discounted payment. In the event of a dispute, a patient may seek review from the business manager, chief financial officer, or other appropriate manager as designated in the charity care policy and the discount				
	(b) A hospital's discount payment policy shall clearly state eligibility criteria based upon income consistent with the application of the federal poverty level. The discount payment policy shall also include an extended payment plan to allow payment of the discounted price over time. The policy shall provide that the hospital and the patient may negotiate the terms of the payment plan.				
	(c) The charity care policy shall state clearly the eligibility criteria for charity care. In determining eligibility under its charity care policy, a hospital may consider income and monetary assets of the patient.				
127410.	(a) Each hospital shall provide patients with a written notice that shall contain information about availability of the hospital's discount payment and charity care policies, including information about eligibility, as well as contact information for a hospital employee or office from which the person may obtain further information about these policies.				
	The notice shall also be provided to patients who receive emergency or outpatient care and who may be billed for that care, but who were not admitted. The notice shall be provided in English, and in languages other than English.				
	Written correspondence to the patient required by this article shall also be in the language spoken by the patient, consistent with Section 12693.30 of the Insurance Code and applicable state and federal law.				
	(b) Notice of the hospital's policy for financially qualified and self-pay patients shall be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, all of the following: (1) Emergency department, if any. (2) Billing office. (3) Admissions office. (4) Other outpatient settings.				
127420.	(b) If a hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, as a part of that billing, the hospital shall provide the patient with a clear and conspicuous notice that includes all of the following: (1) A statement of charges for services rendered by the hospital. (2) A request that the patient inform the hospital if the patient has health insurance coverage,				

State Standard HSC §	Requirement	Met	Not Met	N/A	Surveyor Notes (Short description of the problem and what was not met. Details may be recorded on surveyor notes worksheets.)
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	<p>Medicare, Healthy Families, Medi-Cal, or other coverage.</p> <p>(3) A statement that if the consumer does not have health insurance coverage, the consumer may be eligible for Medicare, Healthy Families, Medi-Cal, California Childrens' Services Program, or charity care.</p> <p>(4) A statement indicating how patients may obtain applications for the Medi-Cal program and the Healthy Families Program and that the hospital will provide these applications. If the patient does not indicate coverage by a third-party payer specified in subdivision (a), or requests a discounted price or charity care then the hospital shall provide an application for the Medi-Cal program, the Healthy Families Program or other governmental program to the patient. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.</p> <p>(5) Information regarding the financially qualified patient and charity care application, including the following:</p> <p>(A) A statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care.</p> <p>(B) The name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's discount payment and charity care policies, and how to apply for that assistance.</p>				
127425.	<p>(a) Each hospital shall have a written policy about when and under whose authority patient debt is advanced for collection, whether the collection activity is conducted by the hospital, an affiliate or subsidiary of the hospital, or by an external collection agency.</p> <p>(b) Each hospital shall establish a written policy defining standards and practices for the collection of debt, and shall obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices.</p>				
127430.	<p>(a) Prior to commencing collection activities against a patient, the hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall provide the patient with a clear and conspicuous written notice containing both of the following:</p> <p>(1) A plain language summary of the patient's rights pursuant to this article, the Rosenthal Fair Debt Collection Practices Act (Title 1.6C (commencing with Section 1788) of Part 4 of Division 3 of the Civil Code), and the federal Fair Debt Collection Practices Act (Subchapter V (commencing with Section 1692) of Chapter 41 of Title 15 of the United States Code). The summary shall include a statement that the Federal Trade Commission enforces the federal act. The summary shall be sufficient if it appears in substantially the following form: "State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors</p>				

State Standard HSC §	Requirement	Met	Not Met	N/A	Surveyor Notes (Short description of the problem and what was not met. Details may be recorded on surveyor notes worksheets.)
	<p>may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at <a href="http://www.ftc.gov">www.ftc.gov</a>."</p> <p>(2) A statement that nonprofit credit counseling services may be available in the area.</p> <p>(b) The notice required by subdivision (a) shall also accompany any document indicating that the commencement of collection activities may occur.</p> <p>(c) The requirements of this section shall apply to the entity engaged in the collection activities. If a hospital assigns or sells the debt to another entity, the obligations shall apply to the entity, including a collection agency, engaged in the debt collection activity.</p>				
127440.	<p>The hospital shall reimburse the patient or patients any amount actually paid in excess of the amount due under this article, including interest. Interest owed by the hospital to the patient shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by the hospital. However, a hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars (\$5.00). The hospital shall give the patient a credit for the amount due for at least 60 days from the date the amount is due.</p>				