

**(1) Amend Section 70055 to read as follows:**

**Section 70055. Personnel.**

(a) Unless otherwise specified in this chapter, the following definitions shall apply to health care personnel:

(1) Accredited Record Technician. Accredited record technician means a person who is accredited by the American Medical Record Association.

(2) Administrator. Administrator means the individual who is appointed by the governing body to act in its behalf in the overall management of the hospital.

(3) Art Therapist. Art therapist means a person who has a masters degree in art therapy or in art with emphasis in art therapy, including an approved clinical internship from an accredited college or university; or a person who is registered or eligible for registration with the American Art Therapy Association.

(4) Audiologist. Audiologist means a person who is licensed as an audiologist by the Board of Medical Examiners.

(5) Biomedical Equipment Technician. Biomedical equipment technician means a person certified by the Association for the Advancement of Medical Instrumentation.

(6) Cardiopulmonary Technologist. Cardiopulmonary technologist means a person who is registered by the National Society of Cardiopulmonary Technologists.

(7) Cardiovascular Technologist. Cardiovascular technologist means a person who is registered by the National Society of Cardiopulmonary Technologists.

(8) Clinical Laboratory Bioanalyst. Clinical laboratory bioanalyst means a person who is licensed as a clinical laboratory bioanalyst by the Department.

(9) Clinical Laboratory Technologist. Clinical laboratory technologist means a person who is licensed as a clinical laboratory technologist by the Department.

(10) Consultant. Consultant means a person who is professionally qualified to provide expert information on a particular subject.

(11) Dance Therapist. Dance therapist means a person who is registered or eligible for registration as a dance therapist registered by the American Dance Therapy Association.

(12) Dentist. Dentist means a person who is licensed as a dentist by the Board of Dental Examiners.

(13) Dietitian. Dietitian means a person who is registered or eligible for registration as a registered dietitian by the American Dietetic Association.

(14) Learning Disability Specialist. Learning disability specialist means a person who has a master's degree in learning disabilities from an accredited university.

(15) Licensed Psychiatric Technician. Licensed psychiatric technician means a person who is licensed as a licensed psychiatric technician by the Board of Vocational Nurse and Psychiatric Technician Examiners.

(16) Licensed Vocational Nurse. Licensed vocational nurse means a person who is licensed as a licensed vocational nurse by the Board of Vocational Nurse and Psychiatric Technician Examiners.

(17) Mental Health Worker. Mental health worker means an unlicensed person who through experience, in-service training or formal education is qualified to participate in the care of the psychiatric patient.

(18) Music Therapist. Music therapist means a person who is registered or eligible for registration as a registered music therapist by the National Association for Music Therapy.

(19) Nurse Anesthetist. Nurse anesthetist means a registered nurse who is certified as a nurse anesthetist by the American Association of Nurse Anesthetists.

(20) Occupational Therapist. Occupational therapist means a person who is certified or eligible for certification as an occupational therapist registered by the American Occupational Therapy Association.

(21) Occupational Therapy Assistant. Occupational therapy assistant means a person who is certified or eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association.

(22) Orthotist and Prosthetist. Orthotist and prosthetist means a person who is certified or eligible for certification by the American Board of Orthotists and Prosthetists Certification, Washington, D.C.

(23) Pharmacist. Pharmacist means a person who is licensed as a pharmacist by the Board of Pharmacy.

(24) Physical Therapist. Physical therapist means a person licensed as a registered physical therapist by the Physical Therapy Examining Committee of the Board of Medical Examiners.

(25) Physical Therapist Assistant. Physical therapist assistant means a person who is approved as a physical therapist assistant by the Physical Therapy Examining Committee of the Board of Medical Examiners.

(26) Physician. Physician means a person licensed as a physician and surgeon by the Board of Medical Examiners or by the Board of Osteopathic Examiners.

(27) Podiatrist. Podiatrist means a person who is licensed as a podiatrist by the Board of Medical Examiners.

(28) Psychiatrist. Psychiatrist means a person who is licensed as a physician and surgeon by the Board of Medical Examiners or the Board of Osteopathic Examiners and who is certified or eligible for certification by the American Board of Psychiatry and Neurology or who has specialized training and/or experience in psychiatry.

(29) Psychologist. Psychologist means a person who is licensed as a psychologist by the Board of ~~Medical Examiners~~ Psychology.

(30) Pulmonary Technologist. Pulmonary technologist means a person who is registered by the National Society of Cardiopulmonary Technologists.

(31) Radiologic Technologist. Radiologic technologist means a person other than a licentiate of the healing arts who has been issued a certificate by the Department to engage in diagnostic radiologic technology without limitations as to procedures or areas of application and under the supervision of a certified X-ray supervisor and operator.

(32) Recreation Therapist. Recreation therapist means a person who is certified or eligible for certification as a registered recreator with specialization in

therapeutic recreation by the California Board of Park and Recreation Personnel or the National Therapeutic Recreation Society.

(33) Registered Nurse.

(A) Registered nurse means a person licensed by the Board of Registered Nursing.

(B) Nurse Midwife. Nurse midwife means a registered nurse certified under Article 2.5, Chapter 6 of the Business and Professions Code.

(34) Registered Record Administrator. Registered record administrator means a person who is registered by the American Medical Record Association.

(35) Respiratory Therapist. Respiratory therapist means a person who is registered or eligible for registration as a respiratory therapist by the American Association for Respiratory Therapy or the National Board for Respiratory Therapy.

(36) Respiratory Therapy Technician. Respiratory therapy technician means a person who is certified or eligible for certification as a respiratory therapy technician by the American Association for Respiratory Therapy or the National Board for Respiratory Therapy.

(37) Social Worker. Social worker means a person who is licensed as a clinical social worker by the Board of Behavioral Science Examiners.

(38) Social Work Assistant. Social work assistant means a person with a baccalaureate in the social sciences or related fields and who receives supervision, consultation and in-service training from a social worker.

(39) Social Work Aide. Social work aide means a staff person with orientation, on-the-job training and supervision from a social worker or a social work assistant.

(40) Speech Pathologist. Speech pathologist means a person who is licensed as a speech pathologist by the Board of Medical Examiners.

(41) Therapeutic Radiologic Technologist. Therapeutic radiologic technologist means a person other than a licentiate of the healing arts who has been issued a certificate by the Department to engage in therapeutic radiologic technology without limitation as to procedures or areas of application and under the supervision of a certified X-ray supervisor and operator.

(42) Vocational Rehabilitation Counselor. Vocational rehabilitation counselor means a person who has a master's degree in rehabilitation counseling, or a master's degree in a related area plus training and skill in the vocational rehabilitation process or has a baccalaureate degree and has worked under the direct supervision of a person with the above qualifications.

(43) X-ray Technician. X-ray technician means a person who has been issued a limited permit by the Department to engage in diagnostic or therapeutic radiologic technology in certain specific categories under the supervision of a certified X-ray supervisor and operator.

(44) Physician's Assistant. Physician's assistant means a person certified as such by the Physician's Assistant Examining Committee of the California Board of Medical Quality Assurance.

NOTE: Authority cited: Sections 1275, ~~and 100275~~ and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(2) Amend Section 70577 to read as follows:**

**Section 70577. Psychiatric Unit General Requirements.**

(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.

(b) The responsibility and the accountability of the psychiatric service to the medical staff and administration shall be defined.

(c) The psychiatric unit shall be used for patients with the diagnosis of a mental disorder requiring hospital care. For purposes of these regulations "mental disorder" is defined as any psychiatric illness or disease, whether functional or of organic origin.

(d) Medical services.

(1) Psychiatrists or clinical psychologists, acting within the scope of their licensure and subject to the rules of the facility, shall be responsible for the diagnostic formulation for their patients and the development and implementation of each patient's treatment plan.

(2) Medical examinations shall be performed as often as indicated by the medical needs of the patient as determined by the patient's attending ~~psychiatrist or psychologist~~ licensed healthcare practitioner acting within the scope of his or her professional licensure. Reports of all medical examinations shall be on file in the patient's medical record.

(3) A psychiatrist shall be available at all times for psychiatric emergencies.

(4) An appropriate committee of the medical services shall:

(A) Identify and recommend to administration the equipment and supplies necessary for emergency medical problems.

(B) Develop a plan for handling and/or referral of patients with emergency medical problems.

(C) Determine the circumstances under which electroconvulsive therapy may be administered.

(D) Develop guidelines for the administration of a drug when given in unusually high dosages or for purposes other than those for which the drug is customarily used.

(e) Psychological services shall be provided by clinical psychologists within the scope of their licensure and subject to the provisions of Section 1316.5 of the Health and Safety Code. Staff physicians shall assume responsibility for those aspects of patient care which may be provided only by physicians.

~~(1) Facilities which permit clinical psychologists to admit patients shall do so only if there are staff physicians who will provide the necessary medical care to the patients.~~

~~(2) Only staff physicians shall assume responsibility for those aspects of patient care which may be provided only by physicians.~~

(f) Provision shall be made for the rendering of social services by social workers at the request of a patient's attending ~~physician or psychologist~~ licensed healthcare practitioner acting within the scope of his or her professional licensure.

(g) Therapeutic activity program.

(1) Every unit shall provide and conduct organized programs of therapeutic activities in accordance with the interests, abilities and needs of the patients.

(2) Individual evaluation and treatment plans which are correlated with the total therapeutic program shall be developed and recorded for each patient.

(h) Education.

(1) No hospital shall accept children of school age who are educable or trainable and who are expected to be a patient in the unit for one month or longer unless an educational or training program can be made available for such children in accordance with their needs and conditions.

(2) Educational programs provided in the facility shall follow those programs established by law, and shall be under the direction of teachers with California teaching credentials.

(3) If children attend community schools, supervision to and from school shall be provided in accordance with the needs and conditions of the patients.

(4) Transportation to and from school shall be provided where indicated.

(i) The medical records of all patients admitted to the unit shall contain a legal authorization for admission. Release of information or medical records concerning any patient shall be only as authorized under the provisions contained in Article 7 (commencing with Section 5325; and Section 5328 in particular) Part 1, Division 5 of the Welfare and Institutions Code.

(j) Restraint of patients.

(1) Restraint shall be used only when alternative methods are not sufficient to protect the patient or others from injury.

(2) Patients shall be placed in restraint only on the written order of the physician licensed healthcare practitioner acting within the scope of his or her professional licensure. This order shall include the reason for restraint and the type of restraint to be used. In a clear case of emergency, a patient may be placed in restraint at the discretion of a registered nurse and a verbal or written order obtained thereafter. If a verbal order is obtained it shall be recorded in the patient's medical record and be signed by the physician licensed healthcare practitioner on his or her next visit.

(3) Patients in restraint by seclusion or mechanical means shall be observed at intervals not greater than 15 minutes.

(4) Restraints shall be easily removable in the event of fire or other emergency.

(5) Record of type of restraint including time of application and removal shall be in the patient's medical record.

(k) Patients' rights.

(1) All patients shall have rights which include, but are not limited to, the following:

(A) To wear his own clothes, to keep and use his own personal possessions including his toilet articles; and to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases.

(B) To have access to individual storage space for his private use.

(C) To see visitors each day.

(D) To have reasonable access to telephones, both to make and receive confidential calls.

(E) To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.

(F) To refuse shock treatment.

(G) To refuse lobotomy.

(H) To be informed of the provisions of law regarding complaints and of procedures for registering complaints confidentially, including but not limited to, the address and telephone number of the complaint receiving unit of the Department.

(I) All other rights as provided by law or regulations.

(2) The physician licensed health care practitioner acting within the scope of his or her professional licensure who has overall responsibility for the unit or his or her designee, may for good cause, deny a person any of the rights specified in (1) above, except those rights specified in subsections (F), (G) and (I) above and the rights under subsection (F) may be denied only under the conditions specified in Section 5326.4, Welfare and Institutions Code. The denial, and the reasons therefore, shall be entered in the patient's medical record.

(3) These rights, written in English and Spanish, shall be prominently posted.

(l) Psychiatric unit staff shall be involved in orientation and in-service training of hospital employees.

(m) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1255, 1276, ~~and~~ 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(3) Amend Section 70703 to read as follows:**

**Section 70703. Organized Medical Staff.**

(a) Each hospital shall have an organized medical staff responsible to the governing body for the adequacy and quality of the medical care rendered to patients in the hospital subject to the bylaws, rules and regulations of the hospital.

(1) The medical staff shall be composed of physicians and, where dental or podiatric services are provided, dentists or podiatrists.

(2) As required by section 1316.5 of the Health and Safety Code:

(A) Where clinical psychological services are provided, by clinical psychologists, may be appointed to clinical psychologists shall be included on the medical staff subject to the by-laws, rules and regulation of the hospital. in a health facility owned and operated by the state, the facility shall establish rules and medical staff bylaws that include provisions for medical staff membership and clinical privileges for clinical psychologists within the scope of their licensure as psychologists.

(B) Where clinical psychological services are provided by clinical psychologists, in a health facility not owned or operated by this state, the facility may enable the appointment of clinical psychologists to the medical staff.

(b) The medical staff, by vote of the members and with the approval of the governing body, shall adopt written by-laws which provide formal procedures for the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeals mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate. The medical staff shall abide by and establish a means of enforcement of its by-laws. Medical staff by-laws, rules and regulations shall not deny or restrict within the scope of their licensure, the voting right of staff members or assign staff members to any special class or category of staff membership, based upon whether such staff members hold an M.D., D.O., D.P.M., OR or D.D.S. degree or clinical psychology license. The medical staff bylaws, rules, and regulations shall provide for the award of all clinical

privileges that are within the scope of practice of each category of licensee represented on the medical staff. The medical staff shall award such clinical privileges on terms and conditions that do not discriminate between medical staff members in different license categories. Failure of the medical staff to approve or deny a request for clinical privileges within reasonable time frames provided in the medical staff bylaws, but in no case to exceed six (6) months from the date of submission of a completed application, shall constitute a limitation or restriction on a basis other than the competence of the individual practitioner.

(c) The medical staff shall meet regularly. Minutes of each meeting shall be retained and filed at the hospital.

(d) The medical staff by-laws, rules, and regulations shall include, but shall not be limited to, provision for the performance of the following functions: executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting the medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services. These functions may be performed by individual committees, or when appropriate, all functions or more than one function may be performed by a single committee. Reports of activities and recommendations relating to these functions shall be made to the executive committee and the governing body as frequently as necessary and at least quarterly. As required by section 1316.5 of the Health and Safety Code, the medical staff bylaws, rules, and regulations shall provide that with respect to any medical staff committee whose function encompass an evaluation of the education, training, or experience of medical staff members, or the fitness, adequacy or quality of the services provided by medical staff members, the medical staff shall, if possible, on an annual basis offer membership on such committee to at least one licensed medical staff member in each category of licensure represented on the medical staff, if the activities of such category's licensees are the subject of any of the committee's functions.

(e) The medical staff shall provide in its by-laws, rules and regulations for appropriate practices and procedures to be observed in the various departments of the hospital. In this connection the practice of division of fees, under any guise whatsoever, shall be prohibited and any such division of fees shall be cause for exclusion from the staff.

(f) The medical staff shall provide for availability of staff physicians or psychologists for emergencies among the in-hospital population in the event that the attending physician or psychologist or his or her alternate is not available.

(g) The medical staff shall participate in a continuing program of professional education. The results of retrospective medical care evaluation shall be used to determine the continuing education needs. Evidence of participation in such programs shall be available.

(h) The medical staff shall develop criteria under which consultation will be required. These criteria shall not preclude the requirement for consultations on any patient when the director of the service, chairman of a department or the chief of staff determines a patient will benefit from such consultation.

NOTE: Authority cited: Sections 208(a) and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1315, 1316, and 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(4) Amend Section 70706 to read as follows:**

**Section 70706. Interdisciplinary Practice and Responsibility for Patient Care.**

(a) In any facility where registered nurses will perform functions requiring standardized procedures pursuant to Section 2725 of the Business and Professions Code, or in which licensed or certified healing arts professionals who are not members of the medical staff will be granted privileges pursuant to Section 70706.1 there shall be a Committee on Interdisciplinary Practice established by and accountable to the Governing Body, for establishing policies and procedures for interdisciplinary medical practice.

(b) The Committee on Interdisciplinary Practice shall include, as a minimum, the director of nursing, the administrator or designee, and an equal number of physicians appointed by the Executive Committee of the medical staff, and registered nurses appointed by the director of nursing. When the hospital has a psychiatric unit and one or more clinical psychologists on its medical staff, one or more clinical psychologists shall be appointed to the Committee on Interdisciplinary Practice by the Executive Committee of the medical staff. Licensed or certified health professionals other than registered nurses who are performing or will perform functions as in (a) above shall be included in the Committee.

(c) The Committee on Interdisciplinary Practice shall establish written policies and procedures for the conduct of its business. Policies and procedures shall include but not be limited to:

(1) Provision for securing recommendations from members of the medical staff in the medical specialty, or clinical field of practice under review, and from persons in the appropriate nonmedical category who practice in the clinical field or specialty under review.

(2) Method for the approval of standardized procedures in accordance with Sections 2725 of the Business and Professions Code in which affirmative approval of the administrator or designee and a majority of the physician members and a majority of the registered nurse members would be required and

that prior to such approval, consultation shall be obtained from facility staff in the medical and nursing specialties under review.

(3) Providing for maintaining clear lines of responsibility of the nursing service for nursing care of patients and of the medical staff for medical services in the facility.

(4) Intended line of approval for each recommendation of the Committee.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(5) Amend Section 70707 to read as follows:**

**Section 70707. Patients' Rights.**

(a) Hospitals and medical staffs shall adopt a written policy on patients' rights.

(b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights may be read by patients. This list shall include but not be limited to the patients' rights to:

(1) Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status, or the source of payment for care.

(2) Considerate and respectful care.

(3) Knowledge of the name of the physician licensed healthcare practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating the care, and the names and professional relationships of other physicians and nonphysicians who will see the patient.

(4) Receive information about the illness, the course of treatment and prospects for recovery in terms that the patient can understand.

(5) Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.

(6) Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment.

(7) Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.

(8) Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care.

(9) Reasonable responses to any reasonable requests made for service.

(10) Leave the hospital even against the advice of members of the medical staff physicians.

(11) Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of persons providing the care.

(12) Be advised if the hospital/ personal physician licensed healthcare practitioner acting within the scope of his or her professional licensure proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects.

(13) Be informed of continuing health care requirements following discharge from the hospital.

(14) Examine and receive an explanation of the bill regardless of source of payment.

(15) Know which hospital rules and policies apply to the patient's conduct while a patient.

(16) Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

(17) Designate visitors of his/her choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, unless:

(A) No visitors are allowed.

(B) The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.

(C) The patient has indicated to the health facility staff that the patient no longer wants this person to visit.

(18) Have the patient's wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any person living in the household.

(19) This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

(c) A procedure shall be established whereby patient complaints are forwarded to the hospital administration for appropriate response.

(d) All hospital personnel shall observe these patients' rights.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(6) Amend Section 70717 to read as follows:**

**Section 70717. Admission, Transfer and Discharge Policies.**

(a) Each hospital shall have written admission, transfer and discharge policies which encompass the types of clinical diagnoses for which patients may be admitted, limitations imposed by law or licensure, staffing limitations, rules governing emergency admissions, advance deposits, rates of charge for care, charges for extra services, terminations of services, refund policies, insurance agreements and other financial considerations, discharge of patients and other related functions.

(b) Hospitals offering emergency and/or outpatient services shall make available, upon request of a patient, a schedule of hospital charges.

(c) Patients shall be admitted only upon the order and under the care of a member of the medical staff of the hospital who is a licensed health care practitioner acting within the scope of his or her professional licensure lawfully authorized to diagnose, prescribe and treat patients. The patient's condition and provisional diagnosis shall be established at time of admission by the member of the medical staff who admits the patient, subject to the rules and regulations of the hospital, and the provisions of Section 70705(a).

(1) Patients admitted to the hospital for podiatric services shall receive the same basic medical appraisal as patients admitted for other services. This shall include the performance and recording of the findings in the health record of an admission history and physical examination which shall be performed by persons lawfully authorized to do so by their respective practice acts.

(d) Within 24 hours after admission, or immediately before, every patient shall have a complete history and physical examination performed providing the condition of the patient permits.

(e) No mentally competent adults shall be detained in a hospital against their will. Emancipated minors shall not be detained in a hospital against their will. Unemancipated minors shall not be detained against the will of their parents or legal guardians. In those cases where law permits unemancipated minors to contract for medical care without the consent of their parents or legal guardians,

the minors shall not be detained in the hospital against their will. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the hospital in the patient's own interest nor the detention of mentally disordered patients for the protection of themselves or others under the provisions of the Lanterman-Petris-Short Act (Welfare and Institutions Code, Section 5000, et seq.) if the hospital has been designated by the county as a treatment facility pursuant to said act nor to prohibit minors legally capable of contracting for medical care from assuming responsibility for their discharge. However, in no event shall a patient be detained solely for nonpayment of a hospital bill.

(f) No patient shall be transferred or discharged solely for the purposes of effecting a transfer from a hospital to another health facility unless:

(1) Arrangements have been made in advance for admission to such health facility.

(2) A determination has been made by the patient's physician licensed health care practitioner acting within the scope of his or her professional licensure, based on his or her assessment of the patient's clinical condition, that such a transfer or discharge would not create a medical hazard to the patient.

(3) The patient or the person legally responsible for the patient has been notified, or attempts have been made over the 24-hour period prior to the patient's transfer and the legally responsible person cannot be reached.

(g) Minors shall be discharged only to the custody of their parents or legal guardians or custodians, unless such parents or guardians shall otherwise direct in writing. This provision shall not be construed to preclude minors legally capable of contracting for medical care from assuming responsibility for themselves upon discharge.

(h) Each patient upon admission shall be provided with a wristband identification tag or other means of identification unless the patient's condition will not permit such identification. Minimum information shall include the name of the patient, the admission number and the name of the hospital.

(i) No patients shall be admitted routinely to a distinct part of a hospital unless it is appropriate for the level of care required by those patients.

(j) Patients with critical burns shall be treated in a burn center unless transfer of the patient to the burn center is contraindicated in the judgment of the attending physician.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1285, 1315, and 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(7) Amend Section 70749 to read as follows:**

**Section 70749. Patient Health Record Content.**

(a) Each inpatient medical record shall consist of at least the following items:

- (1) Identification sheets which include but are not limited to the following:
- (A) Name.
  - (B) Address on admission.
  - (C) Identification number (if applicable).
    - 1. Social Security.
    - 2. Medicare.
    - 3. Medi-Cal.
  - (D) Age.
  - (E) Sex.
  - (F) Marital status.
  - (G) Religion.
  - (H) Date of admission.
  - (I) Date of discharge.
  - (J) Name, address and telephone number of person or agency responsible for patient.
  - (K) Name of patient's admitting licensed health care practitioner acting within the scope of his or her professional licensure physician.
  - (L) Initial diagnostic impression.
  - (M) Discharge or final diagnosis.
- (2) History and physical examination.
- (3) Consultation reports.
- (4) Order sheet including medication, treatment and diet orders.
- (5) Progress notes including current or working diagnosis.
- (6) Nurses' notes which shall include but not be limited to the following:
- (A) Concise and accurate record of nursing care administered.

(B) Record of pertinent observations including psychosocial and physical manifestations as well as incidents and unusual occurrences, and relevant nursing interpretation of such observations.

(C) Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration.

(D) Record of type of restraint and time of application and removal. The time of application and removal shall not be required for soft tie restraints used for support and protection of the patient.

(7) Vital sign sheet.

(8) Reports of all laboratory tests performed.

(9) Reports of all X-ray examinations performed.

(10) Consent forms, when applicable.

(11) Anesthesia record including preoperative diagnosis, if anesthesia has been administered.

(12) Operative report including preoperative and postoperative diagnosis diagnoses, description of findings, technique used, tissue removed or altered, if surgery was performed.

(13) Pathological Pathology report, if tissue or body fluid was removed.

(14) Labor record, if applicable.

(15) Delivery record, if applicable.

(16) A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, his condition on discharge and the recommendations and arrangements for future care.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(8) Amend Section 70751 to read as follows:**

**Section 70751. Medical Record Availability.**

(a) Records shall be kept on all patients admitted or accepted for treatment. All required patient health records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon the request of:

(1) The admitting physician licensed healthcare practitioner acting within the scope of his or her professional licensure.

(2) The nonphysician granted privileges pursuant to Section 70706.1.

(3) The hospital or its medical staff or any authorized officer, agent or employee of either.

(4) Authorized representatives of the Department.

(5) Any other person authorized by law to make such a request.

(b) The medical record, including X-ray films, is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. The hospital shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

(c) Patient records including X-ray films or reproduction thereof shall be preserved safely for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.

(d) If a hospital ceases operation, the Department shall be informed within 48 hours of the arrangements made for safe preservation of patient records as above required.

(e) If ownership of a licensed hospital changes, both the previous licensee and the new licensee shall, prior to the change of ownership, provide the Department with written documentation that:

(1) The new licensee will have custody of the patients' records upon transfer of the hospital and that the records are available to both the new and former licensee and other authorized persons; or

(2) Arrangements have been made for the safe preservation of patient records, as above required, and that the records are available to both the new and former licensees and other authorized persons.

(f) Medical records shall be filed in an easily accessible manner in the hospital or in an approved medical record storage facility off the hospital premises.

(g) Medical records shall be completed promptly and authenticated or signed by a ~~physician, dentist or pediatric~~ licensed healthcare practitioner acting within the scope of his or her professional licensure within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a ~~physician's signature~~ by a licensed healthcare practitioner acting within the scope of his or her professional licensure, only when that ~~physician~~ licensed healthcare practitioner acting within the scope of his or her professional licensure, has placed a signed statement in the hospital administrative offices to the effect that he/she is the only person who:

(1) Has possession of the stamp or key.

(2) Will use the stamp or key.

(h) Medical records shall be indexed according to patient, disease, operation and ~~physician~~ licensed healthcare practitioner acting within the scope of his or her professional licensure.

(i) By July 1, 1976 a unit medical record system shall be established and implemented with inpatient, outpatient and emergency room records combined.

(j) The medical record shall be closed and a new record initiated when a patient is transferred to a different level of care within a hospital which has a distinct part skilled nursing or intermediate care service.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(9) Amend Section 70753 to read as follows:**

**Section 70753. Transfer Summary.**

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, medications, treatments, dietary requirement, rehabilitation potential, known allergies and treatment plan and shall be signed by the physician licensed healthcare practitioner acting within the scope of his or her professional licensure.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(10) Amend Section 71053 to read as follows:**

**Section 71053. Personnel.**

(a) Unless otherwise specified in this chapter, the following definitions shall apply to health care personnel:

(1) Accredited Record Technician.

Accredited record technician means a person who is accredited by the American Medical Record Association.

(2) Administrator. Administrator means the individual who is appointed by the governing body to act in its behalf in the overall management of the hospital.

(3) Art Therapist. Art therapist means a person who has a master's degree in art therapy or in art with emphasis in art therapy, including an approved clinical internship from an accredited college or university; or a person who is registered or eligible for registration with the American Art Therapy Association.

(4) Consultant. Consultant means a person who is professionally qualified to provide expert information on a particular subject.

(5) Dance Therapist. Dance therapist means a person who is registered or eligible for registration as a dance therapist registered by the American Dance Therapy Association.

(6) Dietitian. Dietitian means a person who is registered or eligible by registration as a registered dietitian by the American Dietetic Association.

(7) Licensed Psychiatric Technician. Licensed psychiatric technician means a person who is licensed as a licensed psychiatric technician by the Board of Vocational Nurse and Psychiatric Technician Examiners.

(8) Licensed Vocational Nurse. Licensed vocational nurse means a person who is licensed as a licensed vocational nurse by the Board of Vocational Nurse and Psychiatric Technician Examiners.

(9) Mental Health Worker. Mental health worker means an unlicensed person who through experience, in-service training or formal education is qualified to participate in the care of the psychiatric patient.

(10) Music Therapist. Music therapist means a person who is registered or eligible for registration as a registered music therapist by the National Association for Music Therapy.

(11) Occupational Therapist. Occupational therapist means a person who is certified or eligible for certification as an occupational therapist registered by the American Occupational Therapy Association.

(12) Occupational Therapy Assistant. Occupational therapy assistant means a person who is certified or eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association.

(13) Pharmacist. Pharmacist means a person who is licensed as a pharmacist by the Board of Pharmacy.

(14) Physician. Physician means a person licensed as a physician and surgeon by the Board of Medical Examiners or by the Board of Osteopathic Examiners.

(15) Psychologist. Psychologist means a person who is licensed as a psychologist by the Board of ~~Medical Examiners~~ Psychology.

(16) Psychiatrist. Psychiatrist means a person who is licensed as a physician and surgeon by the Board of Medical Examiners or the Board of Osteopathic Examiners and who has specialized training and/or experience in psychiatry.

(17) Recreation Therapist. Recreation therapist means a person who is certified or eligible for certification as a registered recreator with specialization in therapeutic recreation by the California Board of Park and Recreation personnel or the National Therapeutic Recreation Society.

(18) Registered Nurse. Registered nurse means a person who is licensed by the Board of Registered Nursing.

(19) Registered Record Administrator. Registered record administrator means a person who is registered or eligible for registration as a registered record administrator by the American Medical Record Association.

(20) Social Worker. Social worker means a person who is licensed as a clinical social worker by the Board of Behavioral Science Examiners.

NOTE: Authority cited: Sections 1275, ~~and 100275~~ and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(11) Amend Section 71203 to read as follows:**

**Section 71203. Medical Service General Requirements.**

(a) The medical service shall consist of the following organized and staffed elements:

(1) Psychiatric component.

(A) Psychiatrists or clinical psychologists within the scope of their licensure and subject to the rules of the facility, shall be responsible for the diagnostic formulation for their patients and the development and implementation of each patient's treatment plan.

(B) A psychiatrist shall be available at all times for psychiatric emergencies.

(2) General medicine component.

(A) All incidental medical services necessary for the care and support of patients shall be provided by in-house staff or through the use of outside resources in accordance with Section 71513 of these regulations.

(B) Incidental medical services include but are not limited to:

1. General medicine and surgery.
2. Dental.
3. Radiological.
4. Laboratory.
5. Anesthesia.
6. Podiatry.
7. Physical therapy.
8. Speech pathology.
9. Audiology.

(3) Psychological component.

(A) Psychological service shall be provided by clinical psychologists within the scope of his/her licensure and subject to the provisions of Section 1316.5 of the Health and Safety Code.

~~(B) Facilities which permit clinical psychologists to admit patients shall do so only if there are staff physicians who will provide the necessary medical care for the patients.~~

~~(B)(C) Only staff physicians shall assume responsibility for those aspects of patient care which may be provided only by physicians.~~

(4) Social service component.

(A) Social service shall be provided by social workers under the direction of the medical staff.

(b) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff, where such is appropriate. Policies and procedures shall be consistent with Sections 1316 and 1316.5 of the Health and Safety Code.

(c) The responsibility and the accountability of the medical service to the medical staff and administration shall be defined.

(d) An appropriate committee of the medical service shall:

(1) Identify and recommend to administration the equipment and supplies necessary for coping with emergency medical problems.

(2) Develop a plan for handling and/or referral of patients with emergency medical problems.

(3) Determine the circumstances under which electroconvulsive therapy may be administered.

(4) Develop guidelines for the administration of drugs when given in unusually high dosages or when given for purposes other than those for which the drug is customarily used.

(e) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, and 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(12) Amend Section 71205 to read as follows:**

**Section 71205. Medical Service Staff.**

- (a) A physician shall have overall responsibility for the medical service.
- (b) Psychiatric component.
  - (1) A psychiatrist shall coordinate the psychiatric services provided.
  - (2) There shall be sufficient psychiatrists on the staff to meet the needs of the patients.
- (c) General medical component.
  - (1) A physician shall coordinate the general medical component.
  - (2) This physician shall have training and/or experience sufficient to coordinate the incidental medical services.
- (d) Psychological component.
  - (1) One or more clinical psychologists shall be employed available on a full-time, regular part-time or consulting basis.
- (e) Social service component.
  - (1) One or more social workers shall be employed on a full-time, regular part-time or consulting basis.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

(13) Amend Section 71503 to read as follows:

**Section 71503. Organized Medical Staff.**

(a) Each hospital shall have an organized medical staff responsible to the governing body for the fitness, adequacy and quality of the medical care rendered to patients in the hospital subject to the bylaws, rules and regulations of the hospital.

(b) Medical staff membership.

(1) The medical staff shall be composed of physicians and, where dental or podiatric services are provided, dentists or podiatrists.

(2) As required by section 1316.5 of the Health and Safety Code:

(A) Where clinical psychological services are provided, by clinical psychologists, may be appointed to clinical psychologists shall be included on the medical staff subject to the by laws, rules and regulation of the hospital in a health facility owned and operated by the state, the facility shall establish rules and medical staff bylaws that include provisions for medical staff membership and clinical privileges for clinical psychologists within the scope of their licensure as psychologists.

(B) Where clinical psychological services are provided by clinical psychologists, in a health facility not owned or operated by this state, the facility may enable the appointment of clinical psychologists to the medical staff.

(c) The medical staff, by vote of the members and with the approval of the governing body, shall adopt written bylaws which provide formal procedures for the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeals mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate. The medical staff shall abide by and establish a means of enforcement of its bylaws. Medical staff bylaws, rules and regulations shall not deny or restrict, within the scope of their licensure, the voting rights of staff members or assign staff members to any special class or category of staff membership, based upon whether such staff members hold an M.D., D.O., or D.P.M. degree or clinical psychology license. The medical staff bylaws, rules,

and regulations shall provide for the award of all clinical privileges that are within the scope of practice of each category of licensees represented on the medical staff. The medical staff shall award such clinical privileges on terms and conditions that do not discriminate between medical staff members in different license categories. Failure of the medical staff to approve or deny a request for clinical privileges within reasonable time frames provided in the medical staff bylaws, but in no case to exceed six (6) months from the date of submission of a completed application, shall constitute a limitation or restriction on a basis other than the competence of the individual practitioner.

(d) The medical staff shall meet regularly. Minutes of each meeting shall be retained and filed at the hospital.

(e) The medical staff bylaws, rules, and regulations shall include, but shall not be limited to, provision for the performance of the following functions: executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting the medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services. These functions may be performed by individual committees, or when appropriate, all functions or more than one function may be performed by a single committee. Reports of activities and recommendations relating to these functions shall be made to the executive committee and the governing body as frequently as necessary and at least quarterly. As required by section 1316.5 of the Health and Safety Code, the medical staff bylaws, rules, and regulations shall provide that with respect to any medical staff committee whose function encompass an evaluation of the education, training, or experience of medical staff members, or the fitness, adequacy or quality of the services provided by medical staff members, the medical staff shall, if possible, on an annual basis offer membership on such committee to at least one licensed medical staff member in each category of licensure represented on the medical staff, if the activities of such category's licensees are the subject of any of the committee's functions.

(f) The medical staff shall provide in its bylaws, rules and regulations for appropriate practices and procedures to be observed in the various departments of the hospital. In this connection, the practice of division of fees, under any guise whatsoever, shall be prohibited and any such division of fees shall be cause for exclusion from the staff.

(g) The medical staff shall provide for availability of a staff physician or psychologist for emergencies among the in-hospital population in the event that the attending physician or psychologist or his or her alternate is not available.

(h) The medical staff shall participate in a continuing program of professional education. The results of retrospective medical care evaluation shall be used to determine the continuing education needs. Evidence of participation in such programs shall be available.

(i) The medical staff shall provide at least one physician to participate as a member of the hospital infection control committee.

Note: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1315, 1316, and 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(14) Amend Section 71507 to read as follows:**

**Section 71507. Patients' Rights.**

(a) All patients shall have rights which include, but are not limited to the following:

(1) To wear his own clothes, to keep and use his own personal possessions including his toilet articles; and to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases.

(2) To have access to individual storage space for his private use.

(3) To see visitors each day.

(4) To have reasonable access to telephones, both to make and receive confidential calls.

(5) To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.

(6) To refuse shock treatment.

(7) To refuse psychosurgery as defined in Section 5325, Welfare and Institutions Code.

(8) To be informed of the provisions of law regarding complaints and of procedures for registering complaints confidentially, including but not limited to, the address and telephone number of the complaint receiving unit of the Department.

(9) All other rights as provided by law or regulation.

(b) The physician licensed healthcare practitioner acting within the scope of his or her professional licensure who has overall responsibility for the service, or his or her designee, may for good cause, deny a person any of the rights specified in (a) above, except those rights specified in subsection (7) and (9) above and the rights under subsection (6) may be denied only under the conditions specified in Section 5326.7, Welfare and Institutions Code. The denial, and the reasons therefore, shall be entered in the patient's medical record.

(c) These rights, written in English and Spanish, shall be prominently posted.

(d) There shall be a procedure established whereby patient complaints are forwarded to hospital administration. Knowledge of this procedure shall be readily available to patients. The hospital administration shall, in all cases, acknowledge to the patient their receipt of his complaint. Additional follow-up of the complaint and response to the patient shall be handled as is appropriate.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(15) Amend Section 71517 to read as follows:**

**Section 71517. Admission, Transfer and Discharge Policies.**

(a) Each hospital shall have written admission, transfer and discharge policies which encompass the types of diagnoses for which patients may be admitted, limitations imposed by law or licensure, staffing limitations, rules governing emergency admissions, policies concerning advance deposits, rates of charge for care, charges for extra services, terminations of services, refund policies, insurance agreements and other financial considerations, discharge of patients and other related functions.

(b) Patients shall be admitted only upon the order and under the care of a member of the medical staff of the hospital who is a licensed health care practitioner acting within the scope of his or her professional licensure lawfully authorized to diagnose, prescribe and treat patients. The patient's condition and provisional diagnosis shall be established at time of admission by the member of the medical staff who admits the patient subject to the rules and regulations of the hospital, and the provisions of Section 71505(a).

(c) Within 24 hours after admission or immediately before, every patient shall have a complete history and physical examination and psychiatric evaluation performed by persons lawfully authorized by their respective practice acts to perform such examinations providing the condition of the patient permits. Each patient shall have a complete psychological evaluation performed by a physician and surgeon or clinical psychologist consistent with the medical staff bylaws, and providing the condition of the patient permits.

(d) No mentally competent adult shall be detained in a hospital against his will. An emancipated minor shall not be detained in a hospital against his will. An unemancipated minor shall not be detained against the will of his parent or legal guardian. In those cases where law permits an unemancipated minor to contract for medical care without the consent of his parent or guardian, he shall not be detained in the hospital against his will. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the hospital in his own interest, nor the temporary detention of a mentally disturbed

patient for the protection of himself or others under the provisions of the Lanterman-Petris-Short Act (Welfare and Institutions Code, Section 5000 et seq.) if the hospital has been designated by the county as a treatment facility pursuant to said act, nor to prohibit a minor legally capable of contracting for medical care from assuming responsibility for his discharge. However, in no event shall a patient be detained solely for nonpayment of his hospital bill.

(e) No inpatient shall be transferred or discharged for purposes of effecting a transfer, from a hospital to another health facility, unless arrangements have been made in advance for admission to such health facility and the person legally responsible for the patient has been notified or attempts over a 24-hour period have been made and a responsible person cannot be reached. A transfer or discharge shall not be carried out if, in the opinion of the patient's physician licensed health care practitioner acting within his or her scope of professional licensure, and based on his or her assessment of the patient's clinical condition, such transfer or discharge would create a medical hazard.

(f) A minor shall be discharged only to the custody of his or her parent or to his legal guardian or custodian, unless such parent or guardian shall otherwise direct in writing. This provision shall not be construed to preclude a minor legally capable of contracting for medical care from assuming responsibility for himself upon discharge.

(g) Each patient upon admission shall be provided with a wristband identification tag or other means of identification unless the patient's condition will not permit such identification. Minimum information shall include the name of the patient, hospital admission number and the name of the hospital.

(h) Involuntary admission to the hospital shall be in conformity with the provisions of the Lanterman-Petris-Short Act (Welfare and Institutions Code, Section 5000 et seq.).

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1315, 1316, and 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(16) Amend Section 71545 to read as follows:**

**Section 71545. Restraint of Patients.**

(a) Restraint shall be used only when alternative methods are not sufficient to protect the patient or others from injury.

(b) Patients shall be placed in restraint only on the written order of ~~the physician~~ a licensed health care practitioner acting within the scope of his or her professional licensure. This order shall include the reason for restraint and the type of restraint to be used. In a clear case of emergency, a patient may be placed in restraint at the discretion of a registered nurse and a verbal or written order obtained thereafter. If a verbal order is obtained it shall be recorded in the patient's medical record and be signed by the physician licensed health care practitioner on his or her next visit.

(c) Patients in restraint by seclusion or mechanical means shall be observed at intervals not greater than 15 minutes.

(d) Restraints shall be easily removable in the event of fire or other emergency.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1255, 1276, and 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(17) Amend Section 71551 to read as follows:**

**Section 71551. Medical Record Availability.**

(a) Records shall be kept on all patients admitted or accepted for treatment. All required records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon the request of: the attending physician or psychologist; the hospital or its medical staff or any authorized officer, agent or employee of either; authorized representatives of the Department; or any other person authorized by law to make such a request.

(b) The medical record, including X-ray film, is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. The hospital shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

(c) Patient records including X-ray film or reproductions thereof shall be preserved safely for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.

(d) If a hospital ceases operation, the Department shall be informed within 48 hours of the arrangements made for safe preservation of patient records as above required.

(e) If ownership of a licensed hospital changes, both the previous licensee and the new licensee shall, prior to the change of ownership, provide the Department with written documentation that:

(1) The new licensee will have custody of the patients' records upon transfer of the hospital, and that the records are available to both the new and former licensee and other authorized persons; or

(2) Arrangements have been made for the safe preservation of patient records, as required above, and that the records are available to both the new and former licensees and other authorized persons.

(f) Medical records shall be filed in an easily accessible manner in the hospital or in an approved medical record storage facility off the hospital premises.

(g) Medical records shall be completed promptly and authenticated or signed by a ~~physician, dentist or podiatrist or clinical psychologist~~ licensed healthcare practitioner acting within the scope of his or her professional licensure within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a ~~physician's signature~~ by a licensed healthcare practitioner acting within the scope of his or her professional licensure, only when that ~~physician~~ licensed healthcare practitioner acting within the scope of his or her professional licensure has placed a signed statement in the hospital administrative office to the effect that he/she is the only person who:

(1) Has possession of the stamp or key.

(2) Will use the stamp or key.

(h) Medical records shall be indexed according to patient, diagnoses and ~~physician~~ attending member of the medical staff.

(i) By July 1, 1976 a unit medical record system shall be established and implemented with inpatient, outpatient and emergency room records combined.

(j) The medical record shall be closed and a new record initiated when a patient is transferred to a different level of care within a hospital which has a distinct part skilled nursing or intermediate care service.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(18) Amend Section 71553 to read as follows:**

**Section 71553. Transfer Summary.**

A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the skilled nursing long-term unit of the hospital. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, medications, treatments, dietary requirement, rehabilitation potential, known allergies and treatment plan and shall be signed by the physician licensed healthcare practitioner acting within the scope of his or her professional licensure.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(19) Amend Section 72091 to read as follows:**

**Section 72091. Psychologist.**

(a) Psychologist means a person licensed as such by the California Board of ~~Medical Quality Assurance~~ Psychology.

(b) Clinical psychologist means a psychologist licensed by the Board of ~~Medical Quality Assurance~~ Psychology who (1) possesses an earned doctorate degree in psychology from an educational institution meeting the criteria of Subdivision (b) of Section 2914 of the Business and Professions Code and (2) has at least two years of clinical experience in a multidisciplinary facility licensed or operated by this or another state or by the United States to provide health care, or, is listed in the latest edition of the National Register of Health Services Providers in Psychology, as adopted by the Council for the National Register of Health Service Providers in Psychology.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Section 1276, 1276.1, and 1316.5, 131050, 131051 and 131052, Health and Safety Code.

(20) Amend Section 72109 to read as follows:

**Section 72109. Standing Orders.**

Standing orders means those written orders which are used or intended to be used in the absence of a prescriber's specific order for a specific patient provided by a licensed healthcare practitioner acting within the scope of his or her professional licensure.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

(21) Amend Section 72303 to read as follows:

**Section 72303. Physician Services—General Requirements.**

~~(a) Physician services shall mean those services provided by physicians responsible for the care of individual patients in the facility. All persons admitted or accepted for care by the skilled nursing facility shall be under the care of a physician selected by the patient or patient's authorized representative. All persons admitted or accepted for care by the skilled nursing facility shall be under the care of a physician selected by the patient or patient's authorized representative.~~

(b) Physician services shall mean those services provided by physicians responsible for the care of individual patients in the facility. Physician services shall include but are not limited to:

- (1) Patient evaluation including a written report of a physical examination within 5 days prior to admission or within 72 hours following admission.
  - (2) An evaluation of the patient and review of orders for care and treatment on change of attending physicians.
  - (3) Patient diagnoses.
  - (4) Advice, treatment and determination of appropriate level of care needed for each patient.
  - (5) Written and signed orders for diet, care, diagnostic tests and treatment of patients by others. Orders for restraints shall meet the requirements of Section 72319(b).
  - (6) Health record progress notes and other appropriate entries in the patient's health records.
  - (7) Provision for alternate physician coverage in the event the attending physician is not available.
- ~~(c) Nonphysician practitioners may be permitted to render those medical services which they are legally authorized to perform. Nonphysician practitioners means any of the following:~~

~~(1) Physicians' assistants working under the responsibility and supervision of a physician approved as a supervisor by the Board of Medical Quality Assurance and performing only those selected diagnostic and therapeutic tasks identified in Title 16, California Administrative Code, Chapter 13, Subchapter 3, Article 5.~~

~~(2) Registered nurses may perform patient care services utilizing "Standardized Procedures" which have been approved by the medical staff, or by the medical director if there is no organized medical staff, the registered nurse and the administrator as authorized in the Business and Professions Code, Chapter 5, Article 2, Section 2725.~~

(c) Subsection (b) shall not prevent or limit other licensed healthcare practitioners acting within the scope of their professional licensure from providing services to and being responsible for the care of individual patients in the facility, including providing those services listed in subsection (b) above that are within the scope of their licensure.

NOTE: Authority cited: Sections 208(a) and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1262.7, 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code; and Valdiva Valdivia, et al. v. Coye, U.S. District Court for the Eastern District of California, Case No. CIV S-90-1226.

**(22) Amend Section 72311 to read as follows:**

**Section 72311. Nursing Service—General.**

(a) Nursing service shall include, but not be limited to, the following:

(1) Planning of patient care, which shall include at least the following:

(A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.

(B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited.

(C) Reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition.

(2) Implementing of each patient's care plan according to the methods indicated. Each patient's care shall be based on this plan.

(3) Notifying the attending physician licensed healthcare practitioner acting within the scope of his or her professional licensure promptly of:

(A) The admission of a patient.

(B) Any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient.

(C) An unusual occurrence, as provided in Section 72541, involving a patient, as defined in Section 72541.

(D) A change in weight of five pounds or more within a 30-day period unless a different stipulation has been stated in writing by the patient's physician licensed healthcare practitioner acting within the scope of his or her professional licensure.

(E) Any untoward response or reaction by a patient to a medication or treatment.

(F) Any error in the administration of a medication or treatment to a patient which is life threatening and presents a risk to the patient.

(G) The facility's inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies or services as prescribed under conditions which present a risk to the health, safety or security of the patient.

(b) All attempts to notify ~~physicians~~ licensed healthcare practitioners acting within the scope of their professional licensure shall be noted in the patient's health record including the time and method of communication and the name of the person acknowledging contact, if any. If the attending ~~physician~~ licensed healthcare practitioner acting within the scope of his or her professional licensure or his or her designee is not readily available, emergency medical care shall be provided as outlined in Section 72301(g).

(c) Licensed nursing personnel shall ensure that patients are served the diets as ~~prescribed~~ ordered by attending ~~physicians~~ the attending licensed healthcare practitioner acting within the scope of his or her professional licensure.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(23) Amend Section 72315 to read as follows:**

**Section 72315. Nursing Service—Patient Care.**

(a) No patient shall be admitted or accepted for care by a skilled nursing facility except on the order of a ~~physician~~ physician, licensed health care practitioner acting within the scope of his or her professional licensure.

(b) Each patient shall be treated as individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind.

(c) Each patient, upon admission, shall be given orientation to the skilled nursing facility and the facility's services and staff.

(d) Each patient shall be provided care which shows evidence of good personal hygiene, including care of the skin, shampooing and grooming of hair, oral hygiene, shaving or beard trimming, cleaning and cutting of fingernails and toenails. The patient shall be free of offensive odors.

(e) Each patient shall be encouraged and/or assisted to achieve and maintain the highest level of self-care and independence. Every effort shall be made to keep patients active, and out of bed for reasonable periods of time, except when contraindicated by ~~physician's~~ orders of a licensed health care practitioner acting within the scope of his or her professional licensure.

(f) Each patient shall be given care to prevent formation and progression of decubiti, contractures and deformities. Such care shall include:

(1) Changing position of bedfast and chairfast patients with preventive skin care in accordance with the needs of the patient.

(2) Encouraging, assisting and training in self-care and activities of daily living.

(3) Maintaining proper body alignment and joint movement to prevent contractures and deformities.

(4) Using pressure-reducing devices where indicated.

(5) Providing care to maintain clean, dry skin free from feces and urine.

(6) Changing of linens and other items in contact with the patient, as necessary, to maintain a clean, dry skin free from feces and urine.

(7) Carrying out of physician's orders for treatment of decubitus ulcers. The facility shall notify the physician, when a decubitus ulcer first occurs, as well as when treatment is not effective, and shall document such notification as required in Section 72311(b).

(g) Each patient requiring help in eating shall be provided with assistance when served, and shall be provided with training or adaptive equipment in accordance with identified needs, based upon patient assessment, to encourage independence in eating.

(h) Each patient shall be provided with good nutrition and with necessary fluids for hydration.

(i) Measures shall be implemented to prevent and reduce incontinence for each patient and shall include:

(1) Written assessment by a licensed nurse to determine the patient's ability to participate in a bowel and/or bladder management program. This is to be initiated within two weeks after admission of an incontinent patient.

(2) An individualized plan, in addition to the patient care plan, for each patient in a bowel and/or bladder management program.

(3) A weekly written evaluation in the progress notes by a licensed nurse of the patient's performance in the bowel and/or bladder management program.

(j) Fluid intake and output shall be recorded for each patient as follows:

(1) If ordered by the physician.

(2) For each patient with an indwelling catheter:

(A) Intake and output records shall be evaluated at least weekly and each evaluation shall be included in the licensed nurses' progress notes.

(B) After 30 days the patient shall be reevaluated by the licensed nurse to determine further need for the recording of intake and output.

(k) The weight and length of each patient shall be taken and recorded in the patient's health record upon admission, and the weight shall be taken and recorded once a month thereafter.

(l) Each patient shall be provided visual privacy during treatments and

personal care.

(m) Patient call signals shall be answered promptly.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1262.7, 1275, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(24) Amend Section 72319 to read as follows:**

**Section 72319. Nursing Service—Restraints and Postural Supports.**

(a) Written policies and procedures concerning the use of restraints and postural supports shall be followed.

(b) Restraints shall only be used with a written order of a licensed healthcare practitioner acting within the scope of his or her professional licensure ~~physician or other person lawfully authorized to prescribe care~~. The order must specify the duration and circumstances under which the restraints are to be used. Orders must be specific to individual patients. In accordance with Section 72317, there shall be no standing orders and in accordance with Section 72319(i)(2)(A), there shall be no P.R.N. orders for physical restraints.

(c) The only acceptable forms of physical restraints shall be cloth vests, soft ties, soft cloth mittens, seat belts and trays with spring release devices. Soft ties means soft cloth which does not cause abrasion and which does not restrict blood circulation.

(d) Restraints of any type shall not be used as punishment, as a substitute for more effective medical and nursing care, or for the convenience of staff.

(e) No restraints with locking devices shall be used or available for use in a skilled nursing facility.

(f) Seclusion, which is defined as the placement of a patient alone in a room, shall not be employed.

(g) Restraints shall be used in such a way as not to cause physical injury to the patient and to insure the least possible discomfort to the patient.

(h) Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency.

(i) The requirements for the use of physical restraints are:

(1) Treatment restraints may be used for the protection of the patient during treatment and diagnostic procedures such as, but not limited to, intravenous therapy or catheterization procedures. Treatment restraints shall be applied for no longer than the time required to complete the treatment.

(2) Physical restraints for behavior control shall only be used on the signed order of a physician, psychologist, or other person lawfully authorized to prescribe care, except in an emergency which threatens to bring immediate injury to the patient or others. In such an emergency an order may be received by telephone, and shall be signed within 5 days. Full documentation of the episode leading to the use of the physical restraint, the type of the physical restraint used, the length of effectiveness of the restraint time and the name of the individual applying such measures shall be entered in the patient's health record.

(A) Physical restraints for behavioral control shall only be used with a written order designed to lead to a less restrictive way of managing, and ultimately to the elimination of, the behavior for which the restraint is applied. There shall be no PRN orders for behavioral restraints.

(B) Each patient care plan which includes the use of physical restraint for behavior control shall specify the behavior to be eliminated, the method to be used and the time limit for the use of the method.

(C) Patients shall be restrained only in an area that is under supervision of staff and shall be afforded protection from other patients who may be in the area.

(j) When drugs are used to restrain or control behavior or to treat a disordered thought process, the following shall apply:

(1) The specific behavior or manifestation of disordered thought process to be treated with the drug is identified in the patient's health record.

(2) The plan of care for each patient specifies data to be collected for use in evaluating the effectiveness of the drugs and the occurrence of adverse reactions.

(3) The data collected shall be made available to the prescriber in a consolidated manner at least monthly.

(4) PRN orders for such drugs shall be subject to the requirements of this section.

(k) "Postural support" means a method other than orthopedic braces used to assist patients to achieve proper body position and balance. Postural supports may only include soft ties, seat belts, spring release trays or cloth vests

and shall only be used to improve a patient's mobility and independent functioning, to prevent the patient from falling out of a bed or chair, or for positioning, rather than to restrict movement. These methods shall not be considered restraints.

(1) The use of postural support and the method of application shall be specified in the patient's care plan and approved in writing by the physician, psychologist, or other person lawfully authorized to provide care.

(2) Postural supports shall be applied:

(A) Under the supervision of a licensed nurse.

(B) In accordance with principles of good body alignment and with concern for circulation and allowance for change of position.

NOTE: Authority cited: Sections 208(a) and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code; and *Valdivia, et al. v. Coye*, U.S. District Court for the Eastern District of California, Case No. CIV S-90-1226.

(25) Amend Section 72337 to read as follows:

**Section 72337. Dietetic Service—Diet Manual.**

A current therapeutic diet manual, approved by the dietitian and the patient care policy committee, shall be readily available to ~~the attending physician, nursing and dietetic personnel~~ and licensed healthcare practitioners acting within the scope of their professional licensure or certification. It shall be reviewed annually and revised at least every five years.

NOTE: Authority cited: Sections 208(a) and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(26) Amend Section 72413 to read as follows:**

**Section 72413. Occupational Therapy Service Unit—Services.**

(a) "Occupational therapy service" means those medically prescribed services ordered by the licensed healthcare practitioner acting within the scope of his or her professional licensure in which selected purposeful activity is used as treatment in the rehabilitation of persons with a physical or mental disability.

(b) Occupational therapy services shall include but not be limited to:

(1) Assisting the ~~physician~~ licensed healthcare practitioner acting within the scope of his or her professional licensure in an evaluation of a patient's level of function by applying diagnostic and prognostic tests.

(2) Conducting and preparing written initial and continuing assessment of the patient's condition and modifying treatment goals under the order of a ~~physician~~ licensed healthcare practitioner acting within the scope of his or her professional licensure, consistent with identified needs of the patient.

(3) Decreasing or eliminating disability during patient's initial phase of recovery following injury or illness.

(4) Increasing or maintaining a patient's capability for independence.

(5) Enhancing a patient's physical, emotional and social well-being.

(6) Developing function to a maximum level.

(7) Guiding patients in their use of therapeutic, creative and self-care activities.

(c) An occupational therapy service unit shall meet the following requirements:

(1) Patient health records shall contain pertinent information and signed orders for treatment.

(2) Notes shall be written and entered in the patient's health record after completion of each procedure. The note shall indicate the procedure(s) performed, the reaction of the patient to the procedure(s) and shall be signed by the occupational therapist.

(3) Initial and continuing assessment, development of a treatment plan and discharge summary shall be written and entered in each patient's health record.

(4) Individual progress notes shall be written and signed at least weekly by the occupational therapist.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(27) Amend Section 72423 to read as follows:**

**Section 72423. Speech Pathology and/or Audiology Service Unit—  
Services.**

(a) "Speech pathology and/or audiology services" means those services referred or ordered by a physician licensed healthcare practitioner acting within the scope of his or her professional licensure or certification, which provide for the provision of diagnostic screening and preventive and corrective therapy for persons with speech, hearing and/or language disorders.

(b) Speech pathology and/or audiology service shall include but not be limited to the following:

(1) Conducting and preparing written initial and continuing assessment of a patient.

(2) Notes written and entered in the patient's health record after each treatment. The notes shall indicate the treatment performed, the reaction of the patient to the treatment, and be signed by the speech pathologist or audiologist.

(3) Instruction of other health team personnel and family members in methods of assisting the patient to improve or correct a speech or hearing disorder.

(c) A speech pathology and/or audiology service unit shall meet the following requirements:

(1) Patient health records shall contain a patient's history and signed orders for treatment.

(2) Progress notes shall be written at least weekly and entered in the patient health record and shall be signed by the speech pathologist and/or audiologist.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(28) Amend Section 72433 to read as follows:**

**Section 72433. Social Work Service Unit—Services.**

(a) "Social work services" means those services which assist staff, a patient and a patient's family to understand and cope with a patient's personal, emotional and related health and environmental problems.

(b) Social work services unit shall include but not be limited to the following:

(1) Interview and written assessment of each patient within five days after admission to the service.

(2) Development of a plan, including goals and treatment, for social work services for each patient who needs such services, with participation of the patient, the family, the patient's physician licensed healthcare practitioner acting within the scope of his or her professional licensure, the director of nursing services and other appropriate staff.

(3) Weekly progress reports in the patient's health record written and signed by the social worker, social work assistant or social work aide.

(4) Participation in regular staff conferences with the attending physician licensed healthcare practitioner acting within the scope of his or her professional licensure, the director of nursing service and other appropriate personnel.

(5) Discharge planning for each patient and implementation of the plan.

(6) Orientation and in-service education of other staff members on all shifts shall be conducted at least monthly by the social worker in charge of the social work service.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

(29) Amend Section 72453 to read as follows:

**Section 72453. Special Treatment Program Service Unit—Rights of Patients.**

(a) Each patient admitted to a special treatment program in a skilled nursing facility shall have the following rights, a list of which shall be prominently posted in English and Spanish in all facilities providing such services. The rights shall also be brought to the patient's attention by additional, appropriate means:

(1) To wear their own clothes; to keep and use personal possessions including toilet articles; and to keep and be allowed to spend a reasonable sum of their own money for small purchases.

(2) To have access to individual storage space for private use.

(3) To see visitors each day.

(4) To have reasonable access to telephones, both to make and receive confidential calls.

(5) To have ready access to letter writing materials, including stamps and to mail and receive unopened correspondence.

(6) To refuse shock treatment.

(7) To refuse lobotomy services.

(8) Other rights as provided by law.

(b) The attending ~~physician or psychologist~~ licensed health care practitioner acting within the scope of his or her professional licensure may, for good cause, deny or limit a patient his or her rights, except the right to refuse lobotomy or shock treatment. Any denial or limitation of a patient's rights shall be entered in the patient's health record.

(c) Information pertaining to denial of rights contained in the patient's health record shall be made available on request to the Department and to the individuals authorized by law.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code, Section 5325, Welfare and Institutions Code.

(30) Amend Section 72461 to read as follows:

**Section 72461. Special Treatment Program Service Unit—Orders for Restraint and Seclusion**

(a) Restraint and seclusion shall only be used on the signed order of a ~~physician~~ licensed health care practitioner acting within the scope of his or her professional licensure which ~~and~~ shall be renewed every 24 hours. In a documented case of emergency, which threatens to bring immediate injury to the patient or others, a restraint may be applied, and a ~~physician~~ licensed health care practitioner acting within the scope of his or her professional licensure shall give an order for application of the restraint within one hour. A ~~physician~~ licensed health care practitioner acting within the scope of his or her professional licensure may give the order by telephone. In such an event, the ~~physician~~ licensed health care practitioner shall sign the order within 5 days.

(b) A daily log shall be maintained in each facility exercising behavior restraint and seclusion indicating the name of the patient for whom behavior restraint or seclusion is ordered.

(c) Full documentation of the episode leading to the behavior restraint or seclusion, the type of behavior restraint or seclusion used, the length of time that the restraint or seclusion was applied or utilized, and the name of the individual applying such measures shall be entered in the patient's health record.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(31) Amend Section 72471 to read as follows:**

**Section 72471. Special Treatment Program Service Unit—Patient Health Records and Plans for Care.**

(a) The facility shall maintain an individual health record for each patient which shall include but not be limited to the following:

(1) A list of the patient's care needs, based upon an initial and continuing individual assessment with input as appropriate from the health professionals involved in the care of the patient. Initial assessments by a licensed nurse shall commence at the time of admission of the patient and shall be completed within seven days after admission.

(2) The plan for meeting behavioral objectives. The plan shall include but not be limited to the following:

(A) Resources to be used.

(B) Frequency of plan review and updating.

(C) Persons responsible for carrying out plans.

(3) Development and implementation of an individual, written care plan based on identified patient care needs. The plan shall indicate the care to be given, the objectives to be accomplished, and the professional discipline responsible for each element of care. The objectives shall be measurable, with time frames, and shall be reviewed and updated at least every 90 days.

(b) There shall be a review and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition.

(c) The patient care plan shall be approved, signed and dated by the licensed healthcare practitioner acting within the scope of his or her professional licensure attending physician the patient.

(d) There shall be at least monthly progress notes in the record for each patient which shall include notes written by all members of the staff providing program services to the patient. The notes shall be specific to the needs of the patients and the program objectives and plans.

(e) At the time of reassessment there shall be a summary of the progress of the patient in the program, the appropriateness of program objectives and the success of the plan.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(32) Amend Section 72515 to read as follows:**

**Section 72515. Admission of Patients.**

The licensee shall:

(a) Admit a patient only on ~~physician's~~ ~~physician's the orders of a~~  
~~licensed healthcare practitioner acting within the scope of his or her professional~~  
~~licensure.~~

(b) Accept and retain only those patients for whom it can provide adequate care.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1262.7, 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(33) Amend Section 72523 to read as follows:**

**Section 72523. Patient Care Policies and Procedures.**

(a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved.

(b) All policies and procedures required of these regulations shall be in writing, made available upon request to physicians and other involved health professionals, patients or their representatives, employees and the public shall be carried out as written. Policies and procedures shall be reviewed at least annually, revised as needed and approved in writing by the patient care policy committee.

(c) Each facility shall establish and implement policies and procedures, including but not limited to:

(1) Physician services policies and procedures which include:

(A) Orientation of new physicians to the facility and changes in physician services and/or policies.

(B) Patient evaluation visits by the attending physician and documentation of alternate schedules for such visits.

(2) Nursing services policies and procedures which include:

(A) A current nursing procedure manual.

(B) Provision for the inventory and identification of patients' personal possessions, equipment and valuables.

(C) Screening of all patients for tuberculosis upon admission. These procedures shall be determined by the patient care policy committee. A tuberculosis screening procedure may not be required if there is satisfactory written evidence available that a tuberculosis screening procedure has been completed within 90 days of the date of admission to the facility. Subsequent tuberculosis screening procedures shall be determined by the attending physician.

(D) Notification of ~~physician~~ the licensed healthcare practitioner acting within the scope of his or her professional licensure regarding sudden or marked adverse change in a patient's condition.

(E) Conditions under which restraints are used, the application of restraints, and the mechanism used for monitoring and controlling their use.

(3) Infection control policies and procedures.

(4) Dietary services policies and procedures which include:

(A) Provision for safe, nutritious food preparation and service.

(B) A provision for maintaining a current dietetic service procedure manual.

(5) Pharmaceutical services policies and procedures.

(6) Activity program policies and procedures.

(7) Housekeeping services policies and procedures which include provision for maintenance of a safe, clean environment for patients, employees and the public.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(34) Amend Section 72525 to read as follows:**

**Section 72525. Required Committees.**

(a) Each facility shall have at least the following committees: patient care policy, infection control and pharmaceutical service.

(b) Minutes of every committee meeting shall be maintained in the facility and indicate names of members present, date, length of meeting, subject matter discussed and action taken.

(c) Committee composition and function shall be as follows:

(1) Patient care policy committee.

(A) A patient care policy committee shall establish policies governing the following services: ~~P~~physician, dental, nursing, dietetic, pharmaceutical, health records, housekeeping, activity programs and such additional services as are provided by the facility.

(B) The committee shall be composed of: at least one physician, the administrator, the director of nursing service, a pharmacist, the activity leader and representatives of each required service as appropriate.

(C) The committee shall meet at least annually.

(D) The patient care policy committee shall have the responsibility for reviewing and approving all policies relating to patient care. Based on reports received from the facility administrator, the committee shall review the effectiveness of policy implementation and shall make recommendations for the improvement of patient care.

(E) The committee shall review patient care policies annually and revise as necessary. Minutes shall list policies reviewed.

(F) The ~~P~~patient ~~C~~care ~~P~~policy ~~C~~committee shall implement the provisions of the Health and Safety Code, Sections 1315, 1316 and 1316.5, by means of written policies and procedures.

~~1. Facilities which choose to allow clinical psychologists to refer patients for admission shall do so only if there are physicians who will provide the necessary medical care for the referred patients.~~

~~2.(G) Only physicians a licensed health care practitioner acting within the scope of his or her professional licensure shall assume overall care of patients, including performing admitting history and physical examinations and issuing orders for medical care.~~

~~(G) The Patient care policy committee shall implement the provisions of the Health and Safety Code, Section 1316, by means of written policies and procedures.~~

~~1. Facilities which choose to allow podiatrists to refer patients for admission shall do so only if there are physicians who will provide the necessary medical care for the referred patients.~~

~~2. Only physicians shall assume overall care of patients, including performing admitting history and physical examinations.~~

~~(2) Infection control committee.~~

~~(A) An infection control committee shall be responsible for infection control in the facility.~~

~~(B) The committee shall be composed of representatives from the following services; physician, nursing, administration, dietetic, pharmaceutical, activities, housekeeping, laundry and maintenance.~~

~~(C) The committee shall meet at least quarterly.~~

~~(D) The functions of the infection control committee shall include, but not be limited to:~~

~~1. Establishing, reviewing, monitoring and approving policies and procedures for investigating, controlling and preventing infections in the facility.~~

~~2. Maintaining, reviewing and reporting statistics of the number, types, sources and locations of infections within the facility.~~

~~(3) Pharmaceutical service committee.~~

~~(A) A pharmaceutical service committee shall direct the pharmaceutical services in the facility.~~

~~(B) The committee shall be composed of the following: a pharmacist, the director of nursing service, the administrator and at least one physician.~~

~~(C) The committee shall meet at least quarterly.~~

(D) The functions of the pharmaceutical service committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for safe procurement, storage, distribution and use of drugs and biologicals.

2. Reviewing and taking appropriate action on the pharmacist's quarterly report.

3. Recommending measures for improvement of services and the selection of pharmaceutical reference materials.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1315, 1316, and ~~1316.5~~, 131050, 131051 and 131052, Health and Safety Code.

**(35) Amend Section 72528 to read as follows:**

**Section 72528. Informed Consent Requirements.**

(a) It is the responsibility of the attending physician licensed healthcare practitioner acting within the scope of his or her professional licensure to determine what information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. Information that is commonly appreciated need not be disclosed. The disclosure of the material information and obtaining informed consent shall be the responsibility of the physician licensed healthcare practitioner who, acting within the scope of his or her professional licensure, performs or orders the procedure or treatment for which informed consent is required.

(b) The information material to a decision concerning the administration of a psychotherapeutic drug or physical restraint, or the prolonged use of a device that may lead to the inability of the patient to regain use of a normal bodily function shall include at least the following:

- (1) The reason for the treatment and the nature and seriousness of the patient's illness.
- (2) The nature of the procedures to be used in the proposed treatment including their probable frequency and duration.
- (3) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.
- (4) The nature, degree, duration and probability of the side effects and significant risks, commonly known by the health professions.
- (5) The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment.
- (6) That the patient has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time.

(c) Before initiating the administration of psychotherapeutic drugs, or physical restraints, or the prolonged use of a device that may lead to the inability

to regain use of a normal bodily function, facility staff shall verify that the patient's health record contains documentation that the patient has given informed consent to the proposed treatment or procedure. The facility shall also ensure that all decisions concerning the withdrawal or withholding of life sustaining treatment are documented in the patient's health record.

(d) This section shall not be construed to require obtaining informed consent each time a treatment or procedure is administered unless material circumstances or risks change.

(e) There shall be no violation for initiating treatment without informed consent if there is documentation within the patient's health record that an emergency exists where there is an unanticipated condition in which immediate action is necessary for preservation of life or the prevention of serious bodily harm to the patient or others or to alleviate severe physical pain, and it is impracticable to obtain the required consent, and provided that the action taken is within the customary practice of physicians licensed healthcare practitioners of good standing acting within the scope of their professional licensure in similar circumstances.

(f) Notwithstanding Sections 72527(a)(5) and 72528(b)(4), disclosure of the risks of a proposed treatment or procedure may be withheld if there is documentation of one of the following in the patient's health record:

(1) That the patient or patient's representative specifically requested that he or she not be informed of the risk of the recommended treatment or procedure. This request does not waive the requirement for providing the other material information concerning the treatment or procedure.

(2) That the physician licensed healthcare practitioner acting within the scope of his or her professional licensure relied upon objective facts, as documented in the health record, that would demonstrate to a reasonable person that the disclosure would have so seriously upset the patient that the patient would not have been able to rationally weigh the risks of refusing to undergo the recommended treatment and that, unless inappropriate, a patient's representative gave informed consent as set forth herein.

(g) A general consent provision in a contract for admission shall only encompass consent for routine nursing care or emergency care. Routine nursing care, as used in this section, means a treatment or procedure that does not require informed consent as specified in Section 72528(b)(1) through (6) or that is determined by the physician licensed healthcare practitioner acting within the scope of his or her professional licensure not to require the disclosure of information material to the individual patient. Routine nursing care includes, but is not limited to, care that does not require the order of a physician licensed healthcare practitioner acting within the scope of his or her professional licensure. This section does not preclude the use of informed consent forms for any specific treatment or procedure at the time of admission or at any other time. All consent provisions or forms shall indicate that the patient or incapacitated patient's representative may revoke his or her consent at any time.

(h) If a patient or his or her representative cannot communicate with the physician licensed healthcare practitioner acting within the scope of his or her professional licensure because of language or communication barriers, the facility shall arrange for an interpreter.

(1) An interpreter shall be someone who is fluent in both English and the language used by the patient and his or her legal representative, or who can communicate with a deaf person, if deafness is the communication barrier.

(2) When interpreters are used, documentation shall be placed in the patient's health record indicating the name of the person who acted as the interpreter and his or her relationship to the patient and to the facility.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, and 1599.72, 131050, 131051 and 131052, Health and Safety Code; and *Cobbs v. Grant* (1972) 8 Cal.3d 229.

**(36) Amend Section 72543 to read as follows:**

**Section 72543. Patients' Health Records.**

(a) Records shall be permanent, either typewritten or legibly written in ink, be capable of being photocopied and shall be kept on all patients admitted or accepted for care. All health records of discharged patients shall be completed and filed within 30 days after discharge date and such records shall be kept for a minimum of 7 years, except for minors whose records shall be kept at least until 1 year after the minor has reached the age of 18 years, but in no case less than 7 years. All exposed X-ray film shall be retained for seven years. All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon the request of the attending ~~physician or psychologist~~ licensed healthcare practitioner acting within the scope of his or her professional licensure, the facility staff or any authorized officer, agent, or employee of either, or any other person authorized by law to make such request.

(b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws.

(c) If a facility ceases operation, the Department shall be informed within three business days by the licensee of the arrangements made for the safe preservation of the patients' health records.

(d) The Department shall be informed within three business days, in writing, whenever patient health records are defaced or destroyed before termination of the required retention period.

(e) If the ownership of the facility changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide the Department with written documentation stating:

(1) That the new licensee shall have custody of the patients' health records and that these records or copies shall be available to the former licensee, the new licensee and other authorized persons; or

(2) That other arrangements have been made by the licensee for the safe preservation and the location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons; or

(3) The reason for the unavailability of such records.

(f) Patients' health records shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each patient. Such records shall be filed and maintained in accordance with these requirements and shall be available for review by the Department. All entries in the health record shall be authenticated with the date, name, and title of the persons making the entry.

(g) All current clinical information pertaining to a patient's stay shall be centralized in the patient's health record.

(h) Patient health records shall be filed in an accessible manner in the facility or in health record storage. Storage of records shall provide for prompt retrieval when needed for continuity of care. Health records can be stored off the facility premises only with the prior approval of the Department.

(i) The patient health record shall not be removed from the facility, except for storage after the patient is discharged, unless expressly and specifically authorized by the Department.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(37) Amend Section 72547 to read as follows:**

**Section 72547. Content of Health Records.**

(a) A facility shall maintain for each patient a health record which shall include:

(1) Admission record.

(2) Current report of physical examination, and evidence of tuberculosis screening.

(3) Current diagnoses.

(4) ~~Physician's or psychologist's orders~~ The orders of a licensed health care practitioner acting within the scope of his or her professional licensure, including drugs, treatment and diet orders, progress notes, signed and dated on each visit. ~~Physician's or psychologist's orders~~ The orders of a licensed health care practitioner acting within the scope of his or her professional licensure shall be correctly recapitulated.

(5) Nurses' notes which shall be signed and dated. Nurses' notes shall include:

(A) Records made by nurse assistants, after proper instruction, which shall include:

1. Care and treatment of the patient.

2. Narrative notes of observation of how the patient looks, feels, eats, drinks, reacts, interacts and the degree of dependency and motivation toward improved health.

3. Notification to the licensed nurse of changes in the patient's condition.

(B) Meaningful and informative nurses' progress notes written by licensed nurses as often as the patient's condition warrants. However, weekly nurses' progress notes shall be written by licensed nurses on each patient and shall be specific to the patient's needs, the patient care plan and the patient's response to care and treatments.

(C) Name, dosage and time of administration of drugs, the route of administration or site of injection, if other than oral. If the scheduled time is indicated on the record, the initial of the person administering the dose shall be

recorded, provided that the drug is given within one hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both initials and the time of administration. Medication and treatment records shall contain the name and professional title of staff signing by initials.

(D) Justification for the results of the administration of all PRN medications and the withholding of scheduled medications.

(E) Record of type of restraint and time of application and removal. The time of application and removal shall not be required for postural supports used for the support and protection of the patient.

(F) Medications and treatments administered and recorded as prescribed.

(G) Documentation of oxygen administration.

(6) Temperature, pulse, respiration and blood pressure notations when indicated.

(7) Laboratory reports of all tests prescribed and completed.

(8) Reports of all X-rays prescribed and completed.

(9) Progress notes written and dated by the activity leader at least quarterly.

(10) Discharge planning notes when applicable.

(11) Observation and information pertinent to the patient's diet recorded in the patient's health record by the dietitian, nurse or food service supervisor.

(12) Records of each treatment given by the therapist, weekly progress notes and a record of reports to the ~~physician or psychologist~~ licensed health care practitioner acting within the scope of his or her professional licensure after the first 2 two weeks of therapy and at least every 30 days thereafter. Progress notes written by the social service worker if the patient is receiving social services.

(13) Consent forms for prescribed treatment and medication not included in the admission consent for care.

(14) Condition and diagnoses of the patient at time of discharge or final disposition.

(15) A copy of the transfer form when the patient is transferred to another health facility.

(16) An inventory of all patients' personal effects and valuables as defined in Section 72545 (a) (12) made upon admission and discharge. The inventory list shall be signed by a representative of the facility and the patient or his authorized representative with one copy to be retained by each.

(17) The name, complete address and telephone number where the patient was transferred upon discharge from the facility.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(38) Amend Section 73077 to read as follows:**

**Section 73077. Patient.**

(a) "Patient" means a person accommodated in an intermediate care facility who because of a physical or mental condition, or both, requires supervision and nursing care, but does not in the opinion of the attending physician licensed healthcare practitioner acting within the scope of his or her professional licensure have an illness, injury or disability for which continuous skilled nursing care is required.

(b) Ambulatory Patient. "Ambulatory Patient" means a patient who is capable of demonstrating the mental competence and physical ability to leave a building without assistance or supervision of any person under emergency conditions.

(c) Nonambulatory Patient. "Nonambulatory patient" means a patient who is unable to leave a building unassisted under emergency conditions. It includes, but is not limited to, those persons who depend upon mechanical aids such as crutches, walkers, or wheelchairs, profoundly or severely mentally retarded persons and shall include totally deaf persons.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(39) Amend Section 73089 to read as follows:**

**Section 73089. Psychologist.**

"Psychologist" means a person licensed as a psychologist by the California Board of ~~Medical Examiners~~ Psychology and who meets the requirements set forth in California Health and Safety Code Section 1316.5 (d).

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(40) Amend Section 73301 to read as follows:**

**Section 73301. Required Services.**

(a) Intermediate care facilities shall provide as a minimum, but shall not be limited to, the following required services: Physician, intermittent nursing, dietary, pharmaceutical and an activity program.

(b) Intermediate care facilities caring for patients who are mentally disordered, developmentally disabled or substance abusers and who have identified program needs as described in Section 73391 shall meet also the requirements for a special disability service.

(c) Intermediate care facilities caring for day care patients shall meet all the requirements for inpatients and shall not exceed their licensed bed capacity.

(d) Written arrangements shall be made for obtaining all necessary diagnostic and therapeutic services prescribed by the attending physician, podiatrist, dentist or clinical psychologist subject to the scope of licensure and the policies of the facility. If the service cannot be brought into the facility, the facility shall assist the patient, if necessary, in arranging for transportation to and from the service location.

(e) Provision shall be made for dental examinations and dental treatments by a dentist as indicated by the needs of the patient.

(f) Arrangements shall be made for one or more physicians licensed healthcare practitioners acting within the scope of their professional licensure to be called in an emergency.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(41) Amend Section 73303 to read as follows:**

**Section 73303. Physician Services—General.**

(a) Physician services are services provided by physicians responsible for the care of individual patients in the facility. ~~All persons admitted or accepted for care by the intermediate care facility shall be under the care of a physician.~~ Physician services shall include but are not limited to:

(1) Patient examinations.

(2) Patient diagnosis.

(3) Advice, treatment and treatment plan, and determination of appropriate level of patient care needed for each patient.

(4) Written and signed orders for care, diagnostic tests and treatment of patients by others. Orders for restraints must specify the duration and circumstances under which the restraints are to be used and must comply with the following:

(A) Orders must be specific to individual patients.

(B) In accordance with Section 73355 there shall be no standing orders.

(C) There shall be no P.R.N. orders for physical restraints.

(5) Health record progress notes and other appropriate entries in the patient's health records.

(6) Periodic reevaluation of the patient's condition and the review and updating of treatment orders and care program at least every 60 days unless otherwise approved by the Department.

(7) Provision of emergency medical services in the facility when indicated.

(b) Subsection (a) shall not prevent or limit other licensed healthcare practitioners acting within the scope of their professional licensure from providing services to and being responsible for the care of individual patients in the facility, including providing those services listed in subsection (a) that are within the scope of their licensure.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code; and *Valdivia, et al. v. Coye*, U.S. District Court for the Eastern District of California, Case No. CIV S-90-1226.

**(42) Amend Section 73311 to read as follows:**

**Section 73311. Nursing Service—General.**

Nursing service shall include, but not be limited to, the following:

(a) Identification of problems and development of an individual plan of care for each patient based upon initial and continuing assessment of the patient's needs by the nursing staff and other health care professionals. The plan shall be reviewed and revised as needed but not less often than quarterly.

(b) Notification of the attending physician licensed healthcare practitioner acting within the scope of his or her professional licensure immediately of any patient exhibiting unusual signs or behavior.

(c) Ensuring that patients are served the diets as ~~prescribed~~ ordered by the attending ~~physicians~~ licensed healthcare practitioner acting within the scope of his or her professional licensure, and that patients are provided with the necessary and acceptable equipment for eating and that prompt assistance in eating is given when needed.

(d) Any marked or sudden change in weight shall be reported promptly to the attending physician licensed healthcare practitioner acting within the scope of his or her professional licensure.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(43) Amend Section 73313 to read as follows:**

**Section 73313. Nursing Service—Drug Administration.**

Nursing service shall include but not be limited to the following, with respect to the administration of drugs:

(a) Medications and treatments shall be administered as prescribed and shall be recorded in patient's health records.

(b) Preparation of doses for more than one scheduled administration time shall not be permitted.

(c) Medications shall only be administered by personnel who have completed a state-approved training program in medication administration.

(d) Medications shall be administered as soon as possible after doses are prepared and shall be administered by the same person who prepared the doses for administration. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber.

(e) Patients shall be identified prior to administration of a drug.

(f) The time and dose of drug administered to the patient shall be properly recorded in each patient's medication record by the person who administered the drug.

(g) No medication or treatment shall be given except on the order of a person lawfully authorized to give such order.

(h) Telephone orders shall be received only by a licensed nurse or pharmacist and shall be recorded immediately in the patient's health record and shall be signed by the prescriber within 48 hours.

(i) Medications brought by or with the patient to the facility shall not be used unless all of the conditions specified in Section 73363 are met.

(j) A registered nurse or a pharmacist shall review each patient's medications monthly and if appropriate, request a review from the patient's attending physician licensed healthcare practitioner acting within the scope of his or her professional licensure.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(44) Amend Section 73315 to read as follows:**

**Section 73315. Nursing Service—Patient Care.**

(a) No patient shall be admitted or accepted for care by an intermediate care facility except upon the order of a physician licensed healthcare practitioner acting within the scope of his or her professional licensure.

(b) Each patient shall be treated as an individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind.

(c) Each patient, upon admission, shall be given proper orientation to the intermediate care facility and the facility's services and staff.

(d) Each patient shall show evidence of good personal hygiene, including care of the skin, shampooing and grooming of hair, oral hygiene, shaving or beard trimming, cleaning and cutting of fingernails and toenails and shall be free of offensive odors.

(e) Each patient shall be encouraged and/or assisted to achieve and maintain his highest level of self-care and independence. Every effort shall be made to keep patients active except when contraindicated by physician's orders provided by a licensed health care practitioner acting within the scope of his or her professional licensure.

(f) Such supportive and restorative nursing and personal care needed to maintain maximum functioning of the patient shall be provided.

(g) Treatment for minor illness or routine treatments for minor disorders when ordered by the physician licensed health care practitioner acting within the scope of his or her professional licensure shall be administered by nursing personnel.

(h) Bedside nursing care may be provided on a temporary basis when the attending physician licensed health care practitioner acting within the scope of his or her professional licensure determines the illness to be temporary and minor.

(i) When a patient requires services which are not considered to be intermediate care services, the ~~physician or psychologist~~ licensed health care practitioner acting within the scope of his or her professional licensure shall be

notified and arrangements made to transfer the patient from the intermediate care facility.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(45) Amend Section 73325 to read as follows:**

**Section 73325. Dietetic Service— Food Service.**

(a) The dietetic service shall provide food of the quality and quantity to meet the patient's needs in accordance with ~~physicians' orders~~ of a licensed healthcare practitioner acting within the scope of his or her professional licensure and, to the extent medically possible, to meet "the Recommended Daily Dietary Allowance," 1974 Edition, adopted by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, 2107 Constitution Avenue, Washington, D.C., 20418; and the following:

(1) Not less than three meals shall be served daily.

(2) Not more than 14 hours shall elapse between the evening meal and breakfast of the following day.

(3) Nourishment or between meal feedings shall be provided as required by the diet prescription. Bedtime nourishments shall be offered to all patients unless contraindicated.

(4) Patient food preferences shall be adhered to as much as possible and substitutes for all food refused shall be from appropriate food groups.

(5) Table service shall be provided for all who can and wish to eat at a table. Tables of appropriate height shall be provided for wheelchairs.

(6) When food is provided by an outside commercial food service, all applicable requirements shall be met. The facility shall maintain adequate space, equipment and food supplies to provide patients' food service in emergencies.

(7) Food shall be prepared by methods that conserve nutritive value, flavor and appearance. Food shall be served attractively at appropriate temperatures and in a form to meet individual needs.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(46) Amend Section 73329 to read as follows:**

**Section 73329. Dietetic Service—Diet Manual.**

A current therapeutic diet manual, if appropriate, is approved by the dietitian and readily available to ~~attending physicians and nursing~~ and dietetic service personnel and licensed healthcare practitioners acting within the scope of their professional licensure or certification.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(47) Amend Section 73399 to read as follows:**

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code, Section 5325, Welfare and Institution Code.

**Section 73399. Special Disability Services—Rights of Patients.**

(a) Each patient admitted to a special disability program in an intermediate care facility shall have the following rights, a list of which shall be prominently posted in English and Spanish in all facilities providing such services, and otherwise brought to ~~his~~ the patient's attention by such additional means as is appropriate:

(1) To wear his or her own clothes; to keep and use his or her own personal possessions including ~~his~~ toilet articles; and to keep and be allowed to spend a reasonable sum of his or her own money for small purchases.

(2) To have access to individual storage space for ~~his~~ private use.

(3) To see visitors each day.

(4) To have reasonable access to telephones, both to make and receive confidential calls.

(5) To have ready access to letter writing materials, including stamps and to mail and receive unopened correspondence.

(6) To refuse shock treatment.

(7) To refuse lobotomy.

(8) Other rights as provided by law.

(b) The attending ~~physician or psychologist~~ licensed healthcare practitioner acting within the scope of his or her professional licensure or certification may, for good cause, deny a patient his or her rights under this section, except the right to refuse lobotomy or shock treatment. Any denial of a patient's rights shall be entered in the patient's health record.

(c) Information pertaining to denial of rights contained in the patient's health record shall be made available, on request, to the patient, ~~his~~ the patient's attorney, ~~his~~ the patient's conservator or guardian, or the Department, members of the State Legislature or a member of a county board of supervisors.

**(48) Amend Section 73409 to read as follows:**

**Section 73409. Special Disability Services—Orders for Restraint and Seclusion.**

(a) Restraint and seclusion shall only be used on the signed order of a physician licensed healthcare practitioner acting within the scope of his or her professional licensure which and shall be renewed every 24 hours. In a clear case of medical emergency, a physician licensed healthcare practitioner acting within the scope of his or her professional licensure may give the order by telephone. In such an event, the physician licensed healthcare practitioner shall sign the order within 48 hours.

(b) A daily log shall be maintained in each facility exercising behavior restraint and seclusion indicating the name of the patient for whom behavior restraint or seclusion is ordered, full documentation of the episode leading to the behavior restraint or seclusion, the type of the behavior restraint or seclusion used, the length of time and the name of the individual applying such measures.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(49) Amend Section 73449 to read as follows:**

**Section 73449. Social Work Service Unit.**

(a) Social work services are those services which assist staff, patients and patients' families to understand and cope with patient's personal, emotional and related health and environmental problems.

(b) A social work service unit shall meet the following requirements:

(1) The social worker, social work assistant or social work aide shall develop a plan, including goals and treatment, for social work services for each patient who needs them, with participation of the patient, the family, the patient's physician or psychologist licensed healthcare practitioner acting within the scope of his or her professional licensure, the supervisor of health services and other appropriate staff.

(2) Each patient within five days after admission shall be interviewed and a social work assessment completed. When indicated, a social work treatment plan reviewed and approved by the social worker shall be carried out, as appropriate, by the social worker, social work assistant or social work aide.

(3) Signed and dated progress reports shall be written at least monthly in the health record of each patient receiving social services, by the social worker, social work assistant or social work aide.

(4) The social worker, social work assistant or social work aide shall participate in regular staff conferences with the attending physician licensed healthcare practitioner acting within the scope of his or her professional licensure, the director of nursing service and other appropriate personnel.

(5) There shall be discharge planning and implementation through liaison with local health and welfare agencies, other community personnel and the patient's family or authorized representative.

(6) Orientation and in-service training of other staff members on all shifts shall be conducted at least monthly by the social worker in charge of the social work service, to assist in the recognition and understanding of the emotional problems and social needs of patients and families and to learn how to implement appropriate action to meet such identified needs. Orientation and

training shall include informing the staff about available community resources and services.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(50) Amend Section 73469 to read as follows:**

**Section 73469. Occupational Therapy Service Unit.**

(a) Occupational therapy is a ~~medically prescribed~~ service ordered by the licensed healthcare practitioner acting within the scope of his or her professional licensure, in which selected purposeful activity is used as treatment in the rehabilitation of persons with a physical or emotional disability.

(b) Occupational therapy service includes:

(1) Assisting the ~~physician~~ licensed healthcare practitioner acting within the scope of his or her professional licensure in his or her evaluation of a patient's level of function by applying diagnostic and prognostic tests.

(2) Reevaluating the patient as his condition changes and modifying treatment goals consistent with these changes.

(3) Decreasing or eliminating disability during a patient's initial phase of recovery following injury or illness.

(4) Increasing or maintaining a patient's capability for independence.

(5) Enhancing a patient's physical, emotional and social well-being.

(6) Developing function to a maximum level so that early testing can be applied for future job training and employment.

(7) Guiding patients in their use of therapeutic, creative and self-care activities for improving function.

(c) An occupational therapy service unit shall meet the following requirements:

(1) Health records shall contain pertinent information on the patient and procedures for obtaining signed medical orders.

(2) Notes shall indicate procedures performed and be signed by the occupational therapist.

(3) Initial evaluation, treatment plan and discharge summary shall be written and posted in each patient's health record.

(4) Progress notes shall be written and signed on each visit by the occupational therapist.

(5) Personnel policies shall define the occupational therapy director's responsibilities and the duties assigned to the occupational therapy assistant.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(51) Amend Section 73479 to read as follows:**

**Section 73479. Speech Pathology and/or Audiology Service Unit.**

(a) ~~Speech pathology and/or audiology services are physician-referred services referred by a licensed healthcare practitioner acting within the scope of his or her professional licensure or certification which provide for the provision of~~ diagnostic screening, preventive and corrective therapy for individuals with speech, hearing and/or language disorders.

(b) Speech pathology and/or audiology services include:

(1) Evaluation of patients to determine the type of speech, language and/or hearing disorder.

(2) Determination and recommendation of the appropriate speech, language and hearing therapy.

(3) Instruction of other health team personnel and family members in methods of assisting the patient to improve and/or correct speech or hearing disorders.

(c) A speech pathology and/or audiology service unit shall meet the following requirements:

(1) Health records shall include all pertinent information of patient history and background and a signed ~~medical~~ order for the service.

(2) Progress notes, including the patient's reaction to treatment and any change in condition, shall be written at least monthly and be signed by the speech pathologist and/or audiologist.

(3) Personnel policies shall define the duties of the speech pathology and audiology director and allied personnel in the speech and audiology service unit.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(52) Amend Section 73489 to read as follows:**

**Section 73489. Rehabilitation Service Unit.**

(a) Rehabilitation service is a service prescribed by a physician ordered by a licensed healthcare practitioner acting within the scope of his or her professional licensure for the purpose of maximum reduction of physical and/or psychological disability and restoration of the patient to the highest possible functional level.

(b) A rehabilitation service unit shall include all of the following services:

- (1) Physical Therapy.
- (2) Occupational Therapy.
- (3) Speech Pathology and/or Audiology.
- (4) Social Work Services.
- (5) Rehabilitation Nursing Services.

(c) A rehabilitation service unit shall meet the following requirements:

(1) Health records shall contain pertinent information of the patient's history and background and shall contain signed ~~medical~~ orders for the ~~prescribed~~ services needed.

(2) Daily notes shall indicate procedures performed and be signed by the appropriate discipline member.

(3) Initial evaluation, treatment plan and discharge summary shall be written and posted on each record.

(4) Progress notes shall be written and signed on each visit by the appropriate discipline member.

(5) Personnel policies shall define the duties of the director of rehabilitation service and auxiliary personnel.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(53) Amend Section 73517 to read as follows:**

**Section 73517. Admission of Patients.**

(a) The licensee shall:

(1) Admit a patient only on physician's orders of a licensed healthcare practitioner acting within the scope of his or her professional licensure.

(2) Accept and retain only those patients for whom it can provide adequate care.

(3) Admit each patient only after a preadmission personal interview according to the written policies of the facility, with the patient's ~~physician~~ licensed healthcare practitioner acting within the scope of his or her professional licensure, referring health practitioner, the patient, the patient's next of kin and/or sponsor, as appropriate. A telephone interview may be substituted when a personal interview is not feasible.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1315, 1316, and 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(54) Amend Section 73519 to read as follows:**

**Section 73519. Administrative Policies and Procedures.**

(a) Written administrative policies shall be reviewed and revised at least annually and shall include the following:

(1) Written management and personnel policies to govern the administration of the intermediate care facility shall be established and implemented. Job descriptions detailing the functions of each classification of employee shall be written and available to all personnel. Facility policies shall adhere to the requirements of Sections 1316 and 1316.5 of the Health and Safety Code.

(2) All intermediate care facilities shall have written admission and discharge policies which shall include rate of charge for care, charges for extra services, limitation of services, cause for termination of services and refund policies applying to termination of services. These policies shall be made available to patients or their agents upon admission and upon request and shall be made available to the public upon request.

(b) The following types of patients shall not be admitted, nor cared for, in an intermediate care facility:

(1) Persons with a communicable disease.

(2) Mentally disturbed persons who require special services not available in the intermediate care facility.

(3) Mentally retarded persons requiring special services not available in the intermediate care facility.

(4) Persons requiring skilled nursing care and observation on a 24-hour basis.

(5) Those requiring daily care by a physician the admitting licensed health care practitioner acting within the scope of his or her professional licensure.

(c) All patients shall have a tuberculosis screening procedure done upon admission. These procedures shall be determined by the patient care policy committee. Subsequent tuberculosis screening procedures shall be determined

by attending physicians. A tuberculosis screening procedure may not be required if there is satisfactory written evidence available that a tuberculosis screening procedure has been completed within 90 days of the date of admission to the intermediate care facility.

(d) Nondiscrimination Policies. No intermediate care facility shall deny admission to a patient on account of race, color, religion, ancestry or national origin except as provided in this section. Admission policies shall state that, except as provided herein, patients will be accepted for care and cared for without discrimination on the basis of race, color, religion, ancestry or national origin.

Any bona fide nonprofit religious, fraternal or charitable organization which can demonstrate to the satisfaction of the Department that its primary or substantial purpose is not to evade this section may establish admission policies limiting or giving preference to its own members or adherents and such policies shall not be construed as a violation of the first paragraph of this subdivision. Any admission of nonmembers or nonadherents shall be subject to the first paragraph of this subdivision.

(e) Written policies and procedures governing patient health records shall be developed with the assistance of a person skilled in record maintenance and preservation. Health records shall be stored and systematically organized to facilitate retrieving of information.

(f) The ~~P~~patient ~~C~~care ~~P~~policy ~~C~~committee shall implement the provisions of the Health and Safety Code, Sections 1315, 1316 and 1316.5, by means of written policies and procedures.

~~(1) Facilities which choose to allow clinical psychologists to refer patients for admissions shall do so only if there are physicians who will provide the necessary medical care for the referred patients.~~

~~(2)~~(g) Only physicians a licensed health care practitioner acting within the scope of his or her professional licensure shall assume overall care of patients including performing the admitting history and physical examinations.

~~(3) Facilities which choose to allow dentists to refer patients for admission shall do so only if there are physicians who will provide the necessary~~

medical care for the referred patients. Dentists shall perform only those duties lawfully authorized by their practice act.

~~(g) The patient care policy committee shall implement the provisions of Health and Safety Code, Section 1316, by means of written policies.~~

~~(1) Facilities which choose to allow podiatrists to refer patients for admission shall do so only if a physician provides necessary medical care for the referred patient.~~

~~(2) Only physicians shall assume overall care of patients, including performing the admitting history and physical examinations.~~

NOTE: Authority cited: Sections ~~298(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1315, 1316, and 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(55) Amend Section 73523 to read as follows:**

**Section 73523. Patients' Rights.**

(a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request.

Patients shall have the right:

(1) To be fully informed, as evidenced by the patient's written acknowledgment prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facilities' basic per diem rate or not covered under Title XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing, and psychosocial needs and the planning of related services.

(4) To consent to or to refuse any treatment or procedure or participation in experimental research.

(5) To receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure. The disclosure of material information for administration of psychotherapeutic drugs or physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function shall include the disclosure of information listed in Section 73524(c).

(6) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(7) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(8) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept his written delegation of this responsibility subject to the provisions of Section 73557.

(9) To be free from mental and physical abuse.

(10) To be assured confidential treatment of the patient's financial and health records and to approve or refuse their release, except as authorized by law.

(11) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.

(12) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(13) To associate and communicate privately with persons of the patient's choice, and to send and receive his personal mail unopened.

(14) To meet with and participate in activities of social, religious and community groups at the patient's discretion.

(15) To retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients.

(16) If married, to be assured privacy for visits by the patient's his/her spouse and, if both are patients in the facility, to be permitted to share a room.

(17) To have daily visiting hours established.

(18) To have visits from members of the clergy at the request of the patient or the patient's representative.

(19) To have visits from persons of the patient's choosing at any time if the patient is critically ill, unless medically contraindicated.

(20) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(21) To have reasonable access to telephones both to make and receive confidential calls.

(22) To be free from any requirement to purchase drugs or rent or purchase medical supplies or equipment from any particular source in accordance with the provisions of Section 1320 of the Health and Safety Code.

(23) To be free from psychotherapeutic and/or physical restraints used for the purpose of patient discipline or staff convenience and to be free from psychotherapeutic drugs used as a chemical restraint as defined in Section 73012, except in an emergency which threatens to bring immediate injury to the patient or others. If a chemical restraint is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient and used only for a specified and limited period of time.

(24) Other rights as specified in Health and Safety Code Section 1599.1.

(25) Other rights as specified in Welfare and Institutions Code Sections 5325 and 5325.1 for persons admitted for psychiatric evaluations or treatment.

(26) Other rights as specified in Welfare and Institutions Code, Sections 4502, 4503 and 4505 for patients who are developmentally disabled as defined in Section 4512 of the Welfare and Institutions Code.

(b) A patient's rights as set forth above may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented in the patient's health record.

(c) If a patient lacks the ability to understand these rights and the nature and consequences of proposed treatment, the patient's representative shall have the rights specified in this section to the extent the right may devolve to another, unless the representative's authority is otherwise limited. The patient's incapacity shall be determined by a court in accordance with state law or by the patient's physician licensed healthcare practitioner acting within the scope of his or her professional licensure unless the ~~physician's~~ physician's determination of the licensed

healthcare practitioner acting within the scope of his or her professional licensure is disputed by the patient or patient's representative.

(d) Persons who may act as the patient's representative include a conservator, as authorized by Parts 3 and 4 of Division 4 of the Probate Code (commencing with Section 1800), a person designated as attorney in fact in the patient's valid durable power of attorney for health care, patient's next of kin, other appropriate surrogate decisionmaker, designated consistent with statutory and case law, a person appointed by a court authorizing treatment pursuant to Part 7 (commencing with Section 3200) of Division 4 of the Probate Code, or, if the patient is a minor, informed consent must be obtained from a person lawfully authorized to represent the minor.

(e) Patients' rights policies and procedures established under this section concerning consent, informed consent and refusal of treatments or procedures shall include, but not be limited to the following:

(1) How the facility will verify that informed consent was obtained pertaining to the administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability of the patient to regain the use of a normal bodily function.

(2) How the facility, in consultation with the patient's physician licensed healthcare practitioner acting within the scope of his or her professional licensure, will identify, consistent with current statutory and case law, who may serve as a patient's representative when an incapacitated patient has no conservator or attorney in fact under a valid durable Power of Attorney for Health Care.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 1320, 1599, and 1599.1, 131050, 131051 and 131052, Health and Safety Code; and *Cobbs v. Grant* (1972) 8 Cal.3d 299.

(56) Amend Section 73524 to read as follows:

**Section 73524. Informed Consent Requirements.**

(a) It is the responsibility of the attending physician licensed healthcare practitioner acting within the scope of his or her professional licensure, to determine what information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. Information that is commonly appreciated need not be disclosed. The disclosure of the material information and obtaining informed consent shall be the responsibility of the physician licensed healthcare practitioner who, acting within the scope of his or her professional licensure, performs or orders the procedure or treatment for which informed consent is required.

(b) The information material to a decision concerning the administration of a psychotherapeutic drug or physical restraint, or the prolonged use of a device that may lead to the inability of the patient to regain use of a normal bodily function shall include at least the following:

(1) The reason for the treatment and the nature and seriousness of the patient's illness.

(2) The nature of the procedures to be used in the proposed treatment including their probable frequency and duration.

(3) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.

(4) The nature, degree, duration and the probability of the side effects and significant risks, commonly known by the health professions.

(5) The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment.

(6) That the patient has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time.

(c) Before initiating the administration of psychotherapeutic drugs, or physical restraints, or the prolonged use of a device that may lead to the inability

to regain use of a normal bodily function, facility staff shall verify that the patient has given informed consent to the proposed treatment or procedure. The facility shall also ensure that all decisions concerning the withdrawal or withholding of life sustaining treatment are documented in the patient's health record.

(d) This section shall not be construed to require obtaining informed consent each time a treatment or procedure is administered unless material circumstances or risks change.

(e) There shall be no violation for initiating treatment without informed consent if there is documentation within the patient's health record that an emergency exists where there is an unanticipated condition in which immediate action is necessary for preservation of life or the prevention of serious bodily harm to the patient or others or to alleviate severe physical pain, and it is impracticable to obtain the required consent, and provided that the action taken is within the customary practice of physicians licensed healthcare practitioners of good standing acting within the scope of their professional licensure in similar circumstances.

(f) Notwithstanding Sections 73523(a)(5) and 73524(c)(4), disclosure of the risks of a proposed treatment or procedure may be withheld if there is documentation of one of the following in the patient's health record:

(1) That the patient or patient's representative specifically requested that he or she not be informed of the risk of the recommended treatment or procedure. This request does not waive the requirement for providing the other material information concerning the treatment or procedure.

(2) That the physician licensed healthcare practitioner acting within the scope of his or her professional licensure relied upon objective facts, as documented in the health record, that would demonstrate to a reasonable person that the disclosure would have so seriously upset the patient that the patient would not have been able to rationally weigh the risks of refusing to undergo the recommended treatment and that unless inappropriate a patient's representative gave informed consent as set forth herein.

(g) A general consent provision in a contract for admission shall only encompass consent for routine nursing care or emergency care. Routine nursing

care, as used in this section, means a treatment or procedure that does not require informed consent as specified in Section 73524(c)(1) through (6) or that is determined by the physician licensed healthcare practitioner acting within the scope of his or her professional licensure not to require the disclosure of information material to the individual patient. Routine nursing care includes, but is not limited to, care that does not require the order of a physician licensed healthcare practitioner acting within the scope of his or her professional licensure. This section does not preclude the use of informed consent forms for any specific treatment or procedure at the time of admission or at any other time. All consent provisions or forms shall indicate that the patient or incapacitated patient's representative may revoke his or her consent at any time.

(h) If a patient or his or her representative cannot communicate with the physical licensed healthcare practitioner acting within the scope of his or her professional licensure because of language or communication barriers, the facility shall arrange for an interpreter.

(1) An interpreter shall be someone who is fluent in both English and the language used by the patient and his or her legal representative, or who can communicate with a deaf person, if deafness is the communication barrier.

(2) When interpreters are used, documentation shall be placed in the patient's health record indicating the name of the person who acted as the interpreter and his or her relationship to the patient and to the facility.

NOTE: Authority cited: Sections ~~208(a)~~ and 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code; and *Cobbs v. Grant* (1972) 8 Cal.3d 229.

**(57) Amend Section 73543 to read as follows:**

**Section 73543. Patients' Health Records.**

(a) Records shall be permanent, either typewritten or legibly written with pen and ink and shall be kept on all patients admitted or accepted for treatment. All health and social records of discharged patients shall be completed and filed within 30 days and such records shall be kept for a minimum of seven years, except for minors whose records shall be kept at least until one year after the minor has reached the age of 18 but in no case less than seven years. If a facility operates an X-ray unit, all exposed X-ray film shall be retained for seven years. All required records, either originals or faithful and accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon request of the attending physician licensed healthcare practitioner acting within the scope of his or her professional licensure, the facility or any authorized officer, agent or employee of either or any other person authorized by law to make such request.

(b) Information contained in the records shall be treated as confidential and disclosed only to authorized persons.

(c) If a facility ceases operation, the Department shall be informed immediately of the arrangements made for the safe preservation of the patients' records.

(d) The Department shall be informed in writing immediately whenever patients' health records are defaced or destroyed before termination of the required retention period.

(e) If the ownership of the facility changes, both the licensee and the new applicant for the new license shall, prior to the change of ownership, provide the Department with written documentation, stating:

(1) That the new licensee will have custody of the patients' records and these records will be available to the former licensee, the new licensee and other authorized persons; or

(2) That other arrangements have been made by the current licensee for the safe preservation and location of the patients' health records, and that

they are available to both the new and former licensees and other authorized persons; or

(3) The reasons for the unavailability of such patients' health records.

(f) Patients' health records shall be current and kept in detail consistent with acceptable professional practice based on the service provided to each patient. Such records shall be filed and maintained in accordance with these requirements and shall be available for review by the Department.

(g) Patients' health records shall be filed and stored so as to be protected against loss, destruction or unauthorized use.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(58) Amend Section 73547 to read as follows:**

**Section 73547. Content of Health Records.**

(a) A facility shall maintain for each patient a health record which shall include the following:

- (1) Diagnoses (current).
- (2) Drug and treatment orders.
- (3) Diet orders.
- (4) Progress notes written at the time of visit by professional personnel

in attendance to the patient.

(5) Nurses' notes which shall include:

(A) Narrative notes made by nurses' aides when appropriate, and after

such aides have been properly instructed. They shall include:

1. Care and treatment done with and for the patient.
2. Patients' reactions to care and treatment.
3. Daily observation of how the patient looks, feels, reacts, interacts,

degree of dependency and motivation towards improved health.

(B) Meaningful and informative nurses' progress notes written by licensed nurses as often as the patient's condition warrants. However, weekly nurses' progress notes shall be written by licensed personnel on each patient and shall be specific to the psychological, emotional, social, spiritual, recreational needs and related to the patient care plans.

Progress notes reflecting observations of the patient's response to his environment, physical limitations, independent activities, dependency status, behavioral changes, skin problems, dietary problems and restorative measures to characterize the functional status of progression and/or regression.

(C) Name, dosage and time of administration of drugs, the route of administration if other than oral and site of injection. If the scheduled time is indicated on the record the initial of the person administering the dose shall be recorded, provided that the drug is given within one hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both his initials and the time of administration.

(D) Justification for and the results of the administration of all P.R.N. medications and the withholding of scheduled medications.

(E) Record of type of restraint and time of application and removal. The time of application and removal shall not be required for soft tie restraints prescribed by the physician used for the support and protection of the patient.

(F) Medications and treatments administered and recorded as prescribed.

(6) Current history and physical examination or appropriate health evaluation.

(7) Temperature, pulse and respiration where indicated.

(8) Laboratory reports of all tests prescribed and completed.

(9) Reports of all X-rays prescribed and taken.

(10) Condition and diagnosis of patient at time of discharge and final disposition.

(11) Physician Orders provided by a licensed healthcare practitioner acting within the scope of his or her professional licensure, including drug, treatment and diet orders signed on each visit. Physician Orders provided by the licensed healthcare practitioners acting within the scope of his or her professional licensure recapitulated as appropriate.

(12) Observation and information pertinent to the dietetic treatment recorded in the patient's health record by the dietitian or nurse. Pertinent dietary records shall be included in patient's transfer records to ensure continuity of nutritional care.

(13) Consent forms for prescribed treatment and medication.

(14) An inventory of all patients' personal effects and valuables made upon admission and discharge. The inventory list shall be signed by a representative of the facility and the patient or his authorized representative with one copy to be retained by each.

NOTE: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code

**(59) Amend Section 79315 to read as follows:**

**Section 79315. Restraints.**

(a) Physical restraints shall only be used as a measure to protect the patient from injury to self or others.

(b) Treatment restraints shall only be used during medically prescribed treatment or diagnostic procedures.

(c) Physical and treatment restraints shall only be used upon a physician's written or verbal order of a licensed health care practitioner acting within the scope of his or her professional licensure. Telephone orders shall be received only by authorized professional staff, shall be recorded immediately in the patient's health record and shall be signed by the ordering licensed health care practitioner ~~prescriber~~ within five days.

(d) Restraints shall not be used as punishment or as a substitute for more effective programming or for the convenience of the staff.

(e) Orders for physical restraints shall be in force for not longer than 24 hours.

(f) There shall be no PRN orders (as needed orders) for physical or treatment restraints.

(g) Patients shall be restrained only in an area that is under direct observation of staff and shall be afforded protection from other patients who may be in the area.

(h) A patient placed in physical restraints shall be checked at least every 15 minutes by professional staff to assure that the restraint remains properly applied. A written record shall be kept of these checks and maintained in the individual patient's health record.

NOTE: Authority cited: Sections ~~208(a)~~, 1275, and 1275.2, 100275 and 131200, Health and Safety Code. Reference: Sections 1250.3, 1254, 1254.2, and 1275.2, 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(60) Amend Section 79351 to read as follows:**

**Section 79351. Patient Health Record Availability.**

(a) Accurate and complete records shall be maintained on all patients admitted or accepted for treatment. All required records, either originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon the request of:

(1) The attending physician licensed healthcare practitioner acting within the scope of his or her professional licensure;

(2) Any authorized employee, agent or officer of the hospital;

(3) Authorized representatives of the Department; or

(4) Any person authorized by law to make such a request.

(b) The patient health record is the property of the CDRH and is maintained for the benefit of the patient, the attending physician, the staff and the CDRH. The CDRH shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

(c) Patient health records or reproductions thereof shall be preserved safely for a minimum of seven (7) years following discharge of the patient, except that the records of minors shall be kept at least one (1) year after such minor has reached the age of 18 years and, in all cases not less than seven (7) years.

(d) If a CDRH ceases operation, the Department shall be informed within 48 hours of the arrangements made for safe preservation of patient health records as above required.

(e) If ownership of a CDRH changes, both the previous licensee and the new licensee shall, prior to the change of ownership, provide the Department with written documentation that:

(1) The new licensee will have custody of the patients' health records upon transfer of the CDRH and the health records are available to both the new and former licensee and other authorized persons; or

(2) Arrangements have been made for the safe preservation of patients' health records, and that the health records are available as required in (1) above.

(f) Patient health records shall be filed in an easily accessible manner in the CDRH or in a Department-approved health record storage facility off the CDRH premises.

(g) Patient health records shall be completed promptly and authenticated or signed by the attending physician or psychologist within two weeks following the patient's discharge. Patient health records may be authenticated by a signature stamp or computer key, in lieu of the attending physician's or psychologist's signature, only when that physician has placed a signed statement in the CDRH administrative offices to the effect that he/she is the only person who:

(1) Has possession of the stamp or key.

(2) Will use the stamp or key.

(h) Patient health records shall be indexed according to patient, diagnosis and physician.

(i) A unit health record system shall be established and implemented with inpatient, outpatient and emergency room records combined.

NOTE: Authority cited: Sections ~~209(a)~~, 1275, and 1275.2, 100275 and 131200, Health and Safety Code, and *CAPP v. Rank* (1990) 51 Cal 3d 1. Reference: Sections 1250.3, 1260.3, and 1275.2, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(61) Amend Section 79637 to read as follows:**

**Section 79637. Nursing Service—Patient Care.**

(a) No patient shall be admitted or accepted for care by a correctional treatment center except on the order of a physician licensed healthcare practitioner acting within the scope of his or her professional licensure.

(b) Each patient shall be treated as an individual with dignity and respect, and shall not be subjected to verbal or physical abuse of any kind from employees or independent contractors of the licensee.

(c) Each patient, upon admission, shall be given orientation to the unit, emergency call system, patients' rights and rules of behavior.

(d) Each patient shall be provided care which shows evidence of good personal hygiene, except where staff safety may be compromised, including care of the skin, shampooing and grooming of hair, oral hygiene, shaving or beard trimming (except where contraindicated due to criminal identification purposes), cleaning and cutting of fingernails and toenails. The patient shall be kept free of offensive odors.

(e) Patients, when indicated, shall be given care to prevent formation and progression of decubiti, contractures, and deformities. Such care shall include:

- (1) Changing position of bedfast and chairfast patients with preventive skin care in accordance with the needs of the patient.
- (2) Encouraging, assisting and training in self-care and activities of daily living.
- (3) Maintaining proper body alignment and joint movement to prevent contractures and deformities.
- (4) Using pressure-reducing devices where indicated.
- (5) Providing care to maintain clean, dry skin free from feces and urine.
- (6) Changing of linens and other items in ~~contact~~ contact with the patient, as necessary, to maintain a clean, dry skin free from feces and urine.

(7) Carrying out of physician's orders for treatment of decubitus ulcers. The facility shall notify the physician when a decubitus ulcer first occurs, as well as when treatment is not effective, and shall document such notification.

(f) Each inmate-patient who requires help in eating shall be provided with assistance when served, and shall be provided with training or adaptive equipment in accordance with identified needs, based upon patient assessment, to encourage independence in eating.

(g) Each inmate-patient shall be provided with good nutrition and with necessary fluids for hydration.

(h) Fluid intake and output shall be recorded for each inmate-patient as follows:

(1) If ordered by the physician licensed healthcare practitioner acting within the scope of his or her professional licensure.

(2) For each ~~inmate-physician~~ inmate-patient with an indwelling catheter or receiving intravenous or tube feedings.

(i) The weight and length of each inmate-patient shall be taken and recorded in the inmate-patient's health record upon admission. The weight shall be taken and recorded once a month thereafter.

(j) Each inmate-patient shall be provided visual privacy during medical treatments and personal care, unless contraindicated due to security considerations.

(k) Inmate-patient call signals shall be answered promptly.

(l) The following shall be easily accessible at each nurse's station.

(1) The correctional treatment center's infection control policies and procedures.

(2) Names, addresses and telephone numbers of local health officers.

(3) The correctional treatment center's current diet manual.

(4) The correctional treatment center's current drug formulary.

(5) The correctional treatment center's current nursing policy and procedure manual.

NOTE: Authority cited: Sections ~~208(a)~~ and 1267.10(a), 100275 and 131200, Health and Safety Code. Reference: Sections 1250(j), and 1254, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**(62) Amend Section 79689 to read as follows:**

**Section 79689. Dietary Service Therapeutic Diets.**

(a) Therapeutic diets shall be provided as ~~prescribed~~ ordered by the attending physician licensed healthcare practitioner acting within the scope of his or her professional licensure and shall be planned by a registered dietitian. Therapeutic diets shall be prepared and served with supervision or consultation from a registered dietitian.

(b) Dietary service staff who prepare and serve therapeutic diets shall have received in-service training on the dietary standards and food groups and therapeutic diets and shall have sufficient knowledge of food values to make appropriate substitutions.

NOTE: Authority cited: Sections ~~208(a)~~ and 1267.10(a), 100275 and 131200, Health and Safety Code. Reference: Sections 1250(j), and 1254, 1316.5, 131050, 131051 and 131050, Health and Safety Code.