General Acute Care Hospital Relicensing Survey
Regulations with Survey Procedures

DATE(S) OF SURVEY:

License Number	Facility Name & Address (City, State, Zip)
Type of Survey:	
Name of Team Leader Evaluator & Professional Title	

List Additional Evaluators & Titles	List Additional Evaluators & Titles

SURVEY TEAM COMPOSITION (indicate the number of Evaluators according to discipline) Total # of Evaluators Onsite: __

	HFEN			Other:
	HFE			
	Dietitian			
	Pharmacist			
	Physician			
	Life Safety Code Surveyor			
	Records Administrator			
	Infection Control Specialist			
	Occupational Therapist			
	Consultant			

GACH RELICENSING SURVEY

This document provides guidance to surveyors to complete a General Acute Care Hospital Re-Licensing Survey. All California Code of Regulation, Title 22 General Acute Care Hospital requirements may be used to complete the survey. In addition, all other applicable California laws, such as the Health & Safety Code, pertaining to General Acute Care Hospitals, may be used.

Title 22 is divided into 9 Articles as follows:

Article 1- Definitions
Article 2- License
Article 3- Basic Services
Article 4- Supplemental Services Approval
Article 5- Special Permits
Article 6- Supplemental Services
Article 7- Administration
Article 8- Physical Plant
Article 9-Regs for Small & Rural hospitals

The emphasis or selection of specific Title 22 regulations under each Article in this document does not indicate that some regulations are more important than others. The emphasis is to highlight regulations that can generally be reviewed by surveyors without contact with other State modalities and resources, such as, the application unit, the life and safety unit, consultants, etc. However the process does not inhibit the use of other CDPH resources as needed and all Title 22 requirements apply.

This guidance provides clarifying language and probes for the surveyor but does not lessen the obligation of each surveyor to identify possible violations using the actual regulation or law text.

The term “verify” is used repeatedly in this document. The meaning reflects the use of observation, interview, and record reviews to obtain the necessary information regarding compliance decisions. Allow for your observations to help direct the path to individuals to interview, documents to review including any policy/procedure necessary to validate facilitate practice expectations.

Reviewing of hospital policies and procedures – hospitals have very extensive policies and procedures. It is not an efficient use of surveyor time to ask to see all policies and procedures related to one or more of the basic services, nor is this an effective means of assessing whether the hospital's procedures comply with the regulations. Although there can be exceptions, the method surveyors generally follow involves looking later at policies and procedures as a means of validating or gathering additional supporting evidence collected first through observation and interview. If a potential deficiency has been discovered, ask for the corresponding policy and procedure.

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STATE STANDARD	REQUIREMENT
	ARTICLE 1 DEFINITIONS
§ 70001	**Meaning of Words** Words shall have their usual meaning unless the context or a definition clearly indicates a different meaning. Words used in the present tense include the future; words in the singular number include the plural number; words in the plural number include the singular number; and words in the masculine include the feminine. Shall mean mandatory. May means permissive. Should means suggested or recommended.
§ 70003	**Hospital.** Hospital means a general acute care hospital.
§ 70005	**General Acute Care Hospital.** (a) General acute care hospital means a hospital , licensed by the Department, having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical. Anesthesia, laboratory, radiology, pharmacy , and dietary services. (b) A general acute care hospital shall not include separate buildings which are used exclusively to house personnel or provide activities not related to hospital patients.
§ 70006	**Acute Psychiatric Care Bed Classification.** Acute psychiatric care bed classification means beds designated for acute psychiatric, developmentally disabled or drug abuse patients receiving 24-hour medical care.
§ 70007	**Alteration.** Alteration means any change in the construction or configuration other than maintenance in an existing building and which does not increase the floor or roof area or the volume of enclosed space.
§ 70009	**Autoclaving.** Autoclaving means the process of sterilization by steam under pressure.
§ 70011	**Basic Services.** Basic services means those essential services required by law for licensure as a hospital including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services.
§ 70012	**Certificate of Exemption.** Certificate of Exemption mea ns a document containing Department approval for the exemption of a specified project from Certificate of Need review.
§ 70012.1	**Certificate of Need.** Certificate of need means a document containing Department approval for a specified project.

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§ 70015	**Cleaning.** Cleaning means the process employed to free a surface from dirt or other extraneous material.
§ 70016	**Competency Validation for Patient Care Personnel Other Than Registered Nurses.** Competency validation for patient care personnel other than registered nurses is a determination based on an individual 's satisfactory performance of each specific element of his/her job description , and of the specific requirements for the patient care unit in which he or she is employed. NOTE: Authority cited: Sections l 00275(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.
§ 70016.1	**Competency Validation for Registered Nurses.** Competency validation for registered nurses is a determination based on the satisfactory performance of: (I) The statutorily recognized duties and responsibilities of the registered nurse, as set forth in Business and Professions Code Section 2725, et seq., and regulations promulgated thereunder; and (2) The standards required under Section 702 I 3(c) which are specific to each patient care unit. NOTE : Authority cited: Sections l00275(a) and 1275, Health and Safety Code. Reference: Section 2725, Business and Professions Code; and Section 1276, Health and Safety Code.
§ 70017	**Conservator.** Conservator means a person appointed by the court to take care of the person, the property, or both, of a conservatee under Section 5350, et seq., of the Welfare and Institutions Code, or under Section 1701, et seq., of the Probate Code.
§ 70018	**Critical Burn.** (a) Critical burn means any one or more of the following types of burns: (1) Second degree bums exceeding 30 percent of the body surface. (2) Third degree burns of the face, hands, feet and/or genitals. (3) Third degree burns exceeding 10 percent of the body surface. (4) Burns complicated by respiratory tract injury, major soft tissue injury or fractures. (5) Electrical bums. (6) Any combination of second and third degree bums which in the aggregate poses a medical problem equivalent in seriousness to (1) through (5).
§ 70019	**Defined.** Defined means defined in writing.
§ 70021	**Department.** Department means the State Department of Health Services.
§ 70023	**Director.** Director means the Director of the State Department of Health Services.

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§ 70025	**Disinfection.** Disinfection means the process employed to destroy harmful microorganisms, but ordinarily not viruses and bacterial spores.
§ 70027	**Distinct Part.** Distinct part means an identifiable unit accommodating beds and related facilities including, but not limited to, contiguous rooms, a wing, floor or building that is approved by the Department for a specific purpose.
§ 70029	**Drug Administration.** Drug administration means the act in which a single dose of a pre- scribed drug or biological is given to a patient by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed properly labeled container, including a unit dose container, verifying the dose with the prescriber's orders, giving the individual dose to the proper patient and promptly recording the time and dose given.
§ 70031	**Drug Dispensing.** Drug dispensing means the act entailing the interpretation of an order for a drug or biological and, pursuant to that order, the proper selection, measuring, packaging, labeling and issuance of the drug or biological for a patient or for a service unit of the hospital.
§ 70033	**Existing Hospital Building.** Existing hospital building means an extant structure intended for proper hospital use. This excludes physician offices contiguous with the hospital and independent of the hospital as far as ownership.
§ 70034	**General Acute Care Bed Classification.** (a) "General acute care bed classification" means beds designated for bum, coronary, intensive care, medical-surgical, pediatric, perinatal, rehabilitation, acute respiratory or tuberculosis patients receiving 24-hour medical care. (b) Specialized care with respect to special hospitals shall be considered to be general acute care. NOTE: Authority cited: Sections 208 and 1250.1, Health and Safety Code. Reference: Chapter 854, Statutes of 1976. HISTORY 1. New section filed 10--5-76 as an emergency; effective upon filing (Register 76, No. 41). Certificate of Compliance filed 1-31-77 (Register 77, No. 6).
§ 70035	**Governing Body.** Governing body means the person, persons, board of trustees, directors or other body in whom the final authority and responsibility is vested for conduct of the hospital.
§ 70037	**Guardian.** Guardian means a person appointed by the court to take care of the person or the property, or both, of a ward under Section 1400 et seq., of the Probate Code.

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§ 70037.1	**Human Reproductive Sterilization.** (a) Human reproductive sterilization means any medical treatment, procedure or operation, for the purpose of rendering an individual permanently incapable of reproducing. (b) In this section and in Sections 70707.1 through 70707.8 and 70736, "sterilization" means human reproductive sterilization.
§ 70038	**Intermediate Care Bed Classification.** “Intermediate care bed classification” means beds designated for patients requiring skilled nursing
§ 70041	**License.** License means the basic document issued by the Department permit- ting the operation of a hospital. This document constitutes the authority to receive patients and to perform the services included within the scope of these regulations and as specified on the hospital license.
§ 70042	**License Category.** (a) License category means any of the following categories: (1) General acute care hospital. (2) Acute psychiatric hospital. (3) Skilled nursing facility. (4) Intermediate care facility.
§ 70043	**Licensee.** Licensee means the person, persons, firm, business trust, partnership, association, corporation, political subdivision of the State or other governmental agency within the State to whom a license has been issued.
§ 70045	**Maintenance.** Maintenance means the upkeep of a building and equipment to preserve the original functional and operational state.
§ 70047	**New Construction.** New construction means any of the following: New buildings. Additions to existing buildings. Conversions of existing buildings or portions thereof not currently licensed as a hospital.
§ 70048	**New Special Service.** (a) New special service means any special service identified in Section 70351 of this Chapter which is either offered or is intended to be offered and which was not approved by the Department prior to September 9, 1976. Approval of the Department is inferred if one of the following conditions exist: (1) The special service in question has been evaluated by the Department subsequent to July 13, 1975 and prior to September 9, 1976 and was found to be in compliance with all regulations regarding the

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	service. (2) The special service in question was being provided prior to July 13, 1975, has been provided continuously since that date, and has not been inspected and evaluated by the Department for the quality of the service provided. Departmental approval in this case can be inferred only until such time as the service is evaluated by the Department.
§ 70049	**Nursing Unit.** Nursing unit means a designated patient-care area of the hospital which is planned, organized, operated and maintained to function as a unit. It includes patient rooms with adequate support facilities, services and personnel providing nursing care and necessary management of patients.
§ 70051	**Outpatient Service.** An outpatient service means an organizational unit of the hospital which provides nonemergency health care services to patients.
§ 70053	**Patient.** (a) Patient means a person who is receiving diagnostic , therapeutic or preventive health services or who is under observation or treatment for illness or injury or care during and after pregnancy. (1) An inpatient means a person who has been formally admitted for observation, diagnosis or treatment and who is expected to remain over- night or longer. (2) An outpatient means a person who has been registered or accepted for care but not formally admitted as an inpatient and who does not re- main over 24 hours. (3) Ambulatory patient means a patient who is capable of demonstrating the mental competence and physical ability to leave a building under emergency conditions without assistance or supervision of any person . (4) 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 blind and totally deaf persons.
§ 70053.1	**Patient Care Personnel.** Patient care personnel means hospital personnel, licensed and unlicensed, who provide nursing care to patients, including any unlicensed personnel who assist with simple nursing procedures. NOTE: Authority cited: Sections 100275(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.
§ 70053.2	**Patient Classification System.** (a) Patient classification system means a method for establishing staffing requirements by unit, patient, and shift that includes: (1) A method to predict nursing care requirements of individual patients.

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	(2) An established method by which the amount of nursing care needed for each category of patient is validated for each unit and for each shift. (3) An established method to discern trends and patterns of nursing care deli very by each unit, each shift, and each level of licensed and unlicensed staff. (4) A mechanism by which the accuracy of the nursing care validation method described in (a)(2) above can be tested. This method will address the amount of nursing care needed, by patient category and pattern of care delivery, on an annual basis, or more frequently, if warranted by the changes in patient populations, skill mix of the staff, or patient care delivery model. (5) A method to determine staff resource allocations based on nursing care requirement s for each shift and each unit. (6) A method by which the hospital validates the reliability of the patient classification system for each unit and for each shift. NOTE: Authority cited: Sections 100275(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.
§ 70054	**Permanently Converted.** Permanently converted means space which is not available for patient accommodation because the facility has converted the patient accommodation space to some other use and such space could not be reconverted to patient accommodation within 24 hours.
§ 70055	**Personnel.** Unless otherwise specified in this chapter, the following definitions shall apply to health care personnel: (1) Administrator. Administrator means the individual who is appointed by the governing body to act in its behalf in the overall management of the hospital. (2) Art Therapist. Art Therapist means a person who has a master's degree in art therapy or in art with an 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. (3) Audiologist. Audiologist means a person who is licensed as an audiologist by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board. (4) Biomedical Equipment Technician. Biomedical equipment technician means a person certified by the Association for the Advancement of Medical Instrumentation. (5) Cardiopulmonary Technologist. Cardiopulmonary technologist means a person who is registered by the National Society of Cardiopulmonary Technologists. (6) Cardiovascular Technologist. Cardiovascular technologist means a person who is registered by the National Society of Cardiopulmonary Technologists. (7) Clinical Laboratory Bioanalyst. Clinical laboratory bioanalyst means a person who is licensed as a

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	clinical laboratory bioanalyst by the Department. (8) Clinical Laboratory Technologist. Clinical laboratory technologist means a person who is licensed as a clinical laboratory technologist by the Department. (9) Consultant. Consultant means a person who is professionally qualified to provide expe1t information on a particular subject. (10) 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. (11) Dentist. Dentist means a person who is licensed as a dentist by the Dental Board of California. (12) Dietitian. Dietitian means a registered dietitian who meets the qualifications specified in section 2585 of the Business and Professions Code. (13) Learning Disability Specialist. Learning disability specialist means a person who has a master's degree in learning disabilities from an accredited university. (14) Licensed Vocational Nurse. Licensed vocational nurse means a person who is licensed as a licensed vocational nurse by the Board of Vocational Nursing and Psychiatric Technicians. (15) Mental Health Worker. Mental health worker means an unlicensed person who through experience, inservice training or formal education is qualified to participate in the care of the psychiatric patient. (16) 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. (17) Nurse Anesthetist. Nurse anesthetist means a registered nurse who is licensed by the Board of Registered Nursing as a certified registered nurse anesthetist (CRNA) . (18) Occupational Therapist. Occupational therapist means a person who is licensed as an occupational therapist by the California Board of Occupational Therapy. (19) Occupational Therapy Assistant. Occupational therapy assistant means a person who is licensed as an occupational therapy assistant by the California Board of Occupational Therapy. (20) Orthotist and Prosthetist = means a person who is certified or eligible for certification by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics. (21) Pharmacist. Pharmacist means a person who is licensed as a pharmacist by the California State Board of Pharmacy. (22) Physical Therapist. Physical therapist means a person licensed as a physical therapist by the Physical Therapy Board of California. (23) Physical Therapist Assistant. Physical therapist assistant means a person who is approved as a physical therapist assistant by the Physical Therapy Board of California. (24) Physician. Physician means a person licensed as a physician and surgeon by the Medical Board of California or by the Osteopathic Medical Board of California. (25) Physician's Assistant. Physician's assistant means a person licensed as a physician's assistant by the

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	Physician Assistant Committee of the Medical Board of California. (26) Podiatrist. Podiatrist means a person who is licensed as a podiatrist by the California Board of Podiatric Medicine. (27) Psychiatrist. Psychiatrist means a person who is licensed as a physician and surgeon by the Medical Board of California or the Osteopathic Medical Board of California 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. (28) Psychiatric Technician. Psychiatric technician means a person licensed as a psychiatric technician by the Board of Vocational Nursing and Psychiatric Technicians. (29) Psychologist. Psychologist means a person who is licensed as a psychologist by the Board of 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 licensed registered nurse certified under Article 2.5, Chapter 6 of the Business and Professions Code. (34) Registered Health Information Administrator. Registered health information administrator means a person who is registered as a health information administrator by the American Health Information Management Association. (35) Registered Health Information Technician. Registered health in- formation technician means a person who is registered as a health in- formation technician by the American Health Information Management Association. (36) Respiratory Care Practitioner. Respiratory care practitioner means a person who is licensed as a respiratory care practitioner by the Respiratory Care Board of California. (37) Respiratory Care Technician. Respiratory care technician means a person who is licensed as a respiratory care technician by the Respiratory Care Board of California. (38) Social Worker. Social worker means a person who is licensed as a licensed clinical social worker by

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	the Board of Behavioral Sciences. (39) 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. (40) 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. (41) Speech Pathologist. Speech pathologist means a person who is licensed as a speech pathologist by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board. (42) 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. (43) 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. (44) 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.
§ 70057	**Principal Officer.** Principal officer means the officer designated by an organization who has legal authority and responsibility to act for and in behalf of that organization.
§ 70058	**Registered Domestic Partner.** Registered domestic partner shall have the same meaning as defined in Family Code Sections 297 and 297.5. NOTE: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Sections 297 and 297.5, Family Code; and Sections 1276, 131050, 131051 and 131052, Health and Safety Code.
§ 70059	**Restraint.** Restraint means controlling a patient's physical activity in order to protect the patient or others from injury by seclusion or mechanical devices.
§ 70059.1	**Rural Area.** For the purposes of Health and Safety Code, Section 1250.8(b)(4)(A), "rural area" means any area which is located more than 30 miles or 30 minutes driving distance from the city hall for any metropolitan area with a population of 150,000 or more. NOTE: Authority cited: Sections 100275(a) and 1275, Health and Safety Code. Reference: Section 1250.8, Health and Safety Code.

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§ 70060	**Skilled Nursing Care Bed Classification.** "Skilled nursing care bed classification" means beds designated for patients requiring skilled nursing care on a continuous and extended basis. NOTE: Authority cited: Sections 208 and 1250.l, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.
§ 70061	**Special Permit.** Special permit means the document issued by the Department which constitutes the authority to perform those supplemental services which are identified as special services in Section 70351.
§ 70062	**Special Hospital.** "Special hospital" means a hospital which provides special services in either rehabilitation, maternity, or dentistry, and which meets all of the requirements for a general acute care hospital, except that it is not required to provide surgical or anesthesia services.
§ 70063	**Sterilization.** Sterilization means a process employed to destroy all living organisms.
§ 70065	**Supervision.** Supervision means to instruct an employee or subordinate in his duties and to oversee or direct his work, but does not necessarily require the immediate presence of the supervisor. Direct supervision means that the supervisor shall be present in the same building as the person being supervised and available for consultation and/or assistance. Immediate supervision means that the supervisor shall be physically present while a task is being performed. Supplemental service means an organized inpatient or outpatient service which is not required to be provided by law or regulation.
§ 70067	**Supplemental Service.** Supplemental service means an organized inpatient or outpatient service which is not required to be provided by law or regulation.
§ 70069	**Unit Dose Medication System.** Unit dose medication system means a system in which single dosage units of drugs are prepackaged and pre-labeled in accordance with all applicable laws and regulations governing these practices. The system shall also comprise, but not be limited to, all equipment and appropriate records necessary and used in making the dose available to the patient in an accurate and safe manner. A pharmacist shall be in charge of and responsible for the system.

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§ 70101	**Inspection of Hospitals.** (a) The Department shall inspect and license hospitals. (b) Any officer, employee or agent of the Department may, upon presentation of proper identification, enter and inspect any building or premises at any reasonable time to secure compliance with, or to prevent a violation of, any provision of these regulations. (c) All hospitals for which a license has been issued shall be inspected periodically by a representative or representatives appointed by the Department. Inspections shall be conducted as frequently as necessary, but not less than once every two years, to assure that quality care is being provided. During the inspection, the representative or representatives of the Department shall offer such advice and assistance to the hospital as is appropriate. For hospitals of 100 licensed bed capacity or more, the inspection team shall include at least a physician, registered nurse and persons experienced in hospital administration and sanitary inspections. (d) The Department may provide consulting services upon request to any hospital to assist in the identification or correction of deficiencies or the upgrading of the quality of care provided by the hospital. (e) The Department shall notify the hospital of all deficiencies of compliance with these regulations and the hospital shall agree with the Department upon a plan of corrections which shall give the hospital a reasonable time to correct such deficiencies. If at the end of the allotted time, as revealed by repeat inspection, the hospital has failed to correct the deficiencies, the Director may take action to revoke or suspend the license. (f) Reports on the results of each inspection of a hospital shall be prepared by the inspector or inspection team and shall be kept on file in the Department along with the plan of correction and hospital comments. The inspection report may include a recommendation for re-inspection. All inspection reports, lists of deficiencies and plans of correction shall be open to public inspection without regard to which body performs the inspection. (g) The Department shall have the authority to contract for outside personnel to perform inspections of hospitals as the need arises. The Department, when feasible, shall contract with nonprofit, professional organizations which have demonstrated the ability to carry out the provisions of this section. Such organizations shall include, but not be limited to, the California Medical Association Committee on Medical Staff Surveys and participants in the Consolidated Hospital Survey Program.
§ 70103	**License Required.** (a) No person, firm, partnership, association, corporation, political subdivision of the state or other governmental agency shall establish, operate or maintain a hospital, or hold out, represent, or advertise by any means that it operates a hospital, without first obtaining a license from the Department. (b) The provisions of this article do not apply to any facility conducted by and for the adherents of any well-recognized church or religious denomination for the purpose of providing facilities for the care or

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	treatment of the sick who depend upon prayer or spiritual means for healing in the practice of the religion of such church or denomination.
§ 70105	**Application Required.** (a) A verified application shall be forwarded to the Department whenever any of the following circumstances occur: (1) Construction of a new or replacement facility or addition to an existing facility. (2) Increase or decrease of licensed bed capacity. (3) Added service or change from one service to another. (4) Change of ownership. (5) Change of name of hospital. (6) Change of license category. (7) Change of location of the hospital. (8) Change of bed classification.
§ 70107	**Content of Application.** (a) Any person, firm, partnership, association, corporation, political subdivision of the state, state agency or other governmental agency desiring to obtain a license shall file with the Department an application on forms furnished by the Department. The application shall contain the following information: (1) Name of applicant and, if an individual, verification that the applicant has attained the age of 18 years. (2) Type of facility to be operated and types of services for which approval is requested. (3) Location of the hospital. (4) Name of person in charge of the hospital. (5) If the applicant is an individual, satisfactory evidence that the applicant is of reputable and responsible character. (6) If applicant is a firm, association, organization, partnership, business trust, corporation or company, satisfactory evidence that the members or shareholders thereof and the person in charge of the hospital for which application for license is made are of reputable and responsible character. (7) If the applicant is a political subdivision of the State or other governmental agency, satisfactory evidence that the person in charge of the hospital for which application for license is made is of reputable and responsible character. (8) If the applicant is a partnership, the name and principal business address of each partner. (9) If the applicant is a corporation, the name and principal business address of each officer and director of the corporation; and for nonpublic corporations, the name and business address of each stockholder owning 10 percent or more of the stock and any corporate member who has responsibility in the operation of the hospital.

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	(10) Copy of the current organizational chart. (11) Certificate of Need or a Certificate of Exemption from the Department if required by Chapter 1, Division 7 of this title. (12) Such other information or documents as may be required by the Department for the proper administration and enforcement of the licensing law and requirements.
§ 70109	**Architectural Plans.** Applications submitted for proposed construction of new hospitals or additions to licensed hospitals shall include architectural plans and specifications. Information contained in such applications shall be on file in the Department and available to interested individuals and community agencies.
§ 70110	**Fee.** (a) Each application for a license shall be accompanied by the prescribed fee as authorized by Health and Safety Code, section 1266. (b) No fee shall be refunded to the applicant if the application is withdrawn or if the application is denied by the Department. (c) An additional fee of $25.00 shall be paid for processing any change of name. However, no additional fee shall be charged for any change of name, which is processed upon a renewal application or upon an application filed because of a change of ownership. (d) Fees for licenses which cover periods in excess of 12 months shall be prorated on the basis of the number of months to be licensed divided by 12 months. (e) Fees shall be waived for any facility conducted, maintained or operated by this state or any state department, authority, bureau, commission or officer or by the Regents of the University of California or by a local hospital district, city or county.
§ 70115	**Safety, Zoning and Building Clearance** (a) Architectural plans shall not be approved and a license shall not be originally issued to any hospital which does not conform to: the regulations in this chapter; state requirements on seismic safety, fire and life safety and environmental impact; and local fire safety, zoning and building ordinances. Evidence of such compliance shall be presented in writing to the Department. (b) It shall be the responsibility of the licensee to maintain the hospital in a safe structural condition. If the Department determines that an evaluation of the structural condition of a hospital building is necessary, the licensee may be required to submit a report by a licensed structural engineer which shall establish a basis for eliminating or correcting the structural conditions which are found to be hazardous to occupants.
§ 70117	**Issuance, Expiration and Renewal.** (a) Upon verification of compliance with the licensing requirements, the Department shall issue the applicant a license. (b) If the applicant is not in compliance with the laws or regulations, the Department shall deny the

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	applicant a license and shall immediately notify the applicant in writing. Within 20 days of receipt of the Department's notice, the applicant may present his written petition for a hearing to the Department. The Department shall set the matter for hearing within 30 days after receipt of the petition in proper form. The proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. (c) Each initial license shall expire at midnight, one year from the date of issue. A renewal license: (1) May be issued for a period not to exceed two years if the holder of the license has been found not to have been in violation of any statutory requirements, regulations or standards during the preceding license period. (2) Shall reflect the number of beds that meet construction and operational requirements and shall not include beds formerly located in patient accommodation space which has been permanently converted. (3) Shall not be issued if the hospital is liable for and has not paid the special fees required by Section 90417, Chapter 1, Division 7, of this Title. (d) The Department shall mail an application form for renewal of license to the licensee at least 45 days prior to expiration of a license. Application for renewal, accompanied by the necessary fees, shall be filed with the Department annually and not less than ten days prior to the expiration date. Failure to make a timely renewal application shall result in expiration of the license.
§ 70119	**Provisional Licensing of Distinct Parts.** (a) The initial license, issued by the Department to an applicant when the hospital includes a distinct part which will function as a skilled nursing or intermediate care service, shall include a separate provisional authorization for the distinct part. The provisional authorization for the distinct part service shall terminate six months from the date of issuance. The Department shall give the distinct part, and supporting elements of the hospital, a full and complete inspection within 30 days prior to termination of the provisional authorization. A regular authorization will be included in the license if the hospital and distinct part meet all applicable requirements for licensure. If the hospital does not meet the requirements for licensure but has made substantial progress toward meeting such requirements, as determined by the Department, the initial provisional license shall be renewed for six months. If the Department determines that there has not been substantial progress toward meeting licensure requirements at the time of the first full inspection provided by this section, or if the Department determines upon its inspection made within 30 days of the termination of a renewed provisional license that there is lack of full compliance with such requirements, no further license shall be issued. (b) An applicant who has been denied provisional licensing may contest such denial by filing a statement of issues, as provided in Section 11504 of the Government Code: The proceedings to review such denial shall be conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500), Part 1,

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§ 70121	**Separate Licenses.** Separate licenses shall be required for hospitals which are maintained on separate premises even though they are under the same management. This does not apply to outpatient departments or clinics of hospitals designated as such which are maintained and operated on separate premises. Separate licenses shall not be required for separate buildings on the same grounds or adjacent grounds.
§ 70123	**Posting.** The license, or a true copy thereof, shall be posted conspicuously in a prominent location within the licensed premises and accessible to public view.
§ 70125	**Transferability.** Licenses are not transferable. The licensee shall notify the Department in writing at least 30 days prior to the effective date of any change of ownership. A new application for license shall be submitted by the prospective new owner.
§ 70127	**Report of Changes.** (a) The licensee shall notify the Department in writing any time a change of stockholder owning ten percent or more of the non-public corporate stock occurs. Such notice shall include the name and principal mailing address of the new stockholder. (b) Each licensee shall notify the Department in writing within ten days prior to any change of the mailing address of the licensee. Such notice shall include the new mailing address of the licensee. (c) Any change in the principal officer shall be reported in writing within ten days by the licensee to the Department. Such notice shall include the name and principal business address of such officer.
§ 70129, 70307, 70363	**Program Flexibility.** (a) All hospitals shall maintain continuous compliance with the licensing requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects provided such exceptions are carried out with the provisions for safe and adequate care and with the prior written approval of the Department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the Department. (b) Hospitals which by reason of remoteness are unable to comply with provisions of the regulations for basic services and perinatal or pediatric services, shall submit a written request to the Department for exception. In reviewing such request, special attention may be required regarding qualifications of medical staff and personnel. (c) Special exceptions may be granted under this section for hospitals required to provide services and accommodations for persons who may have dangerous propensities necessitating special precautions, personnel with special qualifications, locked accommodations, special protection for windows, type and

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	location of lighting and plumbing fixtures, signal systems, control switches, beds and other furnishings. This applies to psychiatric units and detention facilities where added protection is necessary for patients, staff members and members of the public. (d) Any approval of the Department granted under this section or a true copy thereof, shall be posted immediately adjacent to the facility's license that is required to be posted by Section 70123. **Survey procedures:** These sections allow facilities to apply for alternate methods, concepts, or procedure to fulfill the regulatory requirements. These must be approved by the Department. However, CDPH policy and procedure manual #310.110 allows for an alternate means of compliance on select sections without a written program flexibility to include sections -70223(g), 70263(g), 70273(m)(4),70525, 7082(a)(4) 70837, 70849(f), 70853. For further reading click link to P&P 301.110.http://cdphintranet/sites/lncintranet/Pages/PPChapter3-Surveys.aspx • Observe that the program flexibility(s) issued by the district office are displayed adjacent to the license and is current. • Interview the hospital's administrative representative and verify the existence of any applicable program flexibility(s). • Further engage/interview the hospital's administrative representative for rationale related to the continuance/discontinuance of program flexibility(s).
§ 70131	**Voluntary Suspension of License or Licensed Beds.** (a) Upon written request, a licensee may request that his license or licensed beds be put in suspense. The Department may approve the request for a period not to exceed 12 months. (b) Any license or portion thereof which has been temporarily suspended by the Department pursuant to this section shall remain subject to all renewal requirements of an active license, including the payment of license renewal fees, during the period of temporary suspension. (c) Any license suspended pursuant to this section may be reinstated by the Department within 12 months of the date of suspension upon receipt of an application and evidence showing compliance with licensing operational requirements in effect at the time of reinstatement. If the license is not reinstated within the 12 month period, the license shall expire automatically and shall not be subject to reinstatement.
§ 70133	**Voluntary Cancellation of License.** (a) The licensee shall notify the Department in writing as soon as possible and in all cases at least 30

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	days prior to the desired effective date of cancellation of the license. (b) Any license voluntarily cancelled pursuant to this section may be reinstated by the Department within 12 months of the date of voluntary cancellation upon receipt of an application along with evidence showing compliance with operational and construction licensing requirements.
§ 70135	**Revocation or Involuntary Suspension of License.** (a) Pursuant to provisions of Chapter 5 (commencing with Section 11500), Part 1, Division 3, of Title 2, Government Code, the Department may suspend or revoke any license issued under the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, upon any of the following grounds. (1) Violation by the licensee of any of the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the regulations promulgated by the Department. (2) Aiding, abetting or permitting the violation of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the regulations promulgated by the Department. (3) Conduct inimical to the public health, morals, welfare or safety of the people of the State of California in the maintenance and operation of the premises or services for which a license is issued. (b) The license of any hospital against which special fees are required by Section 90417, Chapter 1, Division 7, of this Title shall be revoked, after notice of hearing, if it is determined by the Department that the fees required were not paid within the time prescribed. (c) The Director may temporarily suspend any license prior to any hearing when, in his opinion, such action is necessary to protect the public welfare. (1) The Director shall notify the licensee of the temporary suspension and the effective date thereof and at the same time shall serve such licensee with an accusation. (2) Upon receipt of a notice of defense by the licensee, the Director shall set the matter for hearing within 15 days. The hearing shall be held as soon as possible but no later than 30 days after receipt of such notice. (3) The temporary suspension shall remain in effect until such time as the hearing is completed and the Director has made a final determination. (4) If the Director fails to make a final determination within 60 days after the original hearing has been completed, the temporary suspension shall be deemed vacated. (5) If the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the regulations promulgated by the Director are violated by a licensee which is a group, corporation or other association, the Director may suspend the license of such organization or may suspend the license as to any individual person within such organization who is responsible for such violation. (d) The withdrawal of an application for a license shall not deprive the Department of its authority to

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	institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground, unless the Department consents in writing to such withdrawal. (e) The suspension, expiration or forfeiture of a license issued by the Department shall not deprive the Department of its authority to institute or continue a proceeding against the license upon any ground provided by law or to enter an order suspending or revoking a license or otherwise taking disciplinary action against the licensee on any such ground. Note: Authority cited: Section 208(a), Health and Safety Code. Reference: Section 1296, Health and Safety Code.
§ 70136	**Conviction of Crime: Standards for Evaluating Rehabilitation.** When considering the denial, suspension or revocation of a license based on the conviction of a crime in accordance with Section 1265.1 or 1294 of the Health and Safety Code, the following criteria shall be considered in evaluating rehabilitation: (1) The nature and the seriousness of the crime(s) under consideration. (2) Evidence of conduct subsequent to the crime which suggests responsible or irresponsible character. (3) The time which has elapsed since commission of the crime(s) or conduct referred to in subdivision (1) or (2). (4) The extent to which the applicant has complied with any terms of parole, probation, restitution, or any other sanction lawfully imposed against the applicant. (5) Any rehabilitation evidence submitted by the applicant. Note: Authority cited: Sections 208(a), 1265.2 and 1275, Health and Safety Code. Reference: Sections 1265.1, 1265.2 and 1294, Health and Safety Code.
§ 70137	**Bonds.** (a) Each licensee shall file or have on file with the Department a bond issued by a surety company admitted to do business in this State if the licensee is handling or will handle money in the amount of $25 or more per patient or $500 or more for all patients in any month. (1) The amount of the bond shall be according to the following schedule: Amount Handled - $750 or less, Bond Required $1000/ Amount Handled - $751 to $1500,Bond Required $2000/ Amount Handled - $1501 to $2500, Bond Required $3000. (2) Every further increment of $1,000 or fraction thereof shall require an additional $1,000 on the bond. (b) Each application for an original license or renewal of license shall be accompanied by an affidavit on a form provided by the Department. The affidavit shall state whether the licensee handles or will handle money of patients and the maximum amount of money to be handled for any patient and for all patients in

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	any month. (c) No licensee shall either handle money of a patient or handle amounts greater than those stated in the affidavit submitted by him without first notifying the Department and filing a new or revised bond if required.

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§ 70201	**Medical Service Definition.** Medical service means those preventive, diagnostic and therapeutic measures performed by or at the request of members of the organized medical staff.
§ 70203	**Medical Service General Requirements.** (a) A committee of the medical staff shall be assigned responsibility for: (1) Recommending to the governing body the delineation of medical privileges. (2) Developing, maintaining and implementing written policies and procedures 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. (3) Developing and instituting, in conjunction with members of the medial staff and other hospital services, a continuing cardiopulmonary resuscitation training program. (4) Determining what emergency equipment and supplies should be available in all areas of the hospital. (b) The responsibility and accountability of the medical service to the medical staff and administration shall be defined. (c) The following shall be available to all patients in the hospital: (1) Electrocardiographic testing. (2) Pulmonary function testing. (3) Intermittent positive pressure breathing apparatus. (4) Cardiac monitoring capability. (5) Suction. (d) 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. **Survey procedures:** Verify a committee of the medical staff is assigned responsibility for: • Recommending to the governing body the delineation of medical privileges.

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	• Developing, maintain and implementing written policies and procedures in consultation with other appropriate health professionals and administration. Policies are approved by the governing body. Procedures are approved by administration and medical staff where such is appropriate. • Developing and instituting, in conjunction with members of the medical staff and other hospital services, a continuing cardiopulmonary resuscitation training program. • Determining what emergency equipment and supplies should be available in all areas of the hospital. • Interview committee member(s) how the above bulleted items are accomplished. • Observe the following equipment is available to all patients in the hospital: electrocardiographic testing, pulmonary function testing, intermittent positive pressure breathing apparatus, cardiac monitoring capability and suction. • Interview medical staff director regarding their continuing cardiopulmonary resuscitation training program. • Review Medical Staff Appointment/Reappointment policy in the Medical Staff Bylaws and hospital policy if one exists. • Review a sample of medical staff related policies from ED, OR, Internal Medicine and other High risk, high volume areas. Look for date of latest review/revision based on the hospital's policy on how often they will review/revise. Look at minutes of 3-5 Medical Executive Committee meetings. Verify that policies are discussed and privileging/credentialing presented.
§ 70205	**Medical Service Staff.** A physician shall have overall responsibility for the medical service. This physician shall be certified or eligible for certification in internal medicine by the American Board of Internal Medicine. If such an internist is not available, a physician, with training and experience in internal medicine, shall be responsible for the service
§ 70207	**Medical Service Equipment and Supplies.** There shall be adequate equipment and supplies maintained related to the nature of the needs and the services offered.
§ 70209	**Medical Service Space.** There shall be adequate space maintained to meet the needs of the service.
§ 70211	**Nursing Service General Requirements.** (a) The nursing service shall be organized, staffed, equipped, and supplied, including furnishings and resource materials, to meet the needs of patients and the service. (b) The nursing service shall be under the direction of an administrator of nursing services who shall be a registered nurse with the following qualifications: (1) Master's degree in nursing or a related field with at least one year of experience in administration; or (2) Baccalaureate degree in nursing or a related field with at least two years of experience in nursing

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	administration; or (3) At least four years of experience in nursing administration or supervision, with evidence of continuing education directly related to the job specifications. (c) It shall be designated in writing by the hospital administrator that the administrator of nursing services has authority, responsibility and accountability for the nursing service within the facility. (1) The internal structure and accountability of the nursing service, including identification of nursing service units and committees, shall be defined in writing. (2) The relationship between the nursing service and administration, organized medical staff and other departments shall be defined in writing. Such definition of relationship shall be developed in cooperation with respective departments. Administrative, medical staff and other hospital committees that address issues affecting nursing care shall include registered nurses, including those who provide direct patient care. Licensed vocational nurses may serve on those committees. Note: Authority cited: Sections 100275(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** • Interview the administrator of nursing services regarding how nursing services is organized, staffed, equipped, and supplied to meet the patients and the service. • Is the nursing service under the direction of an administrator of nursing services who is a registered nurse with the following qualifications? Master's degree in nursing or related field, with at least one year of experience in administration; or Baccalaureate degree in nursing or related field with at least two years of experience in administration: or at least four years of experience in nursing administration or supervision, with evidence of continuing education directly related to the job specification. • Does the administrator of nursing services have the authority, responsibility and accountability for the nursing service within the facility? • Internal structure and accountability of nursing service, including identification of nursing service units and committees, are defined in writing. • How is the relationship between nursing service and administration, organized medical staff and other departments shall be defined in writing.
§ 70213	**Nursing Service Policies and Procedures.** (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. (1) Policies and procedures which involve the medical staff shall be reviewed and approved by the medical staff prior to implementation. (2) Policies and procedures of other departments which contain requirements for the nursing service shall be reviewed and approved by the nursing service prior to implementation.

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	(3) The nursing service shall review and revise policies and procedures every three years, or more often if necessary. (4) The hospital administration and the governing body shall review and approve all policies and procedures that relate to the nursing service every three years or more often, if necessary. (b) Policies and procedures shall be based on current standards of nursing practice and shall be consistent with the nursing process which includes: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy. (c) Policies and procedures which contain competency standards for staff performance in the delivery of patient care shall be established, implemented, and updated as needed for each nursing unit, including standards for the application of restraints. Standards shall include the elements of competency validation for patient care personnel other than registered nurses as set forth in Section 70016, and the elements of competency validation for registered nurses as set forth in Section 70016.1. At least annually, patient care personnel shall receive a written performance evaluation. The evaluation shall include, but is not limited to, measuring individual performance against established competency standards. (d) Policies and procedures that require consistency and continuity in patient care, incorporating the nursing process and the medical treatment plan, shall be developed and implemented in cooperation with the medical staff. (e) Policies and procedures shall be developed and implemented which establish mechanisms for rapid deployment of personnel when any labor intensive event occurs which prevents nursing staff from providing attention to all assigned patients, such as multiple admissions or discharges, or an emergency health crisis. Note: Authority cited: Sections 100275(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** Reviewing of hospital policies and procedures – hospitals have very extensive policies and procedures. It is not an efficient use of surveyor time to ask to see all policies and procedures related to one or more of the basic services, nor is this an effective means of assessing whether the hospital's procedures comply with the regulations. Although there can be exceptions, the method surveyors generally follow involves looking later at policies and procedures as a means of validating or gathering additional supporting evidence collected first through observation and interview. If a potential deficiency has been discovered, ask for the corresponding policy and procedure.

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	• Observe the provision of care. Ask the patient or patient representative if it is alright to watch care, especially if viewing a body part. • If concerns arise interview direct care nursing staff regarding nursing regarding policies and procedures. It is okay if the staff asks for a hospital representative to be with them. • Ask how policies are accessed? • If indicated interview administrator of nursing services regarding the development and implementation of written policies and procedure for patient care.
§ 70214	**Nursing Staff Development.** (a) There shall be a written, organized in-service education program for all patient care personnel, including temporary staff as described in subsection 70217(m). The program shall include, but shall not be limited to, orientation and the process of competency validation as described in subsection 70213(c). (1) All patient care personnel, including temporary staff as indicated in subsection 70217(m), shall receive and complete orientation to the hospital and their assigned patient care unit before receiving patient care assignments. Orientation to a specific unit may be modified in order to meet temporary staffing emergencies as described in subsection 70213(e). (2) All patient care personnel, including temporary staff as described in subsection 70217(m), shall be subject to the process of competency validation for their assigned patient care unit or units. Prior to the completion of validation of the competency standards for a patient care unit, patient care assignments shall be subject to the following restrictions: (A) Assignments shall include only those duties and responsibilities for which competency has been validated. (B) A registered nurse who has demonstrated competency for the patient care unit shall be responsible for nursing care as described in subsections 70215(a) and 70217(h)(3), and shall be assigned as a resource nurse for those registered nurses and licensed vocational nurses who have not completed competency validation for that unit. (C) Registered nurses shall not be assigned total responsibility for patient care, including the duties and responsibilities described in subsections 70215(a) and 70217(h)(3), until all the standards of competency for that unit have been validated. (3) The duties and responsibilities of patient care personnel who may be temporarily re-directed from their assigned units are subject to the restrictions in (A), (B), and (C) of subsection (a)(2) above. (4) Orientation and competency validation shall be documented in the employee's file and shall be retained for the duration of the individual's employment. (5) A rural General Acute Care Hospital, as defined in Health and Safety Code Section 1250(a), may apply for program flexibility pursuant to Section 70129 of this Chapter, to meet the requirements of subsections 70214(a)(1) through (4) above, by alternate means.

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	(b) The staff education and training program shall be based on current standards of nursing practice, established standards of staff performance as specified in subsection 70213(c) above, individual staff needs and needs identified in the quality assurance process. (c) The administrator of nursing services shall be responsible for seeing that all nursing staff receive mandated education as specified in subsection (a) of this Section. (d) All staff development programs shall be documented by: (1) A record of the title, length of course in hours, and objectives of the education program presented. (2) Name, title, and qualifications of the instructor or the title and type of other educational media. (3) A description of the content. (4) A date, a record of the instructor, process, or media and a list of attendees. (5) Written evaluation of course content by attendees. Note: Authority cited: Sections 100275(a) and 1275, Health and Safety Code. Reference: Sections 1250(a) and 1276, Health and Safety Code. **Survey procedures:** • Interview charge nurse or unit manager regarding orientation and competencies. As per hospital policy, how often are specific competencies renewed, refreshed or needed? • Ensure that nursing orientation and competencies are documented. Are the assignments of nursing personnel consistent with competencies? • Interview nursing personnel. Have they been redirected/floated to other areas? Do they have orientation and appropriate competencies? • If indicated, review staff education records.
§ 70215	**Planning and Implementing Patient Care.** (a) A registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the Business and Professions Code, section 2725(b)(4). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area. (2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation. (3) The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of each patient. Any assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient.

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	(b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. (c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other disciplines involved in the care of the patient. (d) Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record. Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Section 2725(b)(4), Business and Professions Code; and Sections 1276, 131050, 131051 and 131052, Health and Safety Code. **Survey procedures:** • Select at least one patient from a variety of inpatient care units, including Supplemental Services. • Observe the nursing care in progress to determine the adequacy of staffing and to assess the delivery of care. Other sources of information to use in the evaluation of the nursing services are: registered nurses' initial and ongoing assessment(s), nursing care plans, medical records, patients, family members, accident and investigative reports, staffing schedules, nursing policies and procedures. • Interview patients and family members for information relative to the delivery of nursing services.
§ 70217	**Nursing Service Staff.** (a) Hospitals shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the following nurse-to-patient ratios. Licensed nurse means a registered nurse, licensed vocational nurse and, in psychiatric units only, a psychiatric technician. Staffing for care not requiring a licensed nurse is not included within these ratios and shall be determined pursuant to the patient classification system. No hospital shall assign a licensed nurse to a nursing unit or clinical area unless that hospital determines that the licensed nurse has demonstrated current competence in providing care in that area, and has also received orientation to that hospital's clinical area sufficient to provide competent care to patients in that area. The policies and procedures of the hospital shall contain the hospital's criteria for making this determination. Licensed nurse-to-patient ratios represent the maximum number of patients that shall be assigned to one licensed nurse at any one time. “Assigned” means the licensed nurse has responsibility for the provision of care to a particular patient within his/her scope of practice. There shall be no averaging of the number

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	of patients and the total number of licensed nurses on the unit during any one shift nor over any period of time. Only licensed nurses providing direct patient care shall be included in the ratios. Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses, and other licensed nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those licensed nurses are engaged in providing direct patient care. When a Nurse Administrator, Nurse Supervisor, Nurse Manager, Charge Nurse or other licensed nurse is engaged in activities other than direct patient care, that nurse shall not be included in the ratio. Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses who have demonstrated current competence to the hospital in providing care on a particular unit may relieve licensed nurses during breaks, meals, and other routine, expected absences from the unit. Licensed vocational nurses may constitute up to 50 percent of the licensed nurses assigned to patient care on any unit, except where registered nurses are required pursuant to the patient classification system or this section. Only registered nurses shall be assigned to Intensive Care Newborn Nursery Service Units, which specifically require one registered nurse to two or fewer infants. In the Emergency Department, only registered nurses shall be assigned to triage patients and only registered nurses shall be assigned to critical trauma patients. Nothing in this section shall prohibit a licensed nurse from assisting with specific tasks within the scope of his or her practice for a patient assigned to another nurse. “Assist” means that licensed nurses may provide patient care beyond their patient assignments if the tasks performed are specific and time-limited. (1) The licensed nurse-to-patient ratio in a critical care unit shall be 1:2 or fewer at all times. “Critical care unit” means a nursing unit of a general acute care hospital which provides one of the following services: an intensive care service, a burn center, a coronary care service, an acute respiratory service, or an intensive care newborn nursery service. In the intensive care newborn nursery service, the ratio shall be 1 registered nurse:2 or fewer patients at all times. (2) The surgical service operating room shall have at least one registered nurse assigned to the duties of the circulating nurse and a minimum of one additional person serving as scrub assistant for each patient-occupied operating room. The scrub assistant may be a licensed nurse, an operating room technician, or other person who has demonstrated current competence to the hospital as a scrub assistant, but shall not be a physician or other licensed health professional who is assisting in the performance of surgery.

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	(3) The licensed nurse-to-patient ratio in a labor and delivery suite of the perinatal service shall be 1:2 or fewer active labor patients at all times. When a licensed nurse is caring for antepartum patients who are not in active labor, the licensed nurse-to-patient ratio shall be 1:4 or fewer at all times. (4) The licensed nurse-to-patient ratio in a postpartum area of the perinatal service shall be 1:4 mother-baby couplets or fewer at all times. In the event of multiple births, the total number of mothers plus infants assigned to a single licensed nurse shall never exceed eight. For postpartum areas in which the licensed nurse's assignment consists of mothers only, the licensed nurse-to-patient ratio shall be 1:6 or fewer at all times. (5) The licensed nurse-to-patient ratio in a combined Labor/Delivery/Postpartum area of the perinatal service shall be 1:3 or fewer at all times the licensed nurse is caring for a patient combination of one woman in active labor and a postpartum mother and infant The licensed nurse-to-patient ratio for nurses caring for women in active labor only, antepartum patients who are not in active labor only, postpartum women only, or mother-baby couplets only, shall be the same ratios as stated in subsections (3) and (4) above for those categories of patients. (6) The licensed nurse-to-patient ratio in a pediatric service unit shall be 1:4 or fewer at all times. (7) The licensed nurse-to-patient ratio in a postanesthesia recovery unit of the anesthesia service shall be 1:2 or fewer at all times, regardless of the type of anesthesia the patient received. (8) In a hospital providing basic emergency medical services or comprehensive emergency medical services, the licensed nurse-to-patient ratio in an emergency department shall be 1:4 or fewer at all times that patients are receiving treatment. There shall be no fewer than two licensed nurses physically present in the emergency department when a patient is present. At least one of the licensed nurses shall be a registered nurse assigned to triage patients. The registered nurse assigned to triage patients shall be immediately available at all times to triage patients when they arrive in the emergency department. When there are no patients needing triage, the registered nurse may assist by performing other nursing tasks. The registered nurse assigned to triage patients shall not be counted in the licensed nurse-to-patient ratio. Hospitals designated by the Local Emergency Medical Services (LEMS) Agency as a “base hospital,” as defined in section 1797.58 of the Health and Safety Code, shall have either a licensed physician or a registered nurse on duty to respond to the base radio 24 hours each day. When the duty of base radio responder is assigned to a registered nurse, that registered nurse may assist by performing other nursing tasks when not responding to radio calls, but shall be immediately available to respond to requests for medical direction on the base radio. The registered nurse assigned as base radio responder shall not be counted in the licensed nurse-to-patient ratios.

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	When licensed nursing staff are attending critical care patients in the emergency department, the licensed nurse-to-patient ratio shall be 1:2 or fewer critical care patients at all times. A patient in the emergency department shall be considered a critical care patient when the patient meets the criteria for admission to a critical care service area within the hospital. Only registered nurses shall be assigned to critical trauma patients in the emergency department, and a minimum registered nurse-to-critical trauma patient ratio of 1:1 shall be maintained at all times. A critical trauma patient is a patient who has injuries to an anatomic area that: (1) require life saving interventions, or (2) in conjunction with unstable vital signs, pose an immediate threat to life or limb. (9) The licensed nurse-to-patient ratio in a step-down unit shall be 1:4 or fewer at all times. Commencing January 1, 2008, the licensed nurse-to-patient ratio in a step-down unit shall be 1:3 or fewer at all times. A “step down unit” is defined as a unit which is organized, operated, and maintained to provide for the monitoring and care of patients with moderate or potentially severe physiologic instability requiring technical support but not necessarily artificial life support. Step-down patients are those patients who require less care than intensive care, but more than that which is available from medical/surgical care. “Artificial life support” is defined as a system that uses medical technology to aid, support, or replace a vital function of the body that has been seriously damaged. “Technical support” is defined as specialized equipment and/or personnel providing for invasive monitoring, telemetry, or mechanical ventilation, for the immediate amelioration or remediation of severe pathology. (10) The licensed nurse-to-patient ratio in a telemetry unit shall be 1:5 or fewer at all times. Commencing January 1, 2008, the licensed nurse-to-patient ratio in a telemetry unit shall be 1:4 or fewer at all times. “Telemetry unit” is defined as a unit organized, operated, and maintained to provide care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or a disease requiring the electronic monitoring, recording, retrieval, and display of cardiac electrical signals. “Telemetry unit” as defined in these regulations does not include fetal monitoring nor fetal surveillance. (11) The licensed nurse-to-patient ratio in medical/surgical care units shall be 1:6 or fewer at all times. Commencing January 1, 2005, the licensed nurse-to-patient ratio in medical/surgical care units shall be 1:5 or fewer at all times. A medical/surgical unit is a unit with beds classified as medical/surgical in which patients, who require less care than that which is available in intensive care units, step-down units, or specialty care units receive 24 hour inpatient general medical services, post-surgical services, or both general medical and post-surgical services. These units may include mixed patient

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	populations of diverse diagnoses and diverse age groups who require care appropriate to a medical/surgical unit. (12) The licensed nurse-to-patient ratio in a specialty care unit shall be 1:5 or fewer at all times. Commencing January 1, 2008, the licensed nurse-to-patient ratio in a specialty care unit shall be 1:4 or fewer at all times. A specialty care unit is defined as a unit which is organized, operated, and maintained to provide care for a specific medical condition or a specific patient population. Services provided in these units are more specialized to meet the needs of patients with the specific condition or disease process than that which is required on medical/surgical units, and is not otherwise covered by subdivision (a). (13) The licensed nurse-to-patient ratio in a psychiatric unit shall be 1:6 or fewer at all times. For purposes of psychiatric units only, “licensed nurses” also includes psychiatric technicians in addition to licensed vocational nurses and registered nurses. Licensed vocational nurses, psychiatric technicians, or a combination of both, shall not exceed 50 percent of the licensed nurses on the unit. (14) Identifying a unit by a name or term other than those used in this subsection does not affect the requirement to staff at the ratios identified for the level or type of care described in this subsection. (b) In addition to the requirements of subsection (a), the hospital shall implement a patient classification system as defined in Section 70053.2 above for determining nursing care needs of individual patients that reflects the assessment, made by a registered nurse as specified at subsection 70215(a)(1), of patient requirements and provides for shift-by-shift staffing based on those requirements. The ratios specified in subsection (a) shall constitute the minimum number of registered nurses, licensed vocational nurses, and in the case of psychiatric units, psychiatric technicians, who shall be assigned to direct patient care. Additional staff in excess of these prescribed ratios, including non-licensed staff, shall be assigned in accordance with the hospital's documented patient classification system for determining nursing care requirements, considering factors that include the severity of the illness, the need for specialized equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the patient care plan, the ability for self-care, and the licensure of the personnel required for care. The system developed by the hospital shall include, but not be limited to, the following elements: (1) Individual patient care requirements. (2) The patient care delivery system. (3) Generally accepted standards of nursing practice, as well as elements reflective of the unique nature of the hospital's patient population. (c) A written staffing plan shall be developed by the administrator of nursing service or a designee, based on patient care needs determined by the patient classification system. The staffing plan shall be developed and implemented for each patient care unit and shall specify patient care requirements and the staffing levels for registered nurses and other licensed and unlicensed personnel. In no case shall the

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	staffing level for licensed nurses fall below the requirements of subsection (a). The plan shall include the following: (1) Staffing requirements as determined by the patient classification system for each unit, documented on a day-to-day, shift-by-shift basis. (2) The actual staff and staff mix provided, documented on a day-to-day, shift-by-shift basis. (3) The variance between required and actual staffing patterns, documented on a day-to-day, shift-by-shift basis. (d) In addition to the documentation required in subsections (c) (1) through (3) above, the hospital shall keep a record of the actual registered nurse, licensed vocational nurse and psychiatric technician assignments to individual patients by licensure category, documented on a day-to-day, shift-by-shift basis. The hospital shall retain: (1) The staffing plan required in subsections (c)(1) through (3) for the time period between licensing surveys, which includes the Consolidated Accreditation and Licensing Survey process, and (2) The record of the actual registered nurse, licensed vocational nurse and psychiatric technician assignments by licensure category for a minimum of one year. (e) The reliability of the patient classification system for validating staffing requirements shall be reviewed at least annually by a committee appointed by the nursing administrator to determine whether or not the system accurately measures patient care needs. (f) At least half of the members of the review committee shall be registered nurses who provide direct patient care. (g) If the review reveals that adjustments are necessary in the patient classification system in order to assure accuracy in measuring patient care needs, such adjustments must be implemented within thirty (30) days of that determination. (h) Hospitals shall develop and document a process by which all interested staff may provide input about the patient classification system, the system's required revisions, and the overall staffing plan. (i) The administrator of nursing services shall not be designated to serve as a charge nurse or to have direct patient care responsibility, except as described in subsection (a) above. (j) Registered nursing personnel shall: (1) Assist the administrator of nursing service so that supervision of nursing care occurs on a 24-hour basis. (2) Provide direct patient care. (3) Provide clinical supervision and coordination of the care given by licensed vocational nurses and unlicensed nursing personnel. (k) Each patient care unit shall have a registered nurse assigned, present and responsible for the patient care in the unit on each shift.

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	(*l*) A rural General Acute Care Hospital as defined in Health and Safety Code Section 1250(a), may apply for and be granted program flexibility for the requirements of subsection 70217(i) and for the personnel requirements of subsection (j)(1) above. (m) Unlicensed personnel may be utilized as needed to assist with simple nursing procedures, subject to the requirements of competency validation. Hospital policies and procedures shall describe the responsibility of unlicensed personnel and limit their duties to tasks that do not require licensure as a registered or vocational nurse. (n) Nursing personnel from temporary nursing agencies shall not be responsible for a patient care unit without having demonstrated clinical and supervisory competence as defined by the hospital's standards of staff performance pursuant to the requirements of subsection 70213(c) above. (o) Hospitals which utilize temporary nursing agencies shall have and adhere to a written procedure to orient and evaluate personnel from these sources. Such procedures shall require that personnel from temporary nursing agencies be evaluated as often, or more often, than staff employed directly by the hospital. (p) All registered and licensed vocational nurses utilized in the hospital shall have current licenses. A method to document current licensure shall be established. (q) The hospital shall plan for routine fluctuations in patient census. If a healthcare emergency causes a change in the number of patients on a unit, the hospital must demonstrate that prompt efforts were made to maintain required staffing levels. A healthcare emergency is defined for this purpose as an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate medical interventions and care. Note: Authority cited: Sections 1275, 1276.4 and 131200, Health and Safety Code. Reference: Sections 1250(a), 1276, 1276.4, 1797.58, 1790.160, 131050, 131051 and 131052, Health and Safety Code. **Guidance to surveyors:** The aforementioned regulation(s) addresses staffing throughout the general acute care hospital and denotes the nurse to patient ratios at various levels of care. Information is provided in the beginning of the regulation about Nurse Administrators, Nurse Supervisors, Nurse Managers, Charge Nurses, LVN's and triage RN's and how they may or may not be included in the ratio. When addressing the specific concerns with staffing please refer to the appropriate section of the regulation and the EASY USE STAFFING GUIDE/CDPH P&P Section #800.2.2. The surveyor may decide to review the Patient Classification System (PCS) when staffing issues arise. Information for PCS starts after section #14. **Survey procedures:**

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	• Observe the nursing care in progress to determine the adequacy of staffing and to assess the delivery of care. Obtain a nursing unit census and the current nursing staffing assignment. Ensure the nurse to patient ratio is consistent with the specific nursing unit. • Select at least one patient from every inpatient care unit. • Interview patients and family members for information relative to the delivery of nursing services if applicable. Interview direct care staff related to the delivery of care. • Review medical records to determine if the patient care being provided by nursing service is as ordered. • Other sources of information to use in the evaluation of the nursing services are: nursing care plans, medical records, patients, family members, accident and investigative reports, staffing schedules, nursing policies and procedures, and reports. • Based on your RN skills, consider the intensity of illness and nursing needs; training and experience of personnel; availability of nurses' aides and orderlies and other resources for nurses, e.g., housekeeping services, ward clerks etc.
§ 70219	**Nursing Service Space.** (a) Space and components for nurses' stations and utility rooms shall comply with the requirements set forth in California Code of Regulations, Title 24, Part 2, Section 420A.14, California Building Code, 1995. (b) Office space shall be provided for the administrator of nursing services and for the other needs of the service. Note: Authority cited: Sections 100275(a) and 1275, Health and Safety Code. Reference: CCR, Title 24, Section 420A.14, California Building Code; and Sections 1276, Health and Safety Code.
§ 70221	**Surgical Service Definition.** Surgical service means the performance of surgical procedures with the appropriate staff, space, equipment and supplies.
§ 70223	**Surgical Service General Requirements.** (a) Hospitals shall maintain at least the number of operating rooms in ratio to licensed bed capacity as follows: Licensed bed capacity — Number of operating rooms less than 25 — One 25 to 99 — Two 100 or more — Three For each additional 100 beds or major fractions thereof, at least one additional operating room shall be maintained, unless approved to the contrary by the Department. (1) Required operating rooms are in addition to special operating rooms, cystoscopy rooms and fracture rooms which are provided by the hospital. (2) Beds in a distinct part skilled nursing service, intermediate care service or psychiatric unit shall be

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	excluded from calculating the number of operating rooms required. (b) A committee of the medical staff shall be assigned responsibility for: (1) Recommending to the governing body the delineation of surgical privileges for individual members of the medical staff. A current list of such privileges shall be kept in the files of the operating room supervisor. (2) Development, maintenance and implementation of written policies and procedures 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. (3) Determining what emergency equipment and supplies shall be available in the surgery suite. (4) Determining which operative procedures require an assistant surgeon or assistants to the surgeon. (c) The responsibility and the accountability of the surgical service to the medical staff and administration shall be defined. (d) Prior to commencing surgery the person responsible for administering anesthesia, or the surgeon if a general anesthetic is not to be administered, shall verify the patient's identity, the site and side of the body to be operated on, and ascertain that a record of the following appears in the patient's medical record: (1) An interval medical history and physical examination performed and recorded within the previous 24 hours. (2) Appropriate screening tests, based on the needs of the patient, accomplished and recorded within 72 hours prior to surgery. (3) An informed consent, in writing, for the contemplated surgical procedure. (e) The requirements of (d), above, do not preclude rendering emergency medical or surgical care to a patient in dire circumstances. (f) A register of operations shall be maintained including the following information for each surgical procedure performed: (1) Name, age, sex and hospital admitting number of the patient. (2) Date and time of the operation and the operating room number . (3) Preoperative and postoperative diagnosis. (4) Name of surgeon, assistants, anesthetists and scrub and circulating assistant. (5) Surgical procedure performed and anesthetic agent used. (6) Complications, if any, during the operation. (g) All anatomical parts, tissues and foreign objects removed by operation shall be delivered to a pathologist designated by the hospital and a report of his findings shall be filed in the patient's medical record.

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	(h) 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.
	(i) The requirements in this section do not apply to special hospitals unless the special hospital provides this service.
	
	Survey procedures:
	
	Reviewing of hospital policies and procedures – hospitals have very extensive policies and procedures. It is not an efficient use of surveyor time to ask to see all policies and procedures related to one or more of the basic services, nor is this an effective means of assessing whether the hospital's procedures comply with the regulations. Although there can be exceptions, the method surveyors generally follow involves looking later at policies and procedures as a means of validating or gathering additional supporting evidence collected first through observation and interview. If a potential deficiency has been discovered, ask for the corresponding policy and procedure.
	
	• Interview either the nursing director of the surgical service or the physician director. Ask for and review the list for physicians who have been granted surgical privileges. Is the list current and kept on file with the operating room supervisor?
	• Observe for emergency equipment and supplies in the surgery suite or adjacent areas.
	• Are there certain procedures that require an assistant surgeon or assistants to the surgeon? Interview either the nursing director of the surgical service or the physician director.
	• Prior to commencing surgery is the surgical team pausing and actively engaged regarding the identity of the patient, the site and side of the body to be operated on, and ascertain that a record of the following appears in the patient's medical record. Review the hospital's timeout policy or whatever the hospital policy calls for to assure that the right patient and procedure is assured.
	  ▪ An interval medical history and physical examination performed and recorded within the previous 24 hours.
	  ▪ Appropriate screening tests, based on the needs of the patient, accomplished and recorded within 72 hours prior to surgery.
	  ▪ An informed consent, in writing, for the contemplated surgical procedure.
	• If indicated, review the register of operations maintained to include information for each surgical procedure performed for the above content for section.
	• Are the surgical service activities and locations integrated into the hospital-wide quality improvement program? Interview appropriate staff.

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	• See L&C policy and procedure (#301.110) manual related to Program Flexibility(s) for additional guidance.
	• CDPH has a link/account with Association of peri operative Registered Nurses (AORN) for information related to standards of practice link http://aornstandards.org/. Hospitals may use other nationally recognized standards. Find out and use what standards the hospital follows.
	• Observe care being delivered. Are the practices provided in accordance with acceptable standards of practice?
	  ▪ The conformance to aseptic and sterile technique by all individuals in the surgical area; That there is appropriate cleaning between surgical cases and appropriate terminal cleaning applied;
	  ▪ That operating room attire is suitable for the kind of surgical case performed, that persons working in the operating suite must wear only clean surgical garb, that surgical garb are designed for maximum skin and hair coverage
	• Verify if the hospital uses alcohol-based skin preparations in anesthetizing locations, determine whether it has adopted policies and procedures to minimize the risk of surgical fires.
	• That equipment is monitored, inspected, tested, and maintained by the hospital's biomedical equipment program and in accordance with State law, regulations and guidelines and manufacturer's recommendations;
	• Are sterilized materials are packaged, handled, labeled, and stored in a manner that ensures sterility in a moisture and dust controlled environment. Applicable policies and procedures for expiration dates have been developed and are followed in accordance with accepted standards of practice.
	• That temperature and humidity are monitored and maintained within accepted standards of practice. Temperature and humidity should be monitored and recorded daily using a log or electronic documentation of the heating, ventilation, and air conditioning (HVAC) system.
	• Source AORN: The recommended temperature range in an operating room is between 68° F and 73° F (20° C to 23° C). Collaborate with infection prevention, and facility engineers when determining temperature ranges. The recommended humidity range in an operating room is 20% to 60% based upon addendum to ANSI/ASHRAE/ASHE Standard 170-2008. Each facility should determine acceptable ranges for humidity in accordance with regulatory and accrediting agencies and local regulations. The center for Medicaid and Medicare systems has modified their requirements to allow for the 20% lower limit effective June 2013.

§ 70225	**Surgical Service Staff.** (a) A physician shall have overall responsibility for the surgical service. This physician shall be certified or eligible for certification in surgery by the American Board of Surgery. If such a surgeon is not available, a physician, with additional training and experience in surgery shall be responsible for the service. (b) One or more surgical teams consisting of physicians, registered nurses and other personnel shall be

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	available at all times. (c) A registered nurse with training and experience in operating room techniques shall be responsible for the nursing care and nursing management of operating room service. (d) There shall be sufficient nursing personnel so that one person is not serving as circulating assistant for more than one operating room. e) There shall be evidence of continuing education and training programs for the nursing staff. Note: Authority cited: Sections 1275, 1276.4 and 100275(a), Health and Safety Code. Reference: Sections 1276 and 1276.4, Health and Safety Code. **Survey procedures:** • Is a doctor of medicine or osteopathy assigned responsibility for supervision of the operating rooms? Interview surgical service staff. • Verify the nurse to patient ratio is 1:1 (circulating nurse). • Interview surgical services department RN manager/director. Review the aforementioned persons qualifications regarding the management of the surgical services department Review staffing schedules to determine adequacy of staff and RN supervision. • Does the hospital use LPNs and surgical technologists (ST)? Are the STs assisting with circulating duties, do so in accordance with applicable State laws and medical-staff approved policies and procedures?
§ 70227	**Surgical Service Equipment and Supplies.** (a) There shall be adequate and appropriate equipment and supplies maintained related to the nature of the needs and the services offered, including at least the following monitoring equipment and supplies:(1) Cardiac monitor, with a pulse rate meter, for each patient receiving a general anesthetic. (2) D. C. defibrillator. (3) Electrocardiographic machine. (4) Oxygen and respiratory rate alarms. (5) Appropriate supplies and drugs for emergency use. **Survey procedures:** • Observe cleaning between surgical cases and that appropriate terminal cleaning is applied. Interview surgical staff related terminal cleaning and product usage. Are policies and procedures followed in regards to cleaning? Does staff follow recommended manufacturers dwell times for cleaning products? • Observe that operating room attire is suitable for the surgical case performed. Are persons working in the operating suite wearing only clean surgical attire? Is the surgical attire designed for maximum skin and hair coverage? • Is equipment, i.e., sterilizers available for rapid and routine sterilization of operating room materials?

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	Interview staff regarding the process. Interview surgical staff regarding the use of flash sterilization? Review the hospital's policy if indicated. • Equipment is monitored, inspected, tested, and maintained by the hospital's biomedical equipment program in accordance with Federal and State law, regulations and guidelines and manufacturer's recommendations; medical/surgical devices and equipment are checked and maintained routinely by clinical/biomedical engineers.
§ 70229	**Surgical Service Space.** (a) Hospitals shall maintain operating rooms as follows: (1) Operating rooms shall have a minimum floor dimension of 5.4 meters (18 feet) and shall contain not less than 30 square meters (324 square feet) of floor area. (2) Cast rooms, fracture rooms and cystoscopic rooms, if provided, shall have a minimum floor area of 17 square meters (180 square feet), no dimension of which shall be less than three (3) meters (11 feet) net.
§ 70231	**Anesthesia Service Definition.** Anesthesia service means the provision of anesthesia of the type and in the manner required by the patient's condition with appropriate staff, space, equipment and supplies. A postanesthesia recovery unit is a specific area in a hospital, staffed and equipped to provide specialized care and supervision of patients during the immediate postanesthesia period.
§ 70233	**Anesthesia Service 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. The policies and procedures shall include provision for at least: (1) Preanesthesia evaluation of the patient by an individual qualified to administer anesthesia as a licensed practitioner in accordance with his or her scope of licensure. Persons providing preanesthesia evaluations shall appropriately document pertinent information relative to the choice of anesthesia and the surgical or obstetrical procedure anticipated. (2) Review of the patient's condition immediately prior to induction of anesthesia. (3) Safety of the patient during the anesthetic period. (4) Recording of all events taking place during the induction of, maintenance of and emergence from anesthesia, including the amount and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood fractions. (5) Recording of postanesthetic visits that include at least one note describing the presence or absence of complications related to anesthesia. (b) The responsibility and the accountability of the anesthesia service to the medical staff and

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	administration shall be defined. (c) Rules for the safe use of nonflammable and flammable anesthetic agents which conform with the rules of the State Fire Marshal and Section 70849 shall be adopted. (d) Periodically, an appropriate committee of the medical staff shall evaluate the service provided and make appropriate recommendations to the executive committee of the medical staff and administration. (e) The requirements in this section do not apply to special hospitals unless the special hospital provides this service. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code; and Section 2725, Business and Professions Code. **Survey procedures:** • Interview anesthesia and surgical staff regarding the process of the preanesthesia evaluation of patients. Are the evaluations done by an individual qualified to administer anesthesia as a licensed practitioner in accordance with his or her scope of licensure? Do the persons providing preanesthesia evaluations appropriately document pertinent information relative to the choice of anesthesia and the surgical or obstetrical procedure anticipated? Review patient records to validate. • Does the anesthesiologist review the patient's condition immediately prior to induction of anesthesia? How is the safety of the patient maintained during the anesthetic period. • Review if indicated, the documentation of all events taking place during the induction of, maintenance of and emergence from anesthesia, including the amount and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood fractions. Review the documentation regarding the postanesthetic visits that include at least one note describing the presence or absence of complications related to anesthesia. • Interview appropriate staff regarding the safe use of flammable anesthetic agents. Verify if the hospital uses alcohol-based skin preparations in anesthetizing locations determine whether the service has implemented policies and procedures to minimize the risk of surgical fires.
§ 70235	**Anesthesia Service Staff.** (a) A physician shall have overall responsibility for the anesthesia service. His responsibility shall include at least the: (1) Availability of equipment, drugs and parenteral fluids necessary for administering anesthesia and for related resuscitative efforts. (2) Development of regulations concerning anesthetic safety. (3) Operation of the postanesthesia service. (b) Anesthesia care shall be provided by physicians or dentists with anesthesia privileges, nurse anesthetists, or appropriately supervised trainees in an approved educational program.

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	(c) Anesthesia staff shall be available or on call at all times. (d) A registered nurse with training and experience in postanesthesia nursing care shall be responsible for the nursing care and nursing management in the postanesthesia recovery unit. (e) There shall be sufficient licensed nurses assigned to meet the needs of the patients. (f) Nurses assistants, where provided, shall not be assigned patient care duties unless under the direct supervision of a licensed nurse. **Survey procedures:** • Interview RNs in the post anesthesia nursing care regarding the availability of an anesthesiologist available or on call at all times. Review on call list if indicated. • Nurse to patient ratio in post anesthesia care unit is 1:2 or fewer at all times. • Interview the manager/director of the post anesthesia care unit. Ask who is responsible for the day to day care of patients in post anesthesia care unit? Ensure the RN is qualified. Review staffing schedules to determine adequacy of staff and RN. • Observe the provision of care. If nursing assistants are utilized, are they under the direct supervision of a licensed nurse when assigned patient care duties?
§ 70237	**Anesthesia Service Equipment and Supplies.** (a) There shall be adequate and appropriate equipment for the delivery of anesthesia and postanesthesia recovery care. (1) The anesthetist shall check the readiness, availability, and cleanliness of all equipment used prior to the administration of the anesthetic agents. (2) At least the following equipment shall be provided in the postanesthesia recovery room: (A) Cardiac monitor, with pulse rate meter, in the ratio of 1 monitor for each two (2) patients. (B) D. C. defibrillator. (C) Mechanical positive pressure breathing apparatus. (D) Stripchart electrocardiographic recorder. (E) Sphygmomanometer. (F) Crash cart, or equivalent, with appropriate supplies and drugs for emergency use. **Survey procedures:** • Observe the provision of care. Is there adequate and appropriate equipment for the delivery of anesthesia and post anesthesia recovery care? Is there an emergency cart, or equivalent, with appropriate supplies and drugs for emergency use? • Interview the anesthesiologist regarding who has the responsibility of ensuring equipment is ready, available, and clean prior to the administration of the anesthetic agents.

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	• Observe if the following equipment is provided in the postanesthesia recovery room: cardiac monitor, with pulse rate meter, in the ratio of 1 monitor for each two (2) patients, defibrillator, mechanical positive pressure breathing apparatus, stripchart electrocardiographic recorder, sphygmomanometer, crash cart, or equivalent.
§ 70239	**Anesthesia Service Space.** (a) Postanesthesia recovery unit shall maintain the following spaces as required in Section T 17-314, Title 24, California Administrative Code: (1) Floor area of at least 7.5 square meters (80 square feet) per bed exclusive of the spaces listed below in (2) through (6). (2) Space for a nurses' control desk, charting space, locked medicine cabinet, refrigerator and handwashing lavatory not requiring direct contact of the hands for operation. (3) A utility space including a rim-flush clinic sink and countertop work space at least one meter (3 feet) long. Clean and dirty areas shall be separated. (4) Storage space for clean linen. (5) Storage space for soiled linen. (6) Storage space for supplies and equipment. (7) Air Conditioning. (b) The postanesthesia recovery unit is classified as an electrically sensitive area and shall meet grounding requirements in Section 70853. (c) Beds in the postanesthesia recovery unit shall not be included in the licensed bed capacity of the hospital. **Survey procedures:** Does the anesthesia unit have: nurses station, charting space, locked medicine cabinet, refrigerator, handwashing lavatory, not requiring direct contact of the hands, utility space with rim-flush clinic sink and utility countertop space at least 3 feet long?
§ 70241	**Clinical Laboratory Service Definition.** Clinical laboratory service means the performance of clinical laboratory tests with appropriate staff, space, equipment and supplies.
§ 70243	**Clinical Laboratory Service General Requirements.** (a) Clinical laboratories shall be operated in conformance with the California Business and Professions Code, Division 2, Chapter 3 (Sections 1200 to 1322, inclusive) and the California Administrative Code, Title 17, Chapter 2, Subchapter 1, Group 2 (Sections 1030 to 1057, inclusive). (b) All hospitals shall maintain clinical laboratory services and equipment for routine laboratory work, such as urinalysis, complete blood counts, blood typing, cross matching and such other tests as are required

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	by these regulations. (c) All hospitals shall maintain or make provision for clinical laboratory services for performance of tests in chemistry, microbiology, serology, hematology, pathology and such other tests as are required by these regulations. (d) 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. (e) The responsibility and the accountability of the clinical laboratory service to the medical staff and administration shall be defined. (f) The director of the clinical laboratory shall assure that: (1) Examinations are performed accurately and in a timely fashion. (2) Procedures are established governing the provision of laboratory services for outpatients. (3) Laboratory systems identify the patient, test requested, date and time the specimen was obtained, the time the request reached the laboratory, the time the laboratory completed the test and any special handling which was required. (4) Procedures are established to ensure the satisfactory collection of specimens. (5) A communications system to provide efficient information exchange between the laboratory and related areas of the hospital is established. (6) A quality control system within the laboratory designed to ensure medical reliability of laboratory data is established. The results of control tests shall be readily available in the hospital. (7) Reports of all laboratory examinations are made a part of the patient's medical record as soon as is practical. (8) No laboratory procedures are performed except on the order of a person lawfully authorized to give such an order. (g) Tissue specimens shall be examined by a physician who is certified or eligible for certification in anatomical and/or clinical pathology by the American Board of Pathology or possesses qualifications which are equivalent to those required for certification. Oral specimens may be examined by a dentist who is certified or eligible for certification as an oral pathologist by the American Board of Oral Pathology. A record of his findings shall become a part of the patient's medical record. (1) A tissue file shall be maintained at the hospital or the principal office of the consulting pathologist. (h) The use, storage and disposal of radioactive materials shall comply with the California Radiation Control Regulations, Subchapter 4, Chapter 5, Title 17, California Administrative Code. (i) Where the hospital depends on outside blood banks, there shall be a written agreement governing the

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	procurement, transfer and availability of blood. (j) 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, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** • Interview laboratory personnel regarding the type of point of care testing the hospital utilizes. Observe the use of point of care testing consisting of glucometer, prothrombin time, etc. Interview staff that use point of care testing regarding calibration, controls and how the information is distributed into the medical record. • Observe the laboratory setting. Interview the laboratory director/manager related to any credentialing/certification process. Request and review reports from College of America Pathologists (CAP), California Laboratory Field Service (CLFS) etc, if indicated. • Suggested tracer for laboratory: observe the obtaining of a specimen, blood, tissue etc. How does laboratory staff identify patient prior to obtaining specimen? If possible, follow laboratory staff post blood draw and observe how the specimen is processed in to the laboratory service. Does the laboratory systems identify the patient, test requested, date and time the specimen was obtained, the time the request reached the laboratory, the time the laboratory completed the test and any special handling which was required? Interview laboratory staff on how this is accomplished. • Interview laboratory director or staff regarding what quality control systems the laboratory uses to ensure the reliability of laboratory data. Are results of control tests readily available in the hospital? • If indicated, review the hospital's policy/procedure regarding notifications of critical laboratory results. How is this communicated to all the persons involved? • Interview appropriate staff regarding how laboratory data and reports are populated into a specific medical record. • Ask the laboratory director about blood banking. Does the hospital depend on outside blood bank? Verify there are written agreements governing the procurement, transfer and availability of blood. • Cytology studies and examination of tissue? Ask who does these examinations and how are they qualified?
§ 70245	**Clinical Laboratory Service Staff.** (a) A physician shall have overall responsibility for the clinical laboratory service. This physician shall be certified or eligible for certification in clinical pathology and/or pathologic anatomy by the American Board of Pathology. If such a pathologist is not available on a full-time or regular part-time weekly basis, a physician or a licensed clinical laboratory bioanalyst who is available on a full-time or regular part-time

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	basis may administer the clinical laboratory. In this circumstance, a pathologist, qualified as above, shall provide consultation at suitable intervals to assure high quality service. (b) There shall be a physician, clinical laboratory bioanalyst or clinical laboratory technologist on duty or on call at all times to assure the availability of emergency laboratory services. (c) There shall be sufficient staff with adequate training and experience to meet the needs of the service being offered. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** • Interview the physician in charge of laboratory services regarding the specific qualifications. Is he or she a pathologist? • Interview the laboratory director regarding the on call/availability of qualified staff to ensure services in case of emergency. • Assess staffing. Observe requisitions for laboratory requests. Is there a backlog? Is there significant amount of lag time from when an order is received and test results completed? Are stat tests being completed within policy?
§ 70247	**Clinical Laboratory Service Equipment and Supplies.** (a) There shall be sufficient equipment and supplies maintained to perform the laboratory services being offered. (b) The hospital shall maintain blood storage facilities in conformance with the provisions of Section 1002(g), Article 10, Group 1, Subchapter 1, Chapter 2, Title 17, California Administrative Code. Such facilities shall be inspected at appropriately short intervals each day of the week to assure these requirements are being fulfilled. **Survey procedures:** Interview laboratory director and staff regarding floor space available for the service. Does the lab look crowded with equipment? Can staff safely move about ? The survey team may consult with Department's Laboratory Division for expertise.
§ 70249	**Clinical Laboratory Service Space.** (a) Adequate laboratory space as determined by the Department shall be maintained. (b) If tests on outpatients are to be performed, outpatient access to the laboratory shall not traverse a nursing unit.
§ 70251	**Radiological Service Definition.** Radiological service means the use of X-ray, other external ionizing radiation, and/or thermography,

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	and/or ultra sound in the detection, diagnosis and treatment of human illnesses and injuries with appropriate staff, space, equipment and supplies. Ultra sound although properly the province of physical medicine, may be considered part of the radiological service.
§ 70253	**Radiological Service General Requirements.** (a) All hospitals shall maintain a diagnostic radiological service. (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. (c) The responsibility and the accountability of the radiological service to the medical staff and administration shall be defined. (d) The use, storage and shielding of all radiation machines and radioactive materials shall comply with the California Radiation Control Regulations, Subchapter 4, Chapter 5, Title 17, California Administrative Code. (e) All persons operating or supervising the operation of X-ray machines shall comply with the requirements of the Radiologic Technology Regulations, Subchapter 4.5, Chapter 5, Title 17, California Administrative Code. (f) Diagnostic radiological services may be performed on the order of a person lawfully authorized to give such an order. (g) Reports of radiological service examinations shall be filed in the patient's medical record and maintained in the radiology unit. (h) X-ray films or reproductions thereof, shall be retained for the same period of time as is required for other parts of the patient's medical record. (i) 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. **Survey procedures:** • Observe the provision of care. How are patients identified prior to any procedure? • Are reports of radiological service examinations filed in the patient's medical record and maintained in the radiology units? Interview staff regarding this element. • Interview staff if the X-ray films or reproductions thereof are retained for the same period of time as is required for other parts of the patient's medical record.
§ 70255	**Radiological Service Staff.** (a) A physician shall have overall responsibility for the radiological service. This physician shall be certified or eligible for certification by the American Board of Radiology. If such a radiologist is not

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	available on a full-time or regular part-time basis, a physician, with training and experience in radiology, may administer the service. In this circumstance, a radiologist, qualified as above, shall provide consultation services at suitable intervals to assure high quality service. (b) Sufficient certified radiologic technologists shall be employed to meet the needs of the service being offered. (c) There shall be at least one person on duty or on call at all times capable of operating radiological equipment. **Survey procedures**: • Interview the physician in charge of radiology. Ask if he or she is certified or eligible for certification by the American Board of Radiology. If the radiologist is not available on a full-time or regular part-time basis, a physician, with training and experience in radiology, may administer the service. In this circumstance, a radiologist, qualified as above, shall provide consultation services at suitable intervals to assure high quality service. • Observe the provision of care. Are there sufficient certified radiologic technologists to meet the needs of the service being offered? Are the certified radiologic technologists licenses posted? Or available? If not, interview the department manager regarding the above. • Interview radiological staff and ask if there is at least one person on duty or on call at all times capable of operating radiological equipment?
§ 70257	**Radiological Service Equipment and Supplies.** (a) There shall be sufficient equipment and supplies maintained to adequately perform the radiological services that are offered in the hospital. As a minimum, the following equipment shall be available: (1) At least one radiographic and fluoroscopic unit. On and after January 1, 1977, fluoroscopic units shall be equipped with image intensifiers. (2) Film processing equipment. (b) Proper resuscitative and monitoring equipment shall be immediately available. **Survey procedures:** • Observe the provision of care. Is there sufficient equipment and supplies maintained to adequately perform the radiological services that are offered in the hospital. At a minimum, the following equipment shall be available: At least one radiographic and fluoroscopic unit. On and after January 1, 1977, fluoroscopic units shall be equipped with image intensifiers. • Film processing equipment. • Observe that resuscitative and monitoring equipment are immediately available. • Observe the provision of care. Are staff wearing radiological safety badges? Are lead aprons used on

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	staff and patients? Are the aprons in good repair? Is equipment maintained/tested? Ask for the physicist's report if indicated.
§ 70259	**Radiological Service Space.** (a) There shall be sufficient space maintained to adequately provide radiological services. This shall include but not be limited to the following: (1) A separate X-ray room large enough to accommodate the necessary radiographic equipment and to allow easy maneuverability of stretchers and wheelchairs. (2) Toilet facilities located adjacent to or in the immediate vicinity. (3) Dressing room facilities for patients. (4) Film processing area. (5) Sufficient storage space for all the necessary X-ray equipment, supplies and for exposed X-ray film and copies of reports. (6) Suitable area for viewing and reporting of radiographic examinations. (b) If X-ray examinations are to be performed on outpatients, outpatient access to the radiological spaces shall not traverse a nursing unit. **Survey procedures:** • Observe to ensure there is sufficient space maintained to adequately provide radiological service? • Observe for the following: Is there a separate X-ray room large enough to accommodate the necessary radiographic equipment and to allow easy maneuverability of stretchers and wheelchairs, toilet facilities located adjacent to or in the immediate vicinity, dressing room facilities for patients, film processing area, sufficient storage space for all the necessary X-ray equipment, supplies and for exposed X-ray film and copies of reports, suitable area for viewing and reporting of radiographic examinations. • If X-ray examinations are to be performed on outpatients, observe outpatient access to the radiological spaces shall not traverse a nursing unit.
§ 70261	**Pharmaceutical Service Definition.** Pharmaceutical service means the procuring, manufacturing, compounding, dispensing, distributing, storing and administering of drugs, biologicals and chemicals by appropriate staff which has adequate space, equipment and supplies. Pharmaceutical services also include the provision of drug information to other health professionals and patients.
§ 70263	**Pharmaceutical Service General Requirements** (a) All hospitals having a licensed bed capacity of 100 or more beds shall have a pharmacy on the premises licensed by the California Board of Pharmacy. Those hospitals having fewer than 100 licensed beds shall have a pharmacy license issued by the Board of Pharmacy pursuant to Section 4029 or 4056

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	of the Business and Professions Code. (b) The responsibility and the accountability of the pharmaceutical service to the medical staff and administration shall be defined. (c) A pharmacy and therapeutics committee, or a committee of equivalent composition, shall be established. The committee shall consist of at least one physician, one pharmacist, the director of nursing service or his or her representative and the administrator or his or her representative. (1) The committee shall develop written policies and procedures for establishment of safe and effective systems for procurement, storage, distribution, dispensing and use of drugs and chemicals. The pharmacist in consultation with other appropriate health professionals and administration shall be responsible for the development and implementations of procedures. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. (2) The committee shall be responsible for the development and maintenance of a formulary of drugs for use throughout the hospital. (d) There shall be a system maintained whereby no person other than a pharmacist or an individual under the direct supervision of a pharmacist shall dispense medications for use beyond the immediate needs of the patients. (f) Supplies of drugs for use in medical emergencies only shall be immediately available at each nursing unit or service area as required. (1) Written policies and procedures establishing the contents of the supply procedures for use, restocking and sealing of the emergency drug supply shall be developed. (2) The emergency drug supply shall be stored in a clearly marked portable container which is sealed by the pharmacist in such a manner that a seal must be broken to gain access to the drugs. The contents of the container shall be listed on the outside cover and shall include the earliest expiration date of any drugs within. (3) The supply shall be inspected by a pharmacist at periodic intervals specified in written policies. Such inspections shall occur no less frequently than every 30 days. Records of such inspections shall be kept for at least three years. (g) No drugs shall be administered except by licensed personnel authorized to administer drugs and upon the order of a person lawfully authorized to prescribe or furnish. This shall not preclude the administration of aerosol drugs by respiratory care practitioners. The order shall include the name of the drug, the dosage and the frequency of administration, the route of administration, if other than oral, and the date, time and signature of the prescriber or furnisher. Orders for drugs should be written or transmitted by the prescriber or furnisher. Verbal orders for drugs shall be given only by a person lawfully authorized to prescribe or furnish and shall be recorded promptly in the patient's medical record, noting the name of the

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	person giving the verbal order and the signature of the individual receiving the order. The prescriber or furnisher shall countersign the order within 48 hours. (1) Verbal orders for administration of medications shall be received and recorded only by those health care professionals whose scope of licensure authorizes them to receive orders for medication. (2) Medications and treatments shall be administered as ordered. (h) Standing orders for drugs may be used for specified patents when authorized by a person licensed to prescribe. A copy of standing orders for a specific patient shall be dated, promptly signed by the prescriber and included in the patient's medical record. These standing orders shall: (1) Specify the circumstances under which the drug is to be administered. (2) Specify the types of medical conditions of patients for whom the standing orders are intended. (3) Be initially approved by the pharmacy and therapeutics committee or its equivalent and be reviewed at least annually by that committee. (4) Be specific as to the drug, dosage, route and frequency of administration. (i) An individual prescriber may notify the hospital in writing of his or her own standing orders, the use of which is subject to prior approval and periodic review by the pharmacy and therapeutics committee or its equivalent. (j) The hospital shall develop policies limiting the duration of drug therapy in the absence of the prescriber's specific indication of duration of drug therapy or under other circumstances recommended by the pharmacy and therapeutics committee or its equivalent and approved by the executive committee of the medical staff. The limitations shall be established for classes of drugs and/or individual drug entities. (k) If drugs are supplied through a pharmacy, orders for drugs shall be transmitted to the pharmacy either by written prescription of the prescriber, by an order form which produces a direct copy of the order or by an electronically reproduced facsimile. When drugs are not supplied through a pharmacy, such information shall be made available to the hospital pharmacist. (*l*) Medications shall not be left at the patient's bedside unless the prescriber so orders. Such bedside medications shall be kept in a cabinet, drawer or in possession of the patient. Drugs shall not be left at the bedside which are listed in Schedules II, III and IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended. If the hospital permits bedside storage of medications, written policies and procedures shall be established for the dispensing, storage and records of use, of such medications. (m) Medications brought by or with the patient to the hospital shall not be administered to the patient unless all of the following conditions are met: (1) The drugs have been ordered by a person lawfully authorized to give such an order and the order entered in the patient's medical record. (2) The medication containers are clearly and properly labeled.

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	(3) The contents of the containers have been examined and positively identified, after arrival at the hospital, by the patient's physician or the hospital pharmacist. (n) The hospital shall establish a supply of medications which is accessible without entering either the pharmacy or drug storage room during hours when the pharmacist is not available. Access to the supply shall be limited to designated registered nurses. Records of drugs taken from the supply shall be maintained and the pharmacist shall be notified of such use. The records shall include the name and strength of the drug, the amount taken, the date and time, the name of the patient to whom the drug was administered and the signature of the registered nurse. The pharmacist shall be responsible for maintenance of the supply and assuring that all drugs are properly labeled and stored. The drug supply shall contain that type and quantity of drugs necessary to meet the immediate needs of patients as determined by the pharmacy and therapeutics committee. (o) Investigational drug use shall be in accordance with applicable state and federal laws and regulations and policies adopted by the hospital. Such drugs shall be used only under the direct supervision of the principal investigator, who shall be a member of the medical staff and be responsible for assuring that informed consent is secured from the patient. Basic information concerning the dosage form, route of administration, strength, actions, uses, side effects, adverse effects, interactions and symptoms of toxicity of investigational drugs shall be available at the nursing station where such drugs are being administered and in the pharmacy. The pharmacist shall be responsible for the proper labeling, storage and distribution of such drugs pursuant to the written order of the investigator. (p) No drugs supplied by the hospital shall be taken from the hospital unless a prescription or medical record order has been written for the medication and the medication has been properly labeled and prepared by the pharmacist in accordance with state and federal laws, for use outside of the hospital. (q) Labeling and storage of drugs shall be accomplished to meet the following requirements: (1) Individual patient medications, except those that have been left at the patient's bedside, may be returned to the pharmacy for appropriate disposition. (2) All drug labels must be legible and in compliance with state and federal requirements. (3) Drugs shall be labeled only by persons legally authorized to prescribe or dispense or under the supervision of a pharmacist. (4) Test agents, germicides, disinfectants and other household substances shall be stored separately from drugs. (5) External use drugs in liquid, tablet, capsule or powder form shall be segregated from drugs for internal use. (6) Drugs shall be stored at appropriate temperatures. Refrigerator temperature shall be between 2.2^{o}C (36°F) and 7.7^{o}C (46°F) and room temperature shall be between 15°C (59°F) and 30°C (86°F). (7) Drugs shall be stored in an orderly manner in well-lighted cabinets, shelves, drawers or carts of

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	sufficient size to prevent crowding. (8) Drugs shall be accessible only to responsible personnel designated by the hospital, or to the patient as provided in 70263(*l*) above. (9) Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use. (10) Drugs maintained on the nursing unit shall be inspected at least monthly by a pharmacist. Any irregularities shall be reported to the director of nursing service and as required by hospital policy. (11) Discontinued individual patient's drugs not supplied by the hospital may be sent home with the patient. Those which remain in the hospital after discharge that are not identified by lot number shall be destroyed in the following manner: (A) Drugs listed in Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, shall be destroyed in the presence of two pharmacists or a pharmacist and a registered nurse employed by the hospital. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the witnesses required above shall be recorded in the patient's medical record or in a separate log. Such log shall be retained for at least three years. (B) Drugs not listed under Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, shall be destroyed in the presence of a pharmacist. (r) The pharmacist shall develop and implement written quality control procedures for all drugs which are prepackaged or compounded in the hospital including intravenous solution additives. He or she shall develop and conduct an in-service training program for the professional staff to assure compliance therewith. (s) The pharmacist shall be consulted on proper methods for repackaging and labeling of bulk cleaning agents, solvents, chemicals and poisons used throughout the hospital. (t) Periodically, the pharmacy and therapeutics committee, or its equivalent, shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration. Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Sections 1276, 131050, 131051 and 131052, Health and Safety Code. *See DOM 14-06 (12/16/14) Pharmaceutical Service Changes for GACH (Senate Bill 1039) surveyor guidance. **Survey procedures:** • Review hospital license for licensed bed capacity. For hospital with over 100 licensed beds, there shall be a pharmacy licensed by the California Board of Pharmacy on the premises. For hospitals

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	with fewer than 100 licensed beds, a drug room permit issued by the Board of Pharmacy may be obtained in lieu of a pharmacy license. Review the appropriate license/permit posted in the pharmacy/drug room. • Interview the pharmacist-in charge (PIC) or the individual delegated to fulfill the PIC's functions to see if he/she is aware of his/her accountability to the organized medical staff and governing body. Determine that the medical staff has developed policies and procedures regarding the management of pharmaceutical services. Is the accountability of the pharmaceutical services to the organized medical staff and the governing body defined in the hospital Governing Body and/or Medical Staff by-laws? • Interview the Pharmacist-in-charge (PIC) regarding the structure of the Pharmacy and Therapeutics (P&T) Committee. Is the P&T Committee composed of, minimally, at least one physician, one pharmacist, the director of nursing service or her representative and the administrator or his representative? • Verify that written policies and procedures are developed and consistently implemented for establishment of safe and effective systems for procurement, storage, distribution, dispensing and use of drugs with the purpose of ensuring patient safety and minimizing medication errors. • Validate by observation, interviews and record reviews that policies and procedures are developed and consistently implemented for the safe and effective procurement, storage, distribution, dispensing and use of drugs. • Upon review of patient clinical records, are issues with regard to provision of pharmaceutical services identified? Is the facility aware of the issues? Was there a failure to implement a policy and procedure? • Review the pharmaceutical services policies and procedures, and minutes of the Pharmacy and Therapeutics (P&T) Committee meetings. Determine how policies and procedures are approved to ensure the hospital governing body, administration and medical staff are involved and responsible for the approval of pharmaceutical services policies and procedures. • Is there a method to periodically review and revise pharmaceutical services policies and procedures? Interview the Pharmacist-in-charge (PIC) to determine that the P&T Committee has established a drug formulary to assure quality pharmaceuticals at reasonable costs. Interview members of the P&T Committee and review P&T meeting minutes to determine that there is a process for periodic review of the drug formulary system. • Interview nursing staff to ascertain no person other than a pharmacist, or an individual under the direct supervision of a pharmacist, dispenses medications for use beyond the immediate needs of the patients. Is there a hospital policy and procedure defining who may dispense medications for use beyond the immediate needs of the patients?

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	• Interview nursing staff to determine if prescribed medications are available 24 hours a day. Interview the pharmacist-in-charge (PIC) regarding access to drug supplies by nursing staff after pharmacy hours. Interview the PIC on how non-formulary drugs, when ordered, are made available in a timely manner. • Validate that emergency drug supplies are immediately available in patient care areas. Are drug supplies for the management of malignant hyperthermia (MH) readily available if triggering agents are used in the hospital? (Note: Triggering agents are anesthetic agents which can cause an MH crisis in a susceptible person. Examples include anesthesia gases such as halothane, enflurane, isoflurane, sevoflurane and desflurane; and the muscle relaxant succinylcholine.) • Review the emergency drug supply policies and procedures and the emergency drug supply list to ensure the emergency drug supply: 1. Is approved by the appropriate hospital committee 2. Meets the needs of the patient population that the hospital serves. • Spot-check emergency supply carts to verify contents match content list on the outside cover. Verify that the drug supply is stored in a clearly marked portable container (or cart) sealed by the pharmacist and a content list, including the earliest expiring drug is on the outside cover of the container or cart. • Review the inspection records to verify that a pharmacist inspects emergency drug supplies in the hospital no less frequently than every 30 days, and records are kept for at least 3 years. • Interview the PIC and/or nursing staff to determine if personnel other than licensed nurses administer drugs or biologicals? If yes: • Determine if those personnel are administering drugs or biologicals in accordance with Federal and State laws and regulations, including scope of practice, hospital policy, and medical staff by-laws, rules and regulations. • Review a sample of medical records from different patient care areas (Med-Surge, ICU, PACU, Imaging, etc.) to determine whether medication administration conformed to an authorized practitioner's order, i.e., there is an order from an authorized practitioner, or an applicable standing order, and that the correct medication was administered to the right patient at the right dose via the correct route at the right time. Verify the practitioner's order was still in force at the time the drug was administered. • Determine whether all orders for drugs and biologicals are included in the patient's medical record and dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. • Review a sample of both open and closed patient medical records to verify if verbal orders are dated, timed, and authenticated within 48 hours by the ordering practitioner or, if permitted under State law, hospital policy and medical staff bylaws, rules and regulations, another practitioner who is responsible for the care of the patient.

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	• Are verbal orders received and recorded only by those health care professionals whose scope of licensure authorizes them to receive orders for medication? Has the individual receiving the verbal order dated, timed, and signed the order according to hospital policy? Interview direct care staff to determine whether actual practice is consistent with verbal order policies and procedures.
	• Observe the preparation of drugs and their administration to patients (medication pass observation) and reconcile observations with physicians' orders to verify medications are administered as ordered.
	• Is the patient's identity confirmed prior to medication administration?
	• Are procedures to assure the administration/use of the correct medication, dose, and route followed?
	• Are drugs administered with the correct techniques in accordance with the manufacturer's specifications and the hospital's policies and procedures?
	• Does the nurse remain with the patient until medication is taken or used, such as oral, self-administered creams or eye or ear drops, etc.? If self-administered, is there a care plan?
	• Review both open and closed records to determine if standing orders and titration protocols are properly followed.
	• Interview the PIC on approval and review process of standing orders. Review a sample of open and/or closed patient medical records to validate that standing orders were dated, promptly signed by the prescriber and contained the following required elements:
	  ▪ The circumstances under which the drug is to be administered.
	  ▪ The medical conditions the standing orders are intended for.
	  ▪ Drug name, dosage, route and frequency of administration.
	• Review a sample of physician specific standing orders to verify compliance of approval and periodic review, and to evaluate for clinical appropriateness.
	• Interview staff pharmacists on policies on stop order to limit the duration of drug therapy and how stop orders are implemented. Validate consistent implementation of stop-order policies by record review.
	• Interview the pharmacist-in-charge (PIC) to determine how medication orders are transmitted to the pharmacy and how medication orders are reviewed to ensure patient safety and minimize medication errors.
	• If bedside storage of medications is permitted, review hospital policy on bedside storage of medications. Interview nursing staff to determine if any patients have medications stored at bedside. Inspect storage of bedside medications for compliance with this regulation. Verify that drugs listed in Schedules II, III and IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 are not allowed for bedside storage.
	• Ask nursing unit staff if any patients are currently using medications from home. Are there policies and procedures addressing how medications brought in by patients are identified prior to administration to

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	the patients? Select appropriate records to validate compliance on ordering, labeling and identifying of patients' own medications prior to administration. • Interview nursing staff on how to access medications when the pharmacist is not available and who may access the supply of medications. Interview pharmacist(s) on how medications removed from the pharmacy after hours are reconciled and how that drug supply is maintained. Verify through pharmacy record reviews drugs were removed from the after-hour drug supply only by designated registered nurses and only in amounts sufficient for immediate therapeutic needs of patients and there was record indicating the name and strength of the drug, the amount taken, the date and time, the name of the patient to whom the drug was administered and the signature of the registered nurse. • Interview a principal investigator (physician) or the pharmacist responsible for the dispensing of investigational drugs on procedures for obtaining informed consent, handling and use of investigational drugs. Review the policy and procedure on investigational drugs to determine if there is a process to ensure that investigational medications are safely controlled and administered. Is drug information readily available for nurses and pharmacists handling and administering investigational drugs. Are investigational drugs only ordered by the specific physician investigators? Are investigational drugs properly labeled, stored and distributed by pharmacists? • Interview pharmacy staff to verify hospital drug supply is not taken from the hospital unless a prescription or medication order has been written by an authorized prescriber. If the hospital pharmacy dispenses medications for use outside of the hospital such as discharge medications, employee prescriptions and emergency walk-in customers, review dispensing record to verify that such drugs were dispensed pursuant to chart orders or prescriptions in accordance with state and federal laws. See • Interview the pharmacist-in-charge (PIC) to determine how returned medications from nursing units are handled. Does the hospital have a process to ensure appropriate disposition of returned medications? • Spot-check the labels of individual drug containers to verify they conform to state and federal requirements. Is labeling of drugs done by only persons legally authorized to prescribe or dispense or under the supervision of a pharmacist? • Inspect medication storage areas to verify drugs for external use in liquid, tablet, capsule or powder form are segregated from drugs intended for internal use. In addition, test agents, germicides, disinfectants and other chemicals are stored separately from drugs. • Does the hospital have policy and procedures addressing proper medication storage and temperature monitoring of medication storage areas? Spot check medication storage refrigerators and review temperature monitoring records to validate that refrigerator temperature is kept between 2.2˚C (36˚F) and 7.7˚C (46˚F) and room temperature for medication storage is kept between 15˚C (59˚F) and 30˚C

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	(86˚F). [Note: Certain drugs may have stricter temperature ranges for proper storage. Refer to packaging for proper storage condition.] • Inspect drug storage areas. Are drugs stored in an orderly manner in well lighted cabinets, shelves, drawers or carts of sufficient size to prevent crowding? • Review hospital policies and procedures governing the security of drugs and biologicals. Through observation and staff interview, determine if drugs are accessible only to authorized personnel. • Spot-check patient-specific medications, floor stock medication supplies and emergency drug supply containers to identify expired, mislabeled or unusable medications. Look for improperly stored medications, opened single-dose vials, multi-dose vials that are opened but not dated and unidentified medications. • Request floor inspection record from PIC to verify that medication storage areas are inspected by a pharmacist at least monthly and irregularities are reported to the director of nursing and as required by hospital policy. • Review pharmacy controlled substance wastage/disposal record to determine if drugs listed in Schedules II, III and IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, are destroyed in the presence of two pharmacists or a pharmacist and a registered nurse, and such destructions are properly documented and records are retained for at least three years. • Interview the pharmacist-in-charge (PIC) on quality control procedures for drugs prepackaged or compounded in the hospital to determine compliance with current state and federal requirements. Review policies and procedures on compounding and sterile compounding for inclusion of proper quality control procedures. Interview pharmacy and nursing staff on whether in-service training program on prepackaging, compounding of topical/oral agents, admixing/compounding of intravenous drugs was provided. • Interview the pharmacist-in-charge (PIC), other department representatives, housekeeping staff on pharmacy involvement in repackaging and labeling of cleaning agents, solvents, chemicals and poisons used in the hospital. • Interview members of the Pharmacy and Therapeutics (P&T) committee to determine how, and how often pharmaceutical services are being evaluated by administration. Review any recent recommendations on pharmacy services made by the P&T Committee and verify that the Medical Executive Committee (MEC) and the governing body of the hospital responded to the recommendations. Verify pharmacy services are integrated into the hospital-wide quality assurance program.
Health & Safety	Regulation can be found under “Resources,” entitled “GACH HSC Requirements”

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Code § 1339.63 **Medication Error Reduction Program (MERP)**	**Guidance to Surveyors:** If the nurse surveyor is required to review compliance for this regulation, use GACH HSC Requirement documents for regulation language. **Survey procedures:** • Review the hospital's MERP activity records. Does the facility have a method to address each of the "procedures and systems" listed under subdivision (d) of H&SC 1339.63 to identify weaknesses or deficiencies that could contribute to errors in the administration of medication? [Note: Procedures and systems listed under subdivision (d) include, but are not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.] See 1339.63(e)(1) • Did the facility, on an annual basis, assess the effectiveness of the implementation of the plan for each of the procedures and systems listed under subdivision (d) of H&SC 1339.63? [Note: Procedures and systems listed under subdivision (d) include, but are not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.] • Has the plan been modified when weakness or deficiencies are noted to achieve the reduction of medication errors? See 1339.63 (e)(3) • Are the systems or processes utilized by the hospital for identifying actual or potential medication-related errors: a.)proactively, b.) concurrently, and c.) retrospectively? See 1339.63 (e)(5) • Is the committee responsible for the MERP process of the hospital multidisciplinary in nature; i.e., does it include representatives from administration, nursing, pharmacy and medical staffs? Does the multidisciplinary process regularly analyze all identified actual and potential medication related errors? Does the multidisciplinary group regularly analyze all identified actual or potential medication-related errors? Can the facility demonstrate how its multidisciplinary analysis of medication-related events has been utilized to change its procedures and/or systems to reduce medication-related errors? 1339.63 (e)(6) • Does the plan include a process or systems incorporating external medication error alerts to modify current processes and systems? See 1339.63 (e)(7)
§ 70265	**Pharmaceutical Service Staff.** A pharmacist shall have overall responsibility for the pharmaceutical service. He shall be responsible for the procurement, storage and distribution of all drugs as well as the development, coordination, supervision and review of pharmaceutical services in the hospital. Hospitals with a limited permit shall employ a pharmacist on at least a consulting basis. Responsibilities shall be set forth in a job description or agreement between the pharmacist and the hospital. The pharmacist shall be responsible to the

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	administrator and shall furnish him written reports and recommendations regarding the pharmaceutical services within the hospital. Such reports shall be provided no less often than quarterly. **Survey procedures:** • Review the implementation of the pharmacist-in-charge's (PIC's) responsibilities by: • Reviewing written status reports furnished by the PIC to administration; • Reviewing minutes of meetings (if any) regarding pharmaceutical services; • Reviewing the job description or the written agreement to verify the responsibilities of the pharmacist are clearly defined and include development, supervision and coordination of all the activities of pharmacy services; • Determining whether the PIC routinely evaluates the performance and competency of pharmacy personnel. Do performance evaluations include, but are not necessarily limited to, high-risk activities such as the compounding of hazardous medications, pharmacy-based prescriptive activities (e.g. anticoagulants, aminoglycoside protocols) and pharmaceutical care for high-risk patients (pediatric, ICU, geriatric etc.)? Is the pharmacy responsible for the procurement, distribution and control of all medication products used in the hospital (including medication-related devices such as infusion pumps, etc.)?
§ 70267	**Pharmaceutical Service Equipment and Supplies.** (a) There shall be adequate equipment and supplies for the provision of pharmaceutical services within the hospital. (b) Reference materials containing monographs on all drugs in use in the hospital shall be available in each nursing unit. Such monographs must include information concerning generic and brand names, if applicable, available strengths and dosage forms and pharmacological data including indications, side effects, adverse effects and drug interactions. **Survey procedures:** • Interview pharmacy and nursing staff to determine if adequate equipment and supplies are available for the provision of pharmaceutical services to meet patients' needs, including but not limited to, equipment and supplies for drug preparation and administration to ensure patient safety. • Interview nursing staff on available drug references in nursing stations. Spot-check available references to ensure that drug references are current.
§ 70269	**Pharmaceutical Service Space.** (a) Adequate space shall be available at each nursing station for the storage of drugs and preparation of medication doses. (b) All spaces and areas used for the storage of drugs shall be lockable and accessible to authorized

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	personnel only. **Survey procedures**: • Determine during medication administration observation (med pass) and tour of patient care areas if adequate space is available at nursing stations for the storage and preparation of medications. See 70269(a) • Spot-check medication storage areas, including various departments where medications are stored (e.g. Cath Lab) to verify entry to such areas are lockable, and access to drugs are restricted to authorized personnel only. See 70269(b)
§ 70271	**Dietetic Service Definition.** Dietetic service means providing safe, satisfying and nutritionally adequate food for patients with appropriate staff, space, equipment and supplies. • NOTE: please use the California Retail Food Code as reference if needed (not Federal Food Code). http://www.publichealth.lacounty.gov/eh/docs/specialized/cacode.pdf
§ 70273	**Dietetic Service General Requirements.** (a) The dietetic service shall provide food of the quality and quantity to meet the patient's needs in accordance with physicians' orders and, to the extent medically possible, to meet the Recommended Daily Dietary Allowances, 1974 Edition, adopted by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, 2107 Constitution Avenue, Washington, DC 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 and shall be offered to all patients unless counter ordered by the physician. (4) Patient food preferences shall be respected as much as possible and substitutes shall be offered through use of a selective menu or substitutes from appropriate food groups. (5) When food is provided by an outside food service, all applicable requirements herein set forth shall be met. The hospital shall maintain adequate space, equipment and staple food supplies to provide patient food service in emergencies. (b) Policies and procedures shall be developed and maintained in consultation with representatives of the medical staff, nursing staff and administration to govern the provision of dietetic services. Policies shall be approved by the medical staff, administration and governing body. Procedures shall be approved by the medical staff and administration. (c) The responsibility and the accountability of the dietetic service to the medical staff and administration shall be defined.

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	(d) A current diet manual approved by the dietitian and the medical staff shall be used as the basis for diet orders and for planning modified diets. Copies of the diet manual shall be available at each nursing station and in the dietetic service area. (e) Therapeutic diets shall be provided as prescribed by a person lawfully authorized to give such an order and shall be planned, prepared and served with supervision and/or consultation from the dietitian. Persons responsible for therapeutic diets shall have sufficient knowledge of food values to make appropriate substitutions when necessary. (f) A current profile card shall be maintained for each patient indicating diet, likes, dislikes and other pertinent information concerning the patient's dietary needs. (g)Menus: (1) Menus for regular and routine modified diets shall be written at least one week in advance, dated and posted in the kitchen at least three days in advance. (2) If any meal served varies from the planned menu, the change shall be noted in writing on the posted menu in the kitchen. (3) Menus shall provide a variety of foods in adequate amounts at each meal. (4) Menus should be planned with consideration for cultural and religious background and food habits of patients. (5) A copy of the menu as served shall be kept on file for at least 30 days. (6) Records of food purchased shall be kept available for one year. (7) Standardized recipes, adjusted to appropriate yield, shall be maintained and used in food preparation. (h) Food shall be prepared by methods which conserve nutritive value, flavor and appearance. Food shall be served attractively at appropriate temperatures and in a form to meet individual needs. (i) Nutritional Care. (1) Nutritional care shall be integrated in the patient care plan. (2) Observations and information pertinent to dietetic treatment shall be recorded in patient's medical records by the dietitian. (3) Pertinent dietary records shall be included in patient's transfer discharge record to ensure continuity of nutritional care. (j) In-service training shall be provided for all dietetic service personnel and a record of subject areas covered, date and duration of each session and attendance lists shall be maintained. (k) Food Storage. (1) Food storage areas shall be clean at all times. (2) Dry or staple items shall be stored at least 30 cm (12 inches) above the floor, in a ventilated room,

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	not subject to sewage or waste water backflow, or contamination by condensation, leakage, rodents or vermin. (3) All readily perishable foods or beverages capable of supporting rapid and progressive growth of microorganisms which can cause food infections or food intoxication shall be maintained at temperatures of 7 degrees C (45 degrees F) or below, or at 60 degrees C (140 degrees F) or above, at all times, except during necessary periods of preparation and service. Frozen food shall be stored at -18 degrees C (0 degrees F) or below. (4) There shall be a reliable thermometer in each refrigerator and in storerooms used for perishable food. (5) Pesticides, other toxic substances and drugs shall not be stored in the kitchen area or in storerooms for food and/or food preparation equipment and utensils. (6) Soaps, detergents, cleaning compounds or similar substances shall not be stored in food storerooms or food storage areas. (l) Sanitation. (1) All kitchens and kitchen areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. (2) All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas. (3) Plasticware, china and glassware that is unsightly, unsanitary or hazardous because of chips, cracks or loss of glaze shall be discarded. (4) Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner. (5) Kitchen wastes that are not disposed of by mechanical means shall be kept in leakproof, nonabsorbent, tightly closed containers and shall be disposed of as frequently as necessary. (m) All utensils used for eating, drinking and in the preparation and serving of food and drink shall be cleaned and disinfected or discarded after each usage. (1) Gross food particles shall be removed by scraping. (2) The utensils shall be thoroughly washed in hot water with a minimum temperature of 43 degrees C (110 degrees F), using soap or detergent, rinsed in hot water to remove soap or detergent and disinfected by one of the following methods or an equivalent method approved by the Department: (A) Immersion for at least two minutes in clean water at 77 degrees C (170.6 degrees F). (B) Immersion for at least 30 seconds in clean water at 82 degrees C (180 degrees F). (C) Immersion in water containing bactericidal chemical as approved by the Department.

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	(3) After disinfection the utensils shall be allowed to drain and dry in racks or baskets on nonabsorbent surfaces. Drying cloths shall not be used. (4) Results obtained with dishwashing machines shall be equal to those obtained by the methods outlined above and all dishwashing machines shall meet the requirements contained in Standard No. 3 as amended in April 1965 of the National Sanitation Foundation, P.O. Box 1468, Ann Arbor, MI 48106. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** • Ask the director of food service/or other appropriate individual for menu analysis to determine (Recommended Dietary Allowances) RDAs are met for all diets. Observe the provision of care and/or Interview the above regarding the meal times. Are 3 meals provided daily? What is the length of time between dinner and breakfast meals? Not more than 14 hours. Interview patients with a physician ordered supplement to determine if the order has been implemented. Observe for nourishments (snacks) availability on each unit. Interview both staff and patients regarding the delivery of nourishments. Based on hospital's policy, interview the Director of Food Services to see the nourishment par list for each nursing unit. • Interview dietary clerk how patient food preferences are obtained? Review the patient menu. If the hospital doesn't have a selective menu, how do they offer substitutes? What is their policy? Interview both staff and patients regarding their food preferences. • Within the hospital, interview dietary staff regarding whether the meals are produced in the facility or do they outsource? Observe that they have equipment, enough space to create meals, and food supplies. Review and verify policies for use of this kitchen area if food does not come in as planned from the outside service (i.e. emergency). • Verify policies and procedures for dietetic services. Verify that they are approved by medical staff and administration. How is the dietetic services organized (i.e. organization chart), and verify the responsibility and accountability overseen by medical staff and administration. Review diet manual. Verify it is approved by the hospital dietitian and medical staff. Is the diet manual used as the basis for diet orders and planning of modified diets. A diet manual includes these components: the routinely ordered diets in the hospital, nutritional adequacy, purpose, sample menu, foods allowed and not allowed. Interview nursing staff in hospital how they would access diet information or the diet manual? • Review patient medical charts for ordered diets to ensure diets served are ordered by the person lawfully authorized (i.e. physician, PA, NP). • Review the therapeutic menu spread sheet for all diets offered to ensure there is variety of foods.

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	Observe a meal on tray line to ensure portions are plated per the diet order. • Interview cultural diverse population of patients regarding the menu offerings. Review hospital patient population and menu offerings for ethnic foods. • Is a copy of the menu as served kept on file for at least 30 days? Records of food purchased shall be kept available for 1 year. Interview director of dietary for the information. Observe the use of recipes by staff. Recipes should be standardized for yield (how many portions the recipe will produce), and appropriateness of diets. Interview a cook and ask them to describe the preparation of a recipe from the daily menu. The cook should reference the recipe and demonstrate the addition of ingredients to make the recipe equal to the amount of the number on the production sheet (this is a sheet that is a tally of the number of patients on any particular diet). If room service is done, look at recipe for soups or other items that may be done in bulk. • Observe food preparation for: ensure the finished recipe is not completed to soon (45-60 minutes prior to service). Food that is held for extended time frames loses nutritive value and compromises palatability. Observe food at meal times on the nursing units. Interview patients and family regarding food quality, temperatures and if specific dietary needs are being met (are foods are chopped, have adequate moisture and at proper texture for patient safety)**.** • Interview appropriate staff or review census to identify patients at risk for nutrition deficits for dietary care plan, eg. diabetic, renal failure, low sodium. See 70273(i)(1) • Reference documents: 1) patient census, 2) patient diet list. These documents will be used to identify patients at nutritional risk based on: diagnosis, age, length of stay, diet order, height/weight, diet intake, and relevant lab values (i.e. albumin and/or prealbumin, glucose). These documents may or may not have all of these elements. Review the patient census and the patient diet list. Nutritionally related diagnoses may include: Diabetic Ketoacidosis or diabetes out of control, malnutrition, elderly (orthopedic surgery), non-healing wounds, head/neck/throat cancer, dialysis or renal failure, CHF. Diet orders may include: tube feeding (enteral nutrition), total parenteral nutrition, puree, diets with multiple restrictions (2g Na, cardiac, chopped), fluid restrictions, protein restrictions (<40 or >100 grams), calorie restrictions (less than 1200 calories). Length of stay – choose records with variable length of stays >3 days. Note: The longer the length of stay the greater the nutritional risk. Determine if a nutritional need exists - is there a comprehensive nutritional assessment, nutritional interventions (if needed), and timely reassessment of nutritional status. Look at the nutrition screen, po intakes. If the record review reveals deficiencies in nutritional care then interview the clinical RD. Ask the RD to explain the rationale of the care/lack of care provided. Review the policy on nutrition assessment and reassessment time frames/prioritization. If a deficiency in nutrition care is identified the hospital is required to provide care based on patient needs rather than standardized policies • Request a list of transferred or discharged patients with a length of stay of 4 - 7 days. Review for

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	inclusion of pertinent dietary records upon discharge. Instructions should include the most recent diet order, nutrition assessment, or any pertinent diet education. Suggested diagnoses may include: newly diagnosed or out of control diabetic, dialysis, bariatric surgery, head/neck cancer. Choose 2 - 3 discharge patient records from this list to review. • Interview the Director of Food Service. Ask what is required for dietary personnel related to ongoing training and education. Review and verify in-service records for dietetic service personnel e.g. safe food handling, therapeutic diets, etc. • Observe all kitchen areas (all campuses, cafeterias, etc.) for cleanliness. Are they clean? • Observe kitchen and dry storage areas. Is food stored at least 12 inches off the floor? Is the room ventilated? If overhead pipes are observed interview a plant engineer regarding the contents of overhead pipes. If the contents are waste water or sewage in the pipes it will be a finding. • Definition of potentially hazardous food (PHF): food that is capable of supporting the rapid and progressive growth of bacteria associated with foodborne illness. Examples are: meat, milk & milk products, cooked rice, beans, pasta, potatoes, eggs, cut melons, heat treated vegetables, tomatoes, soy products, sprouts, garlic in oil mixture, hot cereal. • Observe the internal refrigerator thermometer. If the temperature is >43 F then take the internal temperature of a PHF. If greater than>45F then recheck food item in 1-2 hours. If still >45F interview the Director of Food Service regarding appropriate refrigerator temperatures. Review food storage temperature policy. If the hospital is following a stricter temperature range (i.e. 41F) then hold them to their policy. • If prepared PHF is observed in the refrigerator, take internal temperatures of PHF. Interview cook who prepared the PHF to determine if the item was cooled properly (i.e. per hospital policy). Hot items must cool to 70F in 2 hours and to 41F or less within an additional 4 hours (total of 6 hours). Food prepared at room temperature (i.e. canned tuna salad). Determine if food was cooled to 41F within 4 hours by interviewing the cook. • Observe the internal freezer thermometer. Are foods frozen solid? • Verify the presence of thermometers in refrigerator and storeroom. • Are they valid and reliable? • Observe food storerooms and kitchen to ensure there are no pesticides, toxic substances and drugs. There should be a separate chemical storeroom in the kitchen. Interview staff regarding the location of cleaning substances. Observe food storerooms and storage areas to ensure soaps, detergents, cleaning agents, and similar not present in food storage areas. • Observe overall sanitation in kitchen (if multiple campuses go to all kitchens and cafeterias). Are surfaces clean, floors free from litter and debris? Observe kitchen and kitchen areas for traces of insects (black droppings, run lines on the baseboards for a grease line from mice whiskers, observe

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	dark area with a flashlight for roaches). If indicated, ask for pest control contract. • Observe shelving and counters to see if the finish is coming off, if rusted or corroded then it is not a cleanable surface. Observe utensils and equipment to are they in good repair? Are they free from chips, cracks, corrosion and open seams? Observe all plasticware (trays included), china and glassware to ensure a smooth surface, they should be shiny not dull (loss of glaze), stained or discolored. • Interview dietary staff regarding the maintenance of ice machines. Who is responsible? If indicated, have dietary staff or maintenance staff take off ice machine cover where ice is produced. Observe for build-up of any brown, black, white, or pink substances in the trough, chute or bin. Ask about the cleaning and sanitation process and how often it is done? If an offsite vendor cleans and sanitizes then get contact information and call them to do a phone interview on their process. Review manufacturer's directions for ice machine (what chemical should be used) and review hospital policy and procedure. • Observe utensils (forks, knives, spoons) to ensure they are clean. • Observe or interview the person regarding the three compartment sink operation. SINK 1 - Are utensils thoroughly washed in hot water with a minimum temperature of 110 degrees F using soap or detergent? Have staff test water temperature. SINK 2 – are items being rinsed (immersed) in hot water to remove soap or detergent? SINK 3 - disinfection of items by one of the following methods or an equivalent approved by the department: ▪ Immersion of at least 2 minutes in water of at least 170° F; ▪ Immersion of at least 30 seconds in clean water of at least 180°F; ▪ Immersion of water containing bactericidal chemical as approved by the department. (Quaternary ammonium is 150-400 ppm, however, look at manufacturer's label; chlorine 50ppm). ▪ Review policy on manual dishwashing. • Observe to see they are putting away dry dishes and they are air drying before stacking. • Drying cloths shall not be used. • Interview the dietary staff to explain the dish machine process and how they ensure accurate operation. If no system to verify dish machine use your lollipop thermometer to run through the dish machine (if a high temperature dish machine 180° F at the manifold, and 160°F at plate level). For low temperature, have the dietary staff verify the sanitizer concentration with a test strip. (Quaternary ammonium 150-400 ppm, look at manufacturer's label; chlorine 50ppm) • Observe the disaster food and water plan, menu & inventory. Ask the Director of Food Service how many people the plan is feeding and for how long. The number should be the licensed bed count (not current census) plus staff & visitors. The amount of days should be based on what the county has instructed. Review the inventory & compare to the food in the storeroom & the menu. Review

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	the inventory, menu & policy. Observe the water on hand with the plan. Interview the Facilities person or who is in charge of ensuring the water is available.
§ 70275	**Dietetic Service Staff.** (a) A registered dietitian shall be employed on a full-time, part-time or consulting basis. Part-time or consultant services shall be provided on the premises at appropriate times on a regularly scheduled basis and of sufficient duration and frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, patient counseling, guidance to the supervisor and staff of the dietetic service, approval of all menus and participation in development or revision of dietetic policies and procedures and in planning and conducting in-service education programs. (b) If a registered dietitian is not employed full-time, a full-time person who meets the training requirements to be a dietetic services supervisor specified in section 1265.4(b) of the Health and Safety Code shall be employed to be responsible for the operation of the food service. (c) Sufficient dietetic service personnel shall be employed, oriented, trained and their working hours scheduled to provide for the nutritional needs of the patients and to maintain the dietetic service areas. If dietetic service employees are assigned duties in other service areas, those duties shall not interfere with the sanitation, safety or time required for dietetic work assignments. (d) Current work schedules by job titles and weekly duty schedules shall be posted in the dietetic service area. (e) A record shall be maintained of the number of persons by job title employed full or part-time in dietetic services and the number of hours each works weekly. (f) Hygiene of Dietetic Service Staff. (1) Dietetic service personnel shall be trained in basic food sanitation techniques, shall be clean, wear clean clothing, including a cap and/or a hair net and shall be excluded from duty when affected by skin infection or communicable diseases. Beards and mustaches which are not closely cropped and neatly trimmed shall be covered. (2) Employee's street clothing stored in the kitchen area shall be in a closed area. (3) Kitchen sinks shall not be used for handwashing. Separate handwashing facilities with soap, running water and individual towels shall be provided. (4) Persons other than dietetic personnel shall not be allowed in the kitchen area unless required to do so in the performance of their duties. Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Sections 1276, 131050, 131051 and 131052, Health and Safety Code **Survey procedures:** • Interview the Registered Dietitian (RD) regarding how many hours are worked at the hospital (full-

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	time, part-time, or consulting) and what times and days are worked. A RD must have oversight to food services and be ranted the authority by the hospital to make decisions related to food service activities. Include in the interview, the RD daily departmental responsibilities. The responsibilities must include oversight of the day to day operations of the department and as the liaison with the medical and nursing staffs, advice to the administrator, patient counseling, guidance to kitchen supervisor and staff, approval of all menus and participation in development or revision of dietetic policies and procedures and in planning and conducting in-service programs. Review the organization chart of the dietetic service department. Verify the position description includes all of these responsibilities. If the Director of Food service is not a RD, then the relationship between the Director and the RD shall not be supervisory but should be a peer level. The RD may report to a hospital administrator, such as a Vice President of Operations/Chief Officer of Operations. Review new hire personnel records in dietetic services for orientation and training for their job position. • Review RD schedule to ensure RD coverage 7 days a week (if multi-campuses ensure coverage for all campuses). If a clinical patient is not seen per policy this could be due to lack of adequate staffing. • Observe for posted schedule to determine if current and includes the job titles. Review the departmental schedule for the last 30 days and verify the number of staff by job title full or part-time in dietetic services and weekly hours worked. • Observe food service staff for hand washing and glove changes. Observe to ensure they are not wearing aprons outside kitchen. Observe staff wearing clean clothes. Observe for food service staff who may be sick or with skin infections. Unless closely cropped and neatly trimed, observe hair nets or caps and/or beard restraints are being worn and completely cover all exposed hair. • When you enter the kitchen, first wash hands in the handwashing sink. Check to make sure there is soap, running water and individual towels. Observe dietary or other staff for handwashing upon entering the kitchen. • Observe for persons, other than dietetic personnel in the kitchen area, they are not allowed unless required to do so in the performance of duties. • Ask the Director of Food Service if they are a hospital employee or a contracted employee. If there is a Contract Food Service Company then ask to review the contract. Ensure the contract specifies that “the hospital retains professional and administrative responsibility for the services rendered."
Health and Safety Code	(a) A licensed health facility, as defined in subdivision (a), (b), (c), (d), (f), or (k) of Section 1250, shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements

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§ 1265.4 **Qualifi-cations of Dietary Supervisor**	of subdivision (b) To supervise dietetic service operations. The dietetic services supervisor shall receive frequently scheduled consultation from a qualified dietitian. (b) The dietetic services supervisor shall have completed at least one of the following educational requirements: (1) A baccalaureate degree with major studies in food and nutrition, dietetics, or food management and has one year of experience in the dietetic service of a licensed health facility. (2) A graduate of a dietetic technician training program approved by the American Dietetic Association, accredited by the Commission on Accreditation for Dietetics Education, or currently registered by the Commission on Dietetic Registration. (3) A graduate of a dietetic assistant training program approved by the American Dietetic Association. (4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. (5) Is a graduate of a college degree program with major studies in food and nutrition, dietetics, food management, culinary arts, or hotel and restaurant management and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. (6) A graduate of a state approved program that provides 90 or more hours of classroom instruction in dietetic service supervision, or 90 hours or more of combined classroom instruction and instructor led interactive Web-based instruction in dietetic service supervision. (7) Received training experience in food service supervision and management in the military equivalent in content to paragraph (2), (3), or (6). **Survey Procedures:** • Does the facility employ a full-time, part-time, or consulting dietitian? • If the facility employs a registered dietitian less than full time in dietetic services, does the facility also employ a full time dietetic services supervisor? • How often does the Dietetic Services Supervisor receive consultation from a qualified dietitian? • The hospital's dietitian and dietetic service supervisor qualifications requirement to see if it has the required educational requirements for a dietitian.

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	• **If there is a consolidated license, each campus will need to have their own qualified DSS. Please call your nutrition consultant if you need assistance in investigating. • This does not limit the evaluator in conducting a full investigation as needed.
§ 70277	**Dietetic Service Equipment and Supplies.** (a) Equipment of the type and in the amount necessary for the proper preparation, serving and storing of food and for proper dishwashing shall be provided and maintained in good working order. (1) The dietetic service area shall be ventilated in a manner that will maintain comfortable working conditions, remove objectionable odors and fumes and prevent excessive condensation. (2) Equipment necessary for preparation and maintenance of menus, records and references shall be provided. (3) Fixed and mobile equipment in the dietetic service area shall be located to assure sanitary and safe operation and shall be of sufficient size to handle the needs of the hospital. (b) Food Supplies. (1) At least one week's supply of staple foods and at least two (2) days supply of perishable foods shall be maintained on the premises. Supplies shall be appropriate to meet the requirements of the menu. (2) All food shall be of good quality and procured from sources approved or considered satisfactory by federal, state and local authorities. Food in unlabeled, rusty, leaking, broken containers or cans with side seam dents, rim dents or swells shall not be accepted or retained. (3) Milk, milk products and products resembling milk shall be processed or manufactured in milk product plants meeting the requirements of Division 15 of the California Food and Agricultural Code. (4) Milk may be served in individual containers, the cap or seal of which shall not be removed except in the presence of the patient. Milk may be served from a dispensing device which has been approved for such use. Milk served from an approved device shall be dispensed directly into the glass or other container from which the patient drinks. (5) Catered foods and beverages from a source outside the hospital shall be prepared, packed, properly identified, stored and transported in compliance with these regulations and other applicable federal, state and local codes as determined by the Department. (6) Foods held in refrigerated or other storage areas shall be appropriately covered. Food which was prepared and not served shall be stored appropriately, clearly labeled and dated. (7) Hermetically sealed foods or beverages served in the hospital shall have been processed in compliance with applicable federal, state and local codes. **Survey procedures:** • Interview dietary staff and observe that the equipment in the kitchen is in good working order. If not

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	working, ask the Director of Food Services what is the system is for getting it fixed. • Observe the dietetic service area is ventilated in a manner that will maintain comfortable working conditions, remove objectionable odors and fumes and prevent excessive condensation. Verify the presence of food preparation equipment that meets the needs of the menu. (For example, is the steam table large enough to hold all the hot foods served during tray line, adequate air space in the refrigerators and freezers, is there a blender to puree foods, and is there adequate space for filing documents). Observe interior circulation of dietetic staff, food, and materials in the daily kitchen activities. Can staff freely move through the kitchen and in their work space (i.e. does staff have to routinely move objects to function). Observe dirty and clean separation in all areas of operation. Areas include cooking, tray line, food production, dishwashing, food supply/receiving, and meal distribution. Is the equipment functional (ie. in safe and good working operation)? • Observe food supplies. • Review the current weekly menu for 2 days ahead of perishable foods/1 week of staple foods to verify if food is on the premises. (Staple foods examples would be muffin mix, dry cereal, ingredients for some preparation, canned fruit, canned/dry beans, rice, instant potatoes, dry pasta, flour). • Observe canned foods in dry storage area. Observe and/or Interview dietary staff for dented cans on shelves where they will be used for production. Hospital should have a practice to separate dented cans once received. • Observe if catered foods and beverages from a source outside the hospital are available. Observe they are prepared, packed, properly identified, stored and transported in compliance with these regulations and other applicable federal, state and local codes as determined by the Department. • Observe food items that were prepared and not served are stored in the refrigerator and other storage areas to ensure they are labeled and dated. Interview the staff to ask what the dates mean at their hospital. • Observe if prepackaged items for individual sale are used. If so, request from the Director of Food Service the outside food vendor's health permit and local county environmental health inspection.
§ 70279	**Dietetic Service Space** (a) Adequate space for the preparation and serving of food shall be provided. Equipment shall be placed so as to provide aisles of sufficient width to permit easy movement of personnel, mobile equipment and supplies. (b) Well ventilated food storage areas of adequate size shall be provided. (c) A minimum of .057 cubic meters (two cubic feet) of usable refrigerated space per bed shall be maintained for the storage of frozen and chilled foods. (d) Adequate space shall be maintained to accommodate equipment, personnel and procedures

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	necessary for proper cleaning and sanitizing of dishes and other utensils. (e) Where employee dining space is provided, a minimum of 1.4 square meters (15 square feet) of floor area per person served, including serving area, shall be maintained. (f) Office or other suitable space shall be provided for the dietitian or dietetic service supervisor for privacy in interviewing personnel, conducting other business related to dietetic service and for the preparation and maintenance of menus and other necessary reports and records. **Survey procedures:** • Observe interior circulation of dietetic staff, food, and materials in the daily kitchen activities. Watch for crowded pathways and food storage for items not in use in food production areas. • Verify the presence of a ventilation system in food storage areas. • Request from the engineering department the cubic feet of each refrigerator and freezer in dietetic services. Verify the presence of two cubic feet of usable space per licensed bed. Note: 40% of any space is considered unusable. • Observe dish washing to ensure adequate space and equipment to wash and air dry all dishes and utensils. • Interview maintenance for square footage of the dining/cafeteria /serving area based on posted occupancy (15 square feet of floor area per person served). • Observe whether there is a private office designated for the Director of Food Service within the dietary service department. If there is a joined diet office and supervisor office interview to ask what they do when the supervisor needs privacy. NOTE: please use the California Retail Food Code as reference if needed (not Federal Food Code). **http://www.publichealth.lacounty.gov/eh/docs/specialized/cacode.pdf**

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	ARTICLE 4 Supplemental Service Approval
§ 70301	**Supplemental Service Approval Required.** (a) Any licensee desiring to establish or conduct, or who holds out, represents or advertises by any means, the provision of a supplemental service, shall obtain prior approval from the Department or a special permit if required by Section 70351. (b) The provisions of this Article shall apply only to any supplemental service for which a special permit is not required. (c) Any licensee who offers a supplemental service for which approval is now required under these regulations is authorized to continue furnishing such service without obtaining approval until the Department inspects and evaluates the quality of the service and determines whether such service meets the requirements for the service contained in these regulations. If the Department determines that the service meets such requirements, it shall notify the licensee in writing. If the Department determines that the service does not meet the requirements, it shall so notify the licensee of all deficiencies of compliance with these regulations and the hospital shall agree with the Department upon a plan of corrections which shall give the hospital a reasonable time to correct such deficiencies. If at the end of the allotted time, as revealed by repeat inspection, the hospital has failed to correct the deficiencies, the licensee shall cease and desist all holding out, advertising or otherwise representing that it furnishes such recognized service. **Survey Procedures:** • Review the license for the existence of any Supplemental Services. • Verify that the hospital still offers those Supplemental Services • Do you see any other potential supplemental services operating or advertised that are not listed on the license?
§ 70303	**Application.** Any licensee desiring approval for a supplemental service shall file with the Department an application on forms furnished by the Department.
§ 70305	**Issuance, Expiration and Renewal.** (a) The Department shall list on the hospital license each supplemental service for which approval is granted. (b) If the applicant is not in compliance with the laws and regulations the Department shall deny the applicant approval and shall immediately notify the applicant in writing. Within 20 days of receipt of the Department's notice, the applicant may present his written petition for a hearing to the Department. The

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	Department shall set the matter for hearing within 30 days after receipt of the petition in proper form. The proceedings shall be conducted in accordance with Chapter 5 (commencing with section 11500) of Part 1of Division 3 of Title 2 of the Government Code. (c) Each supplemental service approval shall expire on the date of expiration of the hospital license. A renewal of the approval may be issued for a period not to exceed two years if the holder of the approval has been found not to have been in violation of any statutory requirements, regulations or standards during the preceding approval period.
§ 70307	**Program Flexibility. SEE 70129**
§ 70309	**Revocation or Involuntary Suspension of Approval.** (a) Pursuant to provisions of Chapter 5 (commencing with Section 11500) Part I, Division 3, Government Code, the Department may suspend or revoke the approval of a supplemental service issued under the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, upon any of the following grounds: (1) Violation by the licensee of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or of the supplemental service regulations promulgated by the Department. (2) Aiding, abetting or permitting the violation of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or of any supplemental service regulations promulgated by the Department. (3) Conduct inimical to the public health, morals, welfare or safety of the people of the State of California in the maintenance and operation of a supplemental service. (b) The Director may temporarily suspend any supplemental service approval prior to any hearing when, in his opinion, such action is necessary to protect the public welfare. (1) The Director shall notify the licensee of the temporary suspension and the effective date thereof and at the same time shall serve such licensee with an accusation. (2) Upon receipt of a notice of contest by the licensee, the Director shall set the matter for hearing within 30 days after receipt of such notice. (3) The temporary suspension shall remain in effect until such time as the hearing is completed and the Director has made a final determination. (4) If the Director fails to make a final determination within 60 days after the original hearing has been

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	completed, the temporary suspension shall be deemed vacated. (5) If the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the supplemental service regulations promulgated by the Director are violated by a licensee which is a group, corporation or other association, the Director may suspend the approval of such organization or may suspend the approval as to any individual person within such organization who is responsible for such violation. (c) The withdrawal of an application for approval shall not deprive the Department of its authority to institute or continue a proceeding against the applicant for the denial of the approval upon any group provided by law or to enter an order denying the approval upon any such ground, unless the Department consents in writing to such withdrawal. (d) The suspension, expiration or forfeiture of an approval issued by the Department shall not deprive the Department of its authority to institute or continue a proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking approval or otherwise taking disciplinary action against the licensee on any such ground. (e) A licensee whose approval has been revoked or suspended may petition the Department for reinstatement or reduction of penalty after a period of not less than one year has elapsed from the effective date of the decision or from the date of the denial of a similar petition. **Survey procedures:** • Review the license for the existence of any Supplemental Services. • Verify that the hospital still offers those Supplemental Services. • Do you see any other potential supplemental services operating or advertised that are not listed on the license?

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	ARTICLE 5 SPECIAL PERMITS
§ 70351	**Special Permit is a Supplemental Service of an acute hospital which requires a special permit from the Department.** **Special Permit Required.** (a) Any licensee desiring to establish or conduct, or who holds out, represents or advertises by any means, the performance of a special service shall obtain a special permit from the Department. (b) The following supplemental services are also special services for which a special permit is required: (1) Basic emergency medical service. (2) Burn center. (3) Cardiovascular surgery service. (4) Chronic dialysis unit. (5) Comprehensive emergency medical service. (6) Intensive care newborn nursery service. (7) Psychiatric unit. (8) Radiation therapy service. (9) Renal transplant center. This section defines the requirements pertaining to the processes of application, licensing, and approval for Special Permits. A hospital may not establish, conduct, or advertise a Supplemental Service, as listed above, without a Special Permit approval from the Department. This sections covers: (1) Application (2) Approval (3) Licensing re: changes, voluntary cancellations suspensions, revocation, involuntary suspensions, denials, and appeal rights of the Special Permit. (3) Program Flexibility available for Special Permit **Survey procedure:** Interview hospital administration as to which Supplemental Services (SSs), (as listed above), exists and have approved Special Permits (SPs). All SSs and SPs should be listed on license.
§ 70353	**Application.**

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	Any licensee desiring to obtain a special permit shall file with the Department an application on forms furnished by the Department. Such other information or documents as may be required for the proper administration and enforcement of the licensing law and requirements shall be submitted with the application.
§ 70355	**Renewal Application.** The licensee shall submit renewal applications as required by the Department.
§ 70357	**Issuance, Expiration and Renewal.** Upon verification of compliance with the supplemental service requirements for any service which is a special service, the Department shall issue a special permit except that no special permit shall be issued for new special services for which there is no valid, subsisting, and unexpired Certificate of Need or Certificate of Exemption.
§ 70359	**Posting.** The special permit, or a true copy thereof, shall be posted conspicuously in a prominent location within the licensed premises and accessible to public view. **Survey procedures:** Verify and observe that all Special Permits are posted in a prominent location within the hospital and accessible to public view.
§ 70361	**Transferability.** Special permits are not transferable. The licensee shall notify the Department in writing at least 30 days prior to the effective date of any change of ownership. A new application for special permit shall be submitted by the prospective new owner.
§ 70363	**Program Flexibility. SEE 70129**
§ 70365	**Voluntary Suspension of Special Permit.** (a) Upon written request and good cause, a licensee may request that a special permit be put in suspense. The Department may approve the request for a period not to exceed 12 months. (b) Any special permit which has been temporarily suspended by the Department pursuant to this section shall remain subject to all renewal requirements of an active special permit, including the payment of renewal fees, during the period of temporary suspension. (c) Any special permit suspended pursuant to this section may be reinstated by the Department within 12 months of the date of suspension upon receipt of an application and evidence showing compliance with supplemental service requirements in effect at the time of reinstatement. If the special permit is not

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	reinstated within the 12-month period, the special permit shall expire automatically.
§ 70367	**Voluntary Cancellation of Special Permit.** (a) The licensee shall notify the Department in writing as soon as possible and in all cases at least 30 days prior to the effective date of cancellation of a special permit. (b) Any special permit cancelled pursuant to this section may be reinstated by the Department on receipt of an application along with evidence showing compliance with supplemental service requirements.
§ 70369	**Revocation or Involuntary Suspension of Special Permit.** **SEE 70309 – SAME REGULATORY LANGUAGE**

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§ 70401	Acute Respiratory Care Service means an intensive care unit in which there are specially trained nursing and supportive personnel and the necessary diagnostic, monitoring and therapeutic equipment to provide specialized medical and nursing care to patients with acute respiratory problems.
§ 70403	**Acute Respiratory Care Service 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 accountability of the acute respiratory care service to the medical staff and administration shall be defined. (c) The unit shall be used primarily for the care of patients with acute respiratory failure. The unit should contain at least four (4) beds and should treat 100 or more patients per year. (d) Data relating to admissions, mortality and morbidity shall be kept and reviewed by an appropriate committee of the medical staff at least quarterly (e) The hospital shall have the capability to perform blood gas analysis and electrolyte determinations at all times. (f) The unit shall be located to prevent through traffic. (g) 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. (h) A physical therapist and a social worker should be available on a regular basis. Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Sections 1276, 131050, 131051 and 131052, Health and Safety Code.
§ 70405	**Acute Respiratory Care Service Staff.** (a) A physician shall have overall responsibility for the acute respiratory care service. When possible this physician shall be certified or eligible for certification in pulmonary disease by the American Board of Internal Medicine or eligible for certification by the American Board of Anesthesiology. (b) A minimum of one other physician experienced in acute respiratory care shall be available to the unit. (c) Consultants in the specialties of medicine and surgery shall be available to the unit. (d) A registered nurse with at least six months of nursing experience in the care of acute respiratory care nursing shall be responsible for the nursing care and management of the unit. (g) Sufficient respiratory care practitioners and/or respiratory care technicians shall provide support for resuscitation and maintenance of the mechanical ventilators in a ratio of 1:4 or fewer on each shift. (h) A physical therapist and a social worker should be available on a regular basis.
§ 70407	**Acute Respiratory Care Service Equipment and Supplies.**

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	(a) Equipment and supplies shall include at least: (1) Vertically adjustable beds with immediately removable headboards with trendelenburg position capability. (2) Bed scales. (3) One pressure cycle respirator for each bed and one volume-cycle respirator for each four beds. (4) Endotracheal tubes and tracheostomy sets. (5) Patient lift. (6) Respiratory and cardiac monitoring for each bed. (7) Crash cart or equivalent. (8) Spirometry equipment. (9) Resuscitative equipment. (10) DC defibrillator. (11) Self-inflating bag and attached mask at each bed. (b) An acute respiratory care unit is classified as an electrically sensitive area and shall meet the requirements of Section 70853 of these regulations.
§ 70409	**Acute Respiratory Care Service Space.** (a) In addition to the construction requirements in Section T17-316, Title 24, California Administrative Code, the following shall be met: (1) Beds in the acute respiratory care service shall be included in the total licensed bed capacity of the hospital. (2) Each bed area shall contain at least 12.2 square meters (132 square feet) of floor space with no dimension less than 3.3 meters (11 feet) and with 1.2 meters (4 feet) of clearance at both sides and at the foot of the bed with a minimum of 2.4 meters (8 feet) between beds. (3) 1.2 meters (4 feet) of floor space shall be provided around nurses' desks and utility areas. (4) All beds shall be placed in relation to the nurses' station or work area to obtain maximum observation of the patients.
§ 70411	**Basic Emergency Medical Service, Physician on Duty, Definition.** Basic emergency medical service, physician on duty, means the provision of emergency medical care in a specifically designated area of the hospital which is staffed and equipped at all times to provide prompt care for any patient presenting urgent medical problems.
§ 70413	**Basic Emergency Medical Service, Physician on Duty, 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.

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	(b) The responsibility and the accountability of the emergency medical service to the medical staff and administration shall be defined. (c) The emergency medical service shall be so located in the hospital as to have ready access to all necessary services. (d) A communications system employing telephone, radiotelephone or similar means shall be in use to establish and maintain contact with the police department, rescue squads and other emergency services of the community. (e) The emergency medical service shall have a defined emergency and mass casualty plan in concert with the parent hospital's capabilities and the capabilities of the community served. (f) The hospital shall require continuing education of all emergency medical service personnel. (g) Medical records shall be maintained on all patients presenting themselves for emergency medical care. These shall become part of the patient's hospital medical record. Past hospital records shall be available to the emergency medical service. (h) An emergency room log shall be maintained and shall contain at least the following information related to the patient: name, date, time and means of arrival, age, sex, record number, nature of complaint, disposition and time of departure. The name of those dead on arrival shall be entered in the log. (i) All medications furnished to patients through the emergency service shall be provided by a pharmacist or an individual lawfully authorized to prescribe. Such medications shall be properly labeled and all required records shall be maintained in accordance with state and federal laws. (j) Each Basic Emergency Medical Service shall be identified to the public by an exterior sign, clearly visible from public thoroughfares. The wording of such signs shall state: BASIC EMERGENCY MEDICAL SERVICE, PHYSICIAN ON DUTY. (k) Standardized emergency nursing procedures shall be developed by an appropriate committee of the medical staff. (l)) A list of referral services shall be available in the basic emergency service. This list shall include the name, address and telephone number of the following: (1) Police department. (2) Antivenin service. (3) Burn center. (4) Drug abuse center. (5) Poison control information center. (6) Suicide prevention center. (7) Director of the State Department of Health or his designee. (8) Local health department.

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	(9) Clergy. (10) Emergency psychiatric service. (11) Chronic dialysis service. (12) Renal transplant center. (13) Intensive care newborn nursery. (14) Emergency maternity service. (15) Radiation accident management service. (16) Ambulance transport and rescue service. (17) County coroner or medical examiner. (m) The hospital shall have the following service capabilities: (1) Intensive care service with adequate monitoring and therapeutic equipment. (2) Laboratory service with the capability of performing blood gas analysis and electrolyte determinations. (3) Radiological service shall be capable of providing the necessary support for the emergency service. (4) Surgical services shall be immediately available for life-threatening situations. (5) Postanesthesia recovery service. (6) The hospital shall have readily available the services of a blood bank containing common types of blood and blood derivatives. Blood storage facilities shall be in or adjacent to the emergency service. (n) 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. **Survey procedures:** • Basic Emergency Department - any hospital furnishing a Basic Emergency Department must also have an intensive care unit, laboratory and radiology service, blood banking, surgical service, and post anesthesia care unit**.** • Observe care being delivered. This may require a patient's verbal consent. • Is triage being provided? Is there a separate RN for the processing and handling of triage? Interview the triage nurse if indicated. • How many licensed nurses do you see and how many patients are there? Not all the licensed nursing staff needs to be RN. Interview direct care staff and nurse manager regarding staffing concerns. Minimum nursing staffing for the basic emergency department nurse to patient ratio is 1:4. More critically ill patients require a ratio of 1:2 or 1:1. • Are patients going to different departments such as imaging? Is the transportation of patients to other

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	departments being conducted in a safe manner? Have patients been assessed? Are they at risk for falls, elopement, or other potential issues? If so, how is this information communicated to other departments? Interview direct care staff. • Are patients issued a name tag bracelet or other form of identification? Are patients being identified prior to blood draws? Medication administration or other procedures? • Interview staff regarding the access to all the necessary services? Intensive care unit, laboratory and radiology service, blood banking, surgical service, and post anesthesia care unit. • Is there an area in which communications can be established with police, fire, rescue squads, and EMT's? Does it work? Ask staff for this location. • If needed, review the emergency department logs. Specific patient information can be found here to include patient name, date, time and means of arrival, age, sex, nature of complaint, disposition, and time of departure or discharge. Dead on arrival (DOA) will also be entered into the log. • A list of referral services should be available and should include names, addresses, and phone numbers. Ask staff where this is located. • Is the quality of the care being provided reviewed and critiqued? Is there a committee that evaluates and recommends changes in the Basic Emergency Department? This information may be found in a quality improvement area of administration. Ask the Basic Emergency Department chief or administrator for this information. • Interview the physician in charge of the Basic Emergency Department. Is he /she trained and experienced in EMS? • Does a registered nurse in the Basic Emergency Department have the required training and experience in EMS? If indicated, ask for and review the job description and review the associated training records. Interview Basic Emergency Department registered nurses related to the qualifications and training needed. • Observe care being delivered. Are there sufficient amounts of other licensed nurses and skilled personnel as required to support the services offered? • Observe and interview ED staff regarding the equipment and supplies necessary for life support available? Examples of such items include but not limited to, airway control and ventilation equipment, suction devices, cardiac monitor defibrillator, pacemaker capability, apparatus to establish central venous pressure monitoring, intravenous fluids and administration devices. • Observe for these required areas: reception area waiting room, treatment room, cast room, nursing station, medication room, public toilets, observation room, and staff support rooms including toilets, showers and lounge. • Observation beds in the emergency medical service are not be counted in the total licensed bed

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	capacity of the hospital. • Verify the exterior hospital signage indicates BASIC EMERGENCY MEDICAL SERVICE, PHYSICIAN ON DUTY. • Interview nursing staff regarding the use of standardized emergency nursing procedures. When are these type of orders utilized?
§ 70415	**Basic Emergency Medical Service, Physician on Duty, Staff.** (a) A physician trained and experienced in emergency medical services, shall have overall responsibility for the service. He or his designee shall be responsible for: (1) Implementation of established policies and procedures. (2) Providing physician staffing for the emergency services 24 hours a day who are experienced in emergency care. (3) Development of a roster of specialty physicians available for consultation at all times. (b) All physicians, dentists and podiatrists providing services in the emergency room shall be members of the organized medical staff. (c) A registered nurse qualified by education/or training shall be responsible for the nursing care within the service. (d) A registered nurse trained and experienced in emergency nursing care shall be on duty at all times. (e) There shall be sufficient other licensed nurses and skilled personnel as required to support the services offered. **Survey procedures:** • If indicated interview the emergency department (ED) nurse manager or the physician in charge regarding the physician in charge qualifications of the emergency services. See 70415(a) • Interview the emergency department (ED) nurse manager and ask how the service is supplied with physicians that are experienced in emergency medical care 24 hours a day? Are all of the physicians that provide care in the ED members of the organized medical staff? (See 70415(a)(b)(2,3). • If indicated interview the ED nurse manager and review his/her qualifications. Does he/she have the required education/training? Review the job description if needed. Interview a charge nurse on duty in the ED. Does he/she have the education and or training regarding emergency nursing care? Is a qualified RN on duty at all times? If indicated review training files. See 70415(3)(c,d). • Observe the provision of care. Is there enough staff to address the needs of the patients? If indicated interview ED staff regarding sufficient amount of staff. See 70415(3)(e).
§ 70417	**Basic Emergency Medical Service, Physician on Duty Staff.** All equipment and supplies necessary for life support shall be available , including but not limited to, airway control and ventilation equipment, suction devices, cardiac monitor defibrillator , pacemaker

	capability, apparatus to establish central venous pressure monitoring, intravenous fluids and administration devices. **Survey procedures:** • Observe for appropriate equipment, supplies and space necessary for life support is available for the service. • Interview staff regarding the availability of the above, and does the equipment work? • Verify by observation and interview the supplies and space are sufficient to meet the needs of the patients and the scope of the services offered. See 70417
§ 70419	**Basic Emergency Medical Service, Physician on Duty, Space.** (a) The following space provisions and designations shall be provided: (1) Treatment room. (2) Cast room. (3) Nursing station. (4) Medication room. (5) Public toilets. (6) Observation room. (7) Staff support rooms including toilets, showers and lounge. (8) Waiting room. (9) Reception area. (b) Observation beds in the emergency medical service shall not be counted in the total licensed bed capacity of the hospital. **Survey procedures:** • Observe if the following space areas are provided: Treatment room, cast room, nursing station, medication room, public toilets, observation room, staff support rooms including toilets, showers and lounge, waiting room, reception area • Observation beds in the emergency medical service shall not be counted in the total licensed bed capacity of the hospital.
§ 70421	**Burn Center Definition.** Burn center means an intensive care unit in which there are specially trained physicians, nursing and supportive personnel and the necessary monitoring and therapeutic equipment needed to provide specialized medical and nursing care to burned patients.
§ 70423	**Burn Center General Requirements.** Burn Center means an intensive care unit in which there are specially trained physicians, nursing and

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	supportive personnel and the necessary monitoring and therapeutic equipment needed to provide specialized medical and nursing care to burned patients. (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 burn center service to the medical staff and administration shall be defined. (c) The burn center shall be used solely for the care of patients with burns or similar and related conditions. The center shall contain at least four (4) beds and should treat fifty (50) or more patients per year. (d) If clinical or laboratory research projects are conducted, they shall be reviewed annually by an appropriate research committee. (e) Data relating to admission, morbidity and mortality shall be kept and reviewed by an appropriate committee of the medical staff at least quarterly. (f) The hospital shall have the capability to perform necessary laboratory studies including blood gas analysis and electrolyte determinations twenty-four (24) hours a day. (g) A photograph shall be taken of all burns upon admission and upon discharge of the patient. (h) The center shall be located to prevent through traffic. (i) Respiratory care service and rehabilitation service shall be available to and associated with the burn center. (j) 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. **Survey procedures:** • If a Burn unit exists, verify that it contains a minimum of 4 beds and treats at least 50 patients per year. • If a Burn unit exists, consult the specific regulations in Title 22. • The licensed nurse-to-patient ratio in a critical care unit shall be 1:2 or fewer at all times. “Critical care unit” means a nursing unit of a general acute care hospital which provides one of the following services: a burn center.
§ 70425	**Burn Center Staff.** (a) A physician shall have responsibility for the burn service. This physician shall be certified or eligible for certification by the American Board of Surgery or American Board of Plastic Surgery and should be a member of the American Burn Association .At least two (2) surgeons, experienced in burn therapy

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	and certified or eligible for certification by the American Board of Surgery or the American Board of Plastic Surgery shall be responsible for the supervision and performance of burn care. (b) Continuous in-house physician coverage shall be provided. (c) Consultants in the specialties of medicine and surgery shall be available to the center. These specialties shall include, but not be limited to: anesthesia, dermatology, pediatrics, psychiatry, orthopedics, otolaryngology, ophthalmology, nephrology, pulmonary medicine and pathology. (d) A registered nurse with at least six months' nursing experience in the treatment of burn patients in a burn center, and with evidence of continuing education in burn care, shall be responsible for the nursing care and nursing management of the burn center. (e) A registered nurse with at least three months' nursing experience in the treatment of burn patients in a burn center shall be on duty on each shift. (f) Sufficient other nursing personnel shall be provided. (g) Psychiatrists, physical therapists, occupational therapists and social workers shall be available on a regular basis to provide needed care and consultation
§ 70427	**Burn Center Equipment and Supplies.** (a) Equipment and supplies available to the burn center shall include at least: (1) Vertically adjustable beds. (2) Circular rotating electric beds or equivalent. (3) A suitable patient weighing device. (4) Ventilators. (5) Respiratory and cardiac monitoring equipment. (6) Cardiopulmonary resuscitation cart.
§ 70429	**Burn Center Space.** (a) The following spaces, services and equipment shall be provided: (1) Nurses' station as defined in Title 24, California Administrative Code, Section T17-306. (2) Utility rooms as defined in Title 24, California Administrative Code, Section T17-308. (3) Storage space for clean linen. (4) Storage space for soiled linen. (5) Air conditioning system as required in Section T17-104. (6) A piped air/oxygen system and a piped suction system providing outlets at each bed. (7) Window area sufficient to provide patients with an awareness of the outdoors. (8) Cubicle curtains or other means of assuring visual privacy for each patient. (9) A treatment room. (10) A fully equipped operating room within the hospital. (11) Bathing facilities for patients.

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	(12) Storage space for equipment and supplies. (13) Waiting area adjacent to the center. b) Beds located in the burn center shall be included in the total licensed bed capacity of the hospital.
§ 70431	**Cardiovascular Surgery Service Definition.** Cardiovascular surgery service means the performance of laboratory procedures for obtaining physiologic, pathologic and angiographic data on patients, and cardiovascular operative procedures, each supported by appropriate staff, space, equipment and supplies. It is the intent of this definition that the two aspects of this service shall not exist separately.
§ 70433	**Cardiovascular Surgery Service 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. These policies and procedures shall include provision for at least: (1) Definitions of qualifications of physicians for privileges to perform cardiovascular laboratory catheterization procedures and/or surgery. (2) Regular review of case management, both preoperatively and postoperatively. (3) Collection, processing and retrieval of data on all patients to include at least: diagnosis, procedure performed, pathophysiologic, angiographic, morbidity and mortality data. (4) Recommendations regarding equipment used, procedures performed and staffing patterns in the catheterization laboratory and cardiovascular surgery units. (b) The responsibility and the accountability of the service to the medical staff and administration shall be defined. (c) An adequate service base shall support the provision of these services. Recommended minimums are: (1) 260 cardiac catheterizations per year. (2) 150 cardiovascular procedures requiring extra corporeal bypass per year. (d) The cardiovascular surgical service shall be available at all times for emergencies. (e) Supportive diagnostic services with trained personnel shall be available and include, where appropriate, electrocardiography, vectorcardiography, exercise stress testing, cardiac pacemaker station, echocardiography, phonocardiography and pulse tracings. (f) An intensive care service with respiratory care capabilities shall be provided by the hospital. (g) An animal laboratory is recommended as support for the cardiovascular surgery service. (h) A cardiac rehabilitation program should be integrated with the cardiovascular surgery service for early identification of the patient who can profit thereby. (i) All persons operating or supervising the operation of X-ray machines shall comply with the

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	requirements of the Radiologic Technology Regulations, Subchapter 4.5, Chapter 5, Title 17, California Administrative Code. (j) 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. Interview either the nursing director of the surgical service or the physician director. Ask for and review the list for physicians who have been granted surgical privileges. Is the list current and kept on file and accessible to staff. CDPH has a link/account with Association of peri operative Registered Nurses (AORN) for information related to standards of practice at: http://www.aornstandards.org/ Hospitals may use other nationally recognized standards. Find out and use what standards the hospital follows. Same as Surgical Services Guidance to Surveyors (70221) **Survey procedures:** • Interview either the nursing director of the surgical service or the physician director. Ask for and review the list for physicians who have been granted surgical privileges. Is the list current and kept on file with the operating room supervisor? See 70433(a)(1) • Observe for emergency equipment and supplies in the surgery suite or adjacent areas. • Interview the department manager regarding the amount of cases done annually. Recommended minimums are 260 catheterizations and 150 cardiovascular procedures requiring extra corporeal bypass per year. • Are cardiovascular surgical services available at all times for emergencies? Interview department manager regarding coverage for emergencies. • Observe for the following: supportive diagnostic services with trained staff, to include, where appropriate, electrocardiography, vectorcardiography, exercise stress testing, cardiac pacemaker station, echocardiography, phonocardiography, pulse tracings. • If the Cardiovascular Surgery Service exists, there must be an intensive care unit. Interview nurse director and ask how the service is integrated with the cardiac rehabilitation program. • Observe inpatient and outpatient operative rooms/suites. Use the proper attire for the inspection. Observe the practices to determine if the services are provided in accordance with acceptable standards of practice. • Review the hospital's timeout policy or whatever the hospital policy calls for to assure that the right patient and procedure is assured and observe the following:

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	• Prior to commencing surgery is the surgical team pausing and actively engaged regarding the identity of the patient, the site and side of the body to be operated on, and ascertain that a record of the following appears in the patient's medical record. • Is the medical history and physical examination performed and recorded within the previous 24 hours: excluding emergencies • Appropriate screening tests, based on the needs of the patient, accomplished and recorded within 72 hours prior to surgery. • An informed consent, in writing, for the contemplated surgical procedure. • Interview members of the surgical services regarding how the above are achieved and are there any other patient safety elements in place. Quality/Patient Safety component – interview staff about a Comprehensive Unit-based Safety Program (CUSP). This is a program the hospital may choose to use to make care safer by improving the foundation of how your physicians, nurses, and other clinical team members work together. It builds the capacity to address safety issues by combining clinical best practices and the science of safety. • Observe care being delivered. Are the practices provided in accordance with acceptable standards of practice? • The conformance to aseptic and sterile technique by all individuals in the surgical area; That there is appropriate cleaning between surgical cases and appropriate terminal cleaning applied; • That operating room attire is suitable for the kind of surgical case performed, that persons working in the operating suite must wear only clean surgical garb, that surgical garb are designed for maximum skin and hair coverage • Verify if the hospital uses alcohol-based skin preparations in anesthetizing locations, determine whether it has adopted policies and procedures to minimize the risk of surgical fires. • That equipment is monitored, inspected, tested, and maintained by the hospital's biomedical equipment program and in accordance with State law, regulations and guidelines and manufacturer's recommendations; • That sterilized materials are packaged, handled, labeled, and stored in a manner that ensures sterility in a moisture and dust controlled environment. Applicable policies and procedures for expiration dates have been developed and are followed in accordance with accepted standards of practice. • That temperature and humidity are monitored and maintained within accepted standards of practice. Temperature and humidity should be monitored and recorded daily using a log or electronic documentation of the heating, ventilation, and air conditioning (HVAC) system. • Source AORN: The recommended temperature range in an operating room is between 68° F and 73° F (20° C to 23° C). Collaborate with infection prevention, and facility engineers when determining

temperature ranges. The recommended humidity range in an operating room is 20% to 60% based upon addendum to ANSI/ASHRAE/ASHE Standard 170-2008. Each facility should determine acceptable ranges for humidity in accordance with regulatory and accrediting agencies and local regulations. The center for Medicaid and Medicare systems has modified their requirements to allow for the 20% lower limit effective June 2013.

INFORMED CONSENT:

Hospitals must assure that the practitioner(s) responsible for the surgery obtain informed consent from patients in a manner consistent with the hospital's policies governing the informed consent process.

The primary purpose of the informed consent process for surgical services is to ensure that the patient, or the patient's representative, is provided information necessary to enable him/her to evaluate a proposed surgery before agreeing to the surgery. Typically, this information would include potential short- and longer-term risks and benefits to the patient of the proposed intervention, including the likelihood of each, based on the available clinical evidence, as informed by the responsible practitioner's professional judgment. Informed consent must be obtained, and the informed consent form must be placed in the patient's medical record, prior to surgery, except in the case of emergency surgery.

Also refer to Surgical Services Guidance to Surveyors and T22 (70221)

§ 70435

Cardiovascular Surgery Service Staff.

(a) Cardiovascular catheterization laboratory.

(1) A physician shall have overall responsibility for the service. This physician shall be certified or eligible for certification in cardiology by either the American Board of Internal Medicine or the American Board of Pediatrics or have equivalent experience and training. He shall be responsible for:

(A) Implementing established policies and procedures.

(B) Supervision and training of all personnel, including in-service training and continuing education.

(C) Assuring proper safety, function, maintenance and calibration of all equipment.

(D) Maintaining a record of all angiographic procedures performed.

(2) A physician who is certified or eligible for certification by the American Board of Radiology with special training or experience in cardiovascular radiology shall be available to the cardiovascular surgery service staff.

(3) Two persons (registered nurses or cardiovascular technicians) shall assist during the performance

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	of all cardiac catheterization procedures. These personnel shall be trained in the use of all instruments and equipment and shall be supervised by a physician. (4) A biomedical engineer shall be available for consultation as required. (5) An electronic technician shall be available where required. (b) Cardiovascular operative service. (1) A physician shall have overall responsibility for the service. This physician shall be certified or eligible for certification by the American Board of Thoracic Surgery or the American Board of Surgery with training and experience in cardiovascular surgery. He shall be responsible for: (A) Implementing established policies and procedures. (B) Training and supervising the nurses and technicians in special techniques. (C) Training and supervising the clinical perfusionists. (2) A minimum of three surgeons shall constitute a surgical team for the performance of all cardiovascular operative procedures which require extracorporeal bypass. At least one surgeon must meet the requirements outlined in subparagraph (b) (1) above. (3) Anesthesia for cardiovascular procedures shall be administered by a physician who is certified or eligible for certification by the American Board of Anesthesiology. (4) A physician who is certified or eligible for certification in cardiology by the American Board of Internal Medicine should be a member of the surgical team and should assist in monitoring the patient. (5) Clinical perfusionists shall operate the extracorporeal equipment under the immediate supervision of the cardiovascular surgeon or cardiologist. **Survey procedures:** • Is the medical director of the service a board certified or eligible in cardiology, internal medicine or pediatrics? Interview appropriate personnel to ascertain. The medical director is responsible for policy/procedure, supervision, training, in servicing, continuing education of all personnel, equipment maintenance and function, record keeping of angiographic procedures performed. • Interview nurse director or medical director and ask how a physician radiologist is available when needed. • Interview staff nurses and technicians regarding the training needed to work in this service area. If indicated, review the job descriptions and training records for selected individuals. Observe that there are two persons (registered nurses or cardiovascular technicians) assisting during the performance of all cardiac catheterization procedures. Are these personnel trained in the use of all instruments and equipment and supervised by a physician. • Are bio medical and electronic technicians available, if needed. Interview nurse director for the

information.

- Is the cardiovascular surgeon board eligible or certified thoracic surgeon? The appropriately credentialed surgeon will be responsible for policy and procedure, training of nursing and technician staff, training and supervision of perfusionists.

3 surgeons are required for all cardiovascular procedures having extracorporeal bypass in operation. One of the surgeons must be a board eligible or certified thoracic surgeon. However, this may be outdated practice and the surveyor is advised to investigate further regarding program flexibility or alternative methods of compliance.

§ 70437

Cardiovascular Surgery Service Equipment and Supplies.

(a) Cardiovascular catheterization laboratory equipment and supplies shall include but not be limited to:

(1) X-ray machine
(2) Image intensifier.
(3) Pulse generator.
(4) Camera.
(5) Spot film device.
(6) Videotape viewing equipment of fluoroscopic procedures.
(7) Magnetic tape recording and playback equipment.
(8) Motor driven cardiac table.
(9) Cinefluorography and radiography equipment.
(10) Monitoring and recording equipment.
(11) Pressure transducers.
(12) Equipment for determining cardiac output.
(13) Equipment for exercising patients during procedures.
(14) Equipment for determining oxygen saturation, hemoglobin, blood gas analysis and pH.
(15) Appropriate cardiac catheters and accessory equipment.
(16) Resuscitation equipment.

(b) Cardiovascular operating room equipment and supplies shall include but not be limited to:

(1) Monitoring and recording equipment for:
(A) Electrocardiograms.
(B) Pressures.
(C) Coronary blood flow.
(D) Cardiac output.
(E) Patient temperature.
(2) Blood gas analyzer.
(3) Heart-lung machine with oxygenator.

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	(4) Device for rapid cooling and heating of the patient. (5) DC or defibrillator. (6)Magnetic tape recording equipment. (7)Suction outlets piped in air and oxygen and tanks of gas including mixtures of oxygen and carbon dioxide. (8) All other necessary equipment and supplies as required in an operation room.
§ 70438	**Cardiac Catheterization Laboratory Service.** Cardiac catheterization laboratory service shall be organized to perform laboratory procedures for obtaining physiologic, pathologic and angiographic data on patients with cardiovascular disease. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1255 and 1255.5, Health and Safety Code.
§ 70438.1	**Cardiac Catheterization Laboratory Service -General Requirements.** The cardiac catheterization laboratory service may be approved in a general acute care hospital which does not provide cardiac surgery provided the following requirements are met: (a) The hospital shall maintain a current written transfer agreement as specified in Section 1255 of the Health and Safety Code, which shall include all of the following: (1) Provisions for emergency and routine transfer of patients. (2) Provisions which specify that cardiac surgery staff and facilities shall be immediately available to the patient upon notification of an emergency. (3) Provisions which specify that the cardiac catheterization laboratory staff shall have responsibility for arranging transportation to the receiving hospitals. (b) Only the following diagnostic procedures shall be performed in the catheterization laboratory: (1) Right heart catheterization and angiography. (2) Right and left heart catheterization and angiography. (3) Left heart catheterization and angiography. (4) Coronary angiography. (5) Electrophysiology studies. (6) Myocardial biopsy. (c) The hospital shall comply with all of the requirements of Sections 70433(a), (b), (c)(1), (e), (i), (j), 70435a) and 70437(a). Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1255 and 1255.5, Health and Safety Code. **Survey procedures:** • Review procedure log and ensure that only the following diagnostic procedures are performed:

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	• Right heart catheterization and angiography • Right and left heart catheterization and angiography • Left heart catheterization and angiography • Coronary angiography • Electrophysiology studies • Myocardial Biopsy • Interview the director/nurse manager to validate any effective program flexibility. • Hospital complies with all requirements in 70433(a),(b),(c),(1),(e),(i),(j),70435(a),and 70437(a). Also Refer to Surgical Services Guidance to Surveyors and T22 (70221)
§ 70438.2	**Cardiac Catheterization Laboratory Service - Expanded.** (a) As used in this article, the following definition applies: (1) "Expanded cardiac catheterization laboratory space" means a catheterization laboratory space, as provided for in Section 70439(a), that is located in a building connected to a general acute care hospital, as described in subdivision (b) below. (b) General acute care hospitals that qualify, pursuant to Section 1255(d)(3) of the Health and Safety Code, to provide cardiac catheterization laboratory service in expanded cardiac catheterization laboratory space, may do so, provided that: (1) There exists an enclosed all-weather passageway that connects the general acute care hospital and the structure in which the expanded cardiac catheterization space is located. Such a passageway shall: (A) be short enough to allow a patient that is undergoing a cardiac catheterization procedure in the expanded cardiac catheterization laboratory space and who needs emergent care to be transported to the appropriate definitive care option within the general acute care hospital in 10 minutes or less. Such a time shall be calculated from the time the physician deems the patient needs to be transported from the expanded cardiac catheterization laboratory space until the patient arrives at the definitive care option within the general acute care hospital; (B) have lighting and emergency lighting and power in accordance with Sections 70851 and 70841, respectively; (C) have installed heating, air conditioning and ventilating systems; (D) be equipped with an emergency call feature at each end of the enclosed all-weather passageway. For the purposes of this subdivision, "emergency call feature" is defined as a telephonic connection, or any other means of communication, permanently located within the enclosed all-weather passageway, that allows the medical staff members to communicate with medical staff members in the general acute care hospital;

(E) have access that is restricted to authorized staff, as determined by the policies and procedures developed, maintained, and implemented by the general acute care hospital, and to patients accompanied by authorized staff; and

(F) be secured by electronic means in accordance with the security policies and procedures developed, maintained, and implemented by the general acute care hospital.

(2) Policies and procedures for expanded cardiac catheterization laboratory space care for both inpatients and outpatients shall be developed, maintained and implemented by the general acute care hospital.

(A) Inpatient care policies and procedures for the expanded cardiac catheterization laboratory space shall include consideration of the acuity of the inpatient and the type of procedure needed by the patient.

(3) Cardiac catheterization laboratory procedures on general acute care hospital inpatients shall not be performed in the expanded cardiac catheterization laboratory space unless the schedule for the cardiac catheterization laboratory space within the general acute care hospital has reached capacity. General acute care hospital inpatients shall have priority for placement in the cardiac catheterization laboratory space within the general acute care hospital.

(4) Pediatric cardiac catheterization, as defined in Health and Safety Code Section 1255.5(e), services shall not be performed in an expanded cardiac catheterization laboratory space, in accordance with Sections 1255.5(d) and (e) of the Health and Safety Code.

(c) Not more than 25 percent of the general acute care hospital's inpatients in need of cardiac catheterization laboratory service may have such procedures performed in the expanded cardiac catheterization laboratory space. The general acute care hospital shall maintain records that provide the number of cardiac catheterization procedures performed in the expanded cardiac catheterization laboratory space, and the patient's status as an inpatient or outpatient.

(d) The hospital shall comply with all of the requirements of Sections 70433(a), (b), (c)(1), (e), (i), (j), 70435(a) and 70437(a). Note: Authority cited: Sections 1255, 131050, 131051 and 131200, Health and Safety Code. Reference: Section 1255, Health and Safety Code.

Survey procedures:

- The meaning of this section explains that the cardiac catheterization laboratory service must exist with a cardiovascular surgery service space [70439(a)] that is located in a building connected to the general acute care hospital. Under Health and safety code section 1255(d)(3)
- Verify that an enclosed all weather passageway exists connecting the cardiac catheterization space and the general acute care hospital. The passageway should be short enough and transition time within 10 minutes once the physician identifies that the cardiac catheterization patient needs to be

	transferred to the general acute care hospital unit. • Verify the expanded space must be equipped with emergency lighting, power, HVAC, emergency call system at each end of the all weather passageway, and access restricted to authorized staff as prescribed in policy. This area should be secured by electronic means. • Inpatients are to be given priority access for placement on the cardiac catheterization laboratory schedule. If needed, conduct extensive interviews with surgeon, cardiologist related as to why outpatient may be placed in front of inpatients on the schedule. • For pediatric patients, cardiac catheterization can only be performed in a general acute care hospital that has the capability to perform cardiac surgery on pediatric patients. Verify this through observation and interview. • Interview the director/manager regarding annual caseloads in the expanded Cardiac Catheterization Laboratory Service. The inpatient limit cannot be more than 25 percent of inpatients per calendar year. Review the procedure logs to determine compliance.
§ 70439	**Cardiovascular Surgery Service Space.** (a) Catheterization laboratory space shall include: (1) A minimum floor area of 40 square meters (450 square feet) for the procedure room. (2) A minimum floor area of 9 square meters (100 square feet) for each of the following: (A) Control, monitoring and recording equipment. (B) X-ray power and controls. (C) Work room. (D) Dressing rooms for doctors and nurses. (b) Cardiovascular surgery space shall include: (1) Operating rooms that comfortably accommodate 12 persons and all necessary equipment with a minimum floor area of 60 square meters (650 square feet). (2) Work room. (3) Pump work room. (4) Adequate storeroom
§ 70441	**Chronic Dialysis Service Definition.** Chronic dialysis service means a specialized unit of a hospital for the treatment of patients with end-stage renal disease who manifest the accumulation of excessive nitrogenous waste products. The scope of services includes hemodialysis per se and may include peritoneal dialysis or other means for removing toxic or excessive waste products from the blood. The service includes supervision of patients undergoing home dialysis.
§ 70443	**Chronic Dialysis Service General Requirements.** (a) Written policies and procedures shall be developed and maintained by the person responsible for the

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	service in consultation with other appropriate health professionals and the administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is app (b) The responsibility and the accountability of the chronic dialysis service to the medical staff and administration shall be defined. (c) The hospital shall: (1) Have two or more dialysis stations. A minimum of five dialysis sessions per week should be performed at each station. (2) Work in cooperation with other facilities providing care for patients with end-stage renal disease. (3) Make chronic dialysis services available to patients with end-stage renal disease referred from other facilities which do not provide chronic dialysis serviced. (4) Participate in the development and use of a registry of prospective recipient patients. (5) Participate in kidney procurement, preservation and transport program. (6) Review all patients with end-state renal disease to determine the appropriateness of their treatment modality, including self-dialysis, home dialysis and renal transplantation and cooperate with other facilities for the timely transfer of medical data. (d) The hospital shall provide directly: (1) Respiratory therapy. (2) Twenty-four hour laboratory capability of performing, as a minimum, the following determinations: C.B.C., B.U.N., creatinine, platelet count, blood typing and cross matching, blood gas analysis, blood pH, serum glucose, electrolytes, coagulation tests, spinal fluid examination and urinalysis. (3) Chronic dialysis on an outpatient basis. (4) Angiography. (e) The hospital shall provide directly or by arrangement: (1) Immunofluorescence studies. (2) Electron microscopy. (3) Microbiological studies for rickettsiae, fungi, bacteria and viruses. (4) Tissue culture. (5) Outpatient services. (6) Self-dialysis training program. (7) Home-dialysis training program. (8) Transplantation evaluation of patients with end-stage renal disease. (9) Renal transplantation. (10) Nuclear medicine service. (f) There shall be a separate designated area as needed for patients undergoing chronic dialysis who are

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	known to be hepatitis B surface antigen positive. (g) The particular requirements for patients on chronic dialysis shall be accommodated in the disaster and fire plans of the hospital. (h) There shall be inservice training and continuing education for all medical, nursing and other personnel. (i) There shall be a written hepatitis control program. (j) Periodically, a 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, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey Procedures:** • Interview the nurse manager regarding the number of stations; ask about how many patients they see per day, per week. Is the unit affiliated with other providers in the community? Review the facility's organ procurement policy. • Interview nurse manager regarding how and when patients have a plan of care review. The review should include self-dialysis, home dialysis, and potential for renal transplant. • Validate that respiratory services, laboratory services, outpatient, angiography, is available. • Validate that the unit provides or has arrangement to provide immunofluorescence studies, electron microscopy, microbiological studies, tissue cultures, outpatient services, transplantation evaluations and transplantations, nuclear medicine. • Interview nurse manager for dialysis staff and ask how patients who are known to be Hepatic B positive are segregated or cohorted. Dialysis patients are not required to be cohorted. • Interview the nurse manager regarding a plan to accommodate chronic dialysis patients in the disaster and fire plans of the hospital. Ask the nurse manager regarding on going inservice training and continuing education for chronic dialysis staff. Interview the nurse manager regarding how often the program is evaluated and whether recommendations are made to medical staff/administration.
§ 70445	**Chronic Dialysis Service Staff.** (a) A physician shall have overall responsibility for the service. This physician shall be certified or eligible for certification by the American Board of Internal Medicine or the American Board of Pediatrics and shall have a minimum of one year's training or experience in the care of patients with end-stage renal disease. (b) Surgeons performing the vascular access procedures shall be certified or eligible for certification by the American Board of Surgery and shall have a minimum of one year's training or experience in vascular surgery.

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	(c) Children being treated for end-stage renal disease shall be under the care of a physician who is certified or eligible for certification by the American Board of Pediatrics. (d) hematology by the American Board of Internal Medicine. (1) Physicians certified or eligible for certification in cardiology, endocrinology, infectious disease or hematology by the American Board of Internal Medicine. (2) A physician certified or eligible for certification in neurology by the American Board of Psychiatry and Neurology. (3) A physician certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology. (4) A physician certified or eligible for certification in orthopaedic surgery by the American Board of Orthopaedic Surgery. (5) A physician certified or eligible for certification by the American Board of Pathology. (6) A physician certified or eligible for certification by the American Board of Urology. (e) There shall be a registered nurse responsible for the nursing service who has had at least 12 months' general nursing experience or six months' experience in the care of patients with end-stage renal disease. (f) There shall be sufficient other licensed nurses and skilled personnel to provide the required patient care. (g) A dietitian shall provide diet management and counseling to meet the needs of patients with end-stage renal disease. (h) A social worker shall provide social service and counseling to meet the needs of patients with end-stage renal disease. **Survey procedures:** • Ask the director/nurse manager regarding physician qualifications. The physician must be board certified in internal medicine or pediatrics with 1 years' experience in ESRD. Validate surgeons performing vascular access procedures are board certified in surgery. • Does the facility provide the following specialties, endocrinology, infectious disease, hematology, neurology, psychiatry, orthopedic, pathology, and urology. • Interview nurse manager and staff regarding competencies related to the chronic dialysis patient. Interview staff and ask if there is enough personnel to provide the patient care? Are dieticians and social workers available to provide services to the ESRD patient?
§ 70447	**Chronic Dialysis Service Equipment and Supplies.** (a) Equipment and supplies shall include at least:

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	(1) A dialysis machine or equivalent (with appropriate monitoring equipment) for each bed or station. (2) Dialysis equipment appropriate for pediatric patients, if treated. Survey procedure: • Observe dialysis. Does the equipment meet the needs of the patient?
§ 70449	**Chronic Dialysis Service Space.** (a) There shall be a minimum of 10 square meters (110 square feet) of floorspace per bed or station. (b) The following areas shall be provided and maintained: (1) Patient waiting area. (2) Conference room. (3) Nurses' station. (4) Segregated area for home dialysis training, if provided. (5) Machine storage room. (6) Supplies storage room. (7) Utility room. (c) Beds in the chronic dialysis service, unless used for stay of over 24 hours, shall not be included in the total licensed bed capacity of the hospital. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedure:** • Observe dialysis areas. Is there sufficient square footage (for each station there is 110 square feet)? • Observe for patient waiting area, conference room, nurses station, segregated home dialysis training area, machine storage room, supply storage room, and utility room. • Interview nurse manager regarding patient stay over 24 hours.
§ 70451	**Comprehensive Emergency Medical Service Definition.** Comprehensive Emergency medical service means the provision of diagnostic and therapeutic services for unforeseen physical and mental disorders which, if not promptly treated, would lead to marked suffering, disability or death. The scope of services is comprehensive with in -house capabilities for managing all medical situations on a definitive and continuing basis.
§ 70453	**Comprehensive Emergency Medical Service 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 emergency medical service to the medical staff and

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	administration shall be defined. (c) The emergency medical service shall be so located in the hospital as to have ready access to all necessary services. (d) A communications system employing telephone, radiotelephone or similar means shall be in use to establish and maintain contact with the police department, rescue squads and other emergency services of the community. (e) The emergency medical service shall have a defined emergency and mass casualty plan in concert with the hospital's capabilities and the capabilities of the community served. (f) The hospital shall require continuing education of all emergency medical service personnel. (g) Medical records shall be maintained on all patients presenting themselves for emergency medical care. These shall become part of the patient's hospital medical record. Past hospital records shall be available to the emergency medical service. (h) An emergency room log shall be maintained and shall contain at least the following information relating to the patient: name, date, time and means of arrival, age, sex, record number, nature of complaint, disposition and time of departure. The name of those dead on arrival shall also be entered in the log. (i) All medications furnished to patients through the emergency service shall be provided by a pharmacist or an individual lawfully authorized to prescribe. Such medications. (j) Each comprehensive emergency medical service shall be identified to the public by an exterior sign, clearly visible from public thoroughfares. The wording of such signs shall state: COMPREHENSIVE EMERGENCY MEDICAL SERVICE PHYSICIAN ON DUTY.hall be properly labeled and all required records shall be maintained in accordance with state and federal laws. (k) Standardized emergency nursing procedures shall be developed by an appropriate committee of the medical staff. (l) A list of referral services shall be available in the emergency center. This list shall include the name, address and telephone number of the following: (1) Police department. (2) Antivenin service. (3) Drug abuse center. (4) Poison control information center. (5) Suicide prevention center. (6) Director of State Department of Health or his designee. (7) Local health department. (8) Clergy. (9) County coroner or medical examiner.

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	(m) The hospital shall have the following additional services which shall be continuously staffed in a manner that permits the performance of all required functions: (1) Chronic dialysis service. (2) Burn center. (3) Respiratory care service. (4) Intensive care newborn nursery. (5) Coronary care service. (6) Intensive care service. (7) Pediatric service. (8) Psychiatric unit. (9) Cardiovascular surgery service. (10) Postanesthesia recovery unit. (n) The radiological service shall have the capability of performing contrast studies including angiography in addition to its usual capabilities. (o) The clinical laboratory shall be capable of performing blood gas analysis, pH, serum electrolytes and other procedures appropriate for emergency medical care. (p) Surgical services shall be immediately available for life-threatening situations. (q) The hospital shall have readily available the service of a blood bank containing common types of blood and blood derivatives. Blood storage facilities shall be in or adjacent to the emergency service. (r) There shall be affiliation of the emergency medical service with a medical school. (s) 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. **Survey procedures:** Observe care being delivered. This may require a patient's verbal consent. • Interview staff regarding the access to all the necessary services? Intensive care unit, laboratory and radiology service, blood banking, surgical service, and post anesthesia care unit. Are surgical services immediately available for life threatening situations? • Is there an area in which communications can be established with police, fire, rescue squads, and EMT's? Does it work? Ask staff for this location. • Interview the nurse ED director and ask about the emergency medical service emergency and mass casualty plan. • Interview the nurse ED director. Ask how is the ongoing education of all emergency medical staff accomplished? See • Is triage being provided? Is there a separate RN for the processing and handling of triage? Interview the

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	triage nurse if indicated. • Interview staff regarding access to medical records. Is past medical history readily available to patients presenting to the ED? • Observe care being delivered. How many licensed nurses do you see and how many patients are there? Not all the licensed nursing staff needs to be RN. Interview direct care staff and nurse manager regarding staffing concerns. Minimum nursing staffing for the basic emergency department nurse to patient ratio is 1:4. More critically ill patients require a ratio of 1:2 or 1:1. • Observe care being delivered. Are patients going to different departments such as imaging? Is the transportation of patients to other departments being conducted in a safe manner? Have patients been assessed? Are they at risk for falls, elopement, or other potential issues? If so, how is this information communicated to other departments? Interview direct care staff. • Observe care being delivered. Are patients issued a name tag bracelet or other form of identification? Are patients being identified prior to blood draws? Medication administration or other procedures? • If needed, review the emergency department logs. Specific patient information can be found here to include patient name, date, time and means of arrival, age, sex, nature of complaint, disposition, and time of departure or discharge. Dead on arrival (DOA) will also be entered into the log. • View exterior signage. Is it is visible from a public thoroughfare and contains wordage that states COMPREHENSIVE EMERGENCY MEDICAL SERVICE, PHYSICIAN ON DUTY? • A list of referral services should be available and should include names, addresses, and phone numbers. Ask staff where this is located. • Verify with interview of the hospital's administration that the hospital has the required additional services associated with the Comprehensive Emergency Medical Service. Are they continuously staffed to permit the performance of all required functions? • Required additional functions include, chronic dialysis, burn center, respiratory care service, ICU newborn nursery, coronary care service, ICU, pediatric service, psychiatric unit, cardiovascular surgery service, post anesthesia recovery unit. • Is the quality of the care being provided reviewed and critiqued? Is there a committee that evaluates and recommends changes in the Comprehensive Emergency Department? This information may be found in a quality improvement area of administration. Ask the Comprehensive Emergency Department chief or administrator for this information. • Observe and interview ED staff regarding the equipment and supplies necessary for life support available? Examples of such items include but not limited to, airway control and ventilation equipment, suction devices, cardiac monitor defibrillator, pacemaker capability, apparatus to establish central venous pressure monitoring, intravenous fluids and administration devices. • Observe for these required areas: reception area waiting room, treatment room, cast room, nursing

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	station, medication room, public toilets, observation room, and staff support rooms including toilets, showers and lounge. • Observation beds in the emergency medical service are not be counted in the total licensed bed capacity of the hospital. • Verify the exterior hospital signage indicates BASIC EMERGENCY MEDICAL SERVICE, PHYSICIAN ON DUTY. • Interview nursing staff regarding the use of standardized emergency nursing procedures. When are these type of orders utilized? • Verify referral services are available. • Ask staff where is the blood bank? The blood bank should be in or adjacent to the emergency service. • Is the Comprehensive Emergency Medical Service associated with a medical school? Interview the nurse director, chief of service, or hospital administration.
§ 70455	**Comprehensive Emergency Medical Service Staff.** (a) A full-time physician trained and experienced in emergency medical service shall have overall responsibility for the service. The physician or her or his designee shall be responsible for: (1) Implementation of established policies and procedures. (2) Providing continuous staffing with physicians trained and experienced in emergency medical service. Such physicians shall be assigned to and be located in the emergency service area 24 hours a day. (3) Providing experienced physicians in specialty categories to be available in-house 24 hours a day. Such specialities include but are not limited to medicine, surgery, anesthesiology, orthopedics, neurosurgery, pediatrics and obstetrics-gynecology. (A) The most senior resident in any of the specialities may be considered an experienced physician. (4) Maintenance of a roster of specialty physicians immediately available for consultation and/or assistance. (5) Assurance of continuing education for all emergency service staff including physicians, nurses and other personnel. (b) All physicians, dentists and podiatrists providing services in the emergency room shall be members of the organized medical staff. (c) A registered nurse qualified by education and/or training shall be responsible for nursing care within the service. (d) All registered nurses shall have training and experience in emergency lifesaving and life support procedures. (e) A registered nurse trained and experienced in emergency nursing care shall be on duty at all times.

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	(f) There shall be sufficient licensed nurses and other skilled personnel on duty as required to support the services. Note: Authority cited: Sections 1252, 1255(c), 1275, 1276.4 and 100275(a), Health and Safety Code. Reference: Section 1250(a), Health and Safety Code. **Survey procedures:** • If indicated, interview the emergency department (ED) nurse manager or the physician in charge regarding the physician in charge qualifications of the emergency services. • Interview the emergency department (ED) nurse manager and ask how the service is supplied with physicians that are experienced with emergency medical care, 24 hours a day? Are all the physicians that provide care in the ED members of the organized medical staff? Are physician specialists available for consultation • If indicated, interview the ED nurse manager and review his/her qualifications. Does he/she have the needed education/training? Review the job description if needed. Interview a charge RN on duty in the ED. Does he/she have the education and/or training regarding emergency nursing care? Is a qualified RN on duty at all times? If indicated, review training files. • Observe the provision of care. Is there enough staff to address the needs of the patients? If indicated, interview ED staff regarding sufficient amount of staff. How many licensed nurses do you see and how many patients are there? Not all the licensed nursing staff needs to be RN. Interview direct care staff and nurse manager regarding staffing concerns. Minimum nursing staffing for the basic emergency department nurse to patient ratio is 1:4. More critically ill patients require a ratio of 1:2 or 1:1. • Does a registered nurse in the Comprehensive Emergency Department have the required training and experience in EMS? Interview staff RN's. If indicated, ask for and review the job description and review the associated training records. Interview Comprehensive Emergency Department registered nurses related to the qualifications and training needed.
§ 70457	**Comprehensive Emergency Medical Service Equipment and Supplies.** All equipment and supplies necessary for life support shall be available, including but not limited to: airway control and ventilation equipment, suction devices, cardiac monitor, defibrillators, pacemaker capability, apparatus to establish central nervous system monitoring and administration devices. **Survey procedures:** • Observe for the appropriate equipment, supplies and space necessary for life support is available for the service. Interview staff regarding the availability of above, and does the equipment work. • Verify by observation and interview, the equipment and supplies and space are sufficient to meet the

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	needs of the patients and the scope of services.
§ 70459	**Comprehensive Emergency Medical Service Space.** (a) The following space provisions and designations shall be provided: (1) Treatment rooms. (2) Cast rooms. (3) Operating room fully equipped. (4) Intensive care in or adjoining the emergency medical service area. (5) Nursing station. (6) Medication room. (7) Clean and dirty utility room. (8) X-ray spaces. (9) Laboratory facilities. (10) Staff support rooms including toilets, showers, lounge and sleeping area. (11) Public toilets. (12) Observation room. (13) Police and press room. (14) Waiting room. (15) Reception area. (b) Observation beds in the emergency medical service shall not be counted in the total licensed bed capacity of the hospital. **Survey procedures:** • Observe that the space provisions and designations are provided: treatment rooms, cast rooms, operating room fully equipped, Intensive care in or adjoining the emergency medical service area, nursing station, medication room, clean and dirty utility room, x-ray spaces, laboratory facilities, staff support rooms including toilets, showers, lounge and sleeping area, public toilets, observation room, police and press room, waiting room, reception area. • Observation beds in the emergency medical service shall not be counted in the total licensed bed capacity of the hospital.
§ 70461	**Coronary Care Service Definition.** Coronary care service means an intensive care unit in which there are specially trained nursing and supportive personnel with necessary diagnostic, monitoring and therapeutic equipment needed to provide specialized medical and nursing care to patients suspected of or having significant coronary artery disease, heart failure or dysrhythmia.

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	Survey Procedures: • The surveyor may find that coronary units are now under the umbrella of Intensive Care. In that case, use Intensive Care requirements.
§ 70463	**Coronary Care Service 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. The policies and procedures shall include but not be limited to: (1) Admission, transfer and discharge policies. (2) Staffing requirements. (3) Routine procedures. (4) Emergency procedures. (b) The responsibility and the accountability of the coronary care service to the medical staff and administration shall be defined. (c) 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, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** If indicated, review written policies and procedures have been developed and maintained by the person responsible for the service. The policies and procedures include but not limited to: Admission, transfer and discharge policies, staffing requirements, routine procedures, emergency procedures.
§ 70465	**Coronary Care Service Staff.** (a) A physician shall have overall responsibility for the service. This physician shall be certified or eligible for certification in cardiovascular disease by the American Board of Internal Medicine. If such a cardiologist is not available, a physician certified or eligible for certification in internal medicine by the American Board of Internal Medicine, with training and experience in cardiovascular disease, may administer the service. In this circumstance, a cardiologist, qualified as above, shall provide consultation at such frequency as to assure high quality service. The physician in charge shall be responsible for: (1) Implementation of established policies and procedures. (2) Development of a system for assuring physician coverage. (3) Conducting education programs in coronary care for physicians. (4) Assuring there is a continuing education program for nursing personnel in coronary care. (5) Final decision regarding admissions to and discharges from unit.

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	(b) A registered nurse with training and experience in coronary care nursing shall be responsible for the nursing care and nursing management of the service. (c) All licensed nurses shall have had training and experience in coronary care nursing. (d) their shall not be less than two nursing personal physically present in the coronary unit when a patient is present. At least one of the personal shall be a registered nurse. (e) The licensed nurse: patient ratio shall be 1:2 or fewer at all times. Licensed vocational nurses may constitute up to 50 percent of the licensed nurses. **Survey procedures:** • If needed, verify the qualifications of the physician in charge. Interview the physician and ask how he implements policies and procedures, ensures systems for assuring physician coverage, and conducts coronary care education for physicians and all nursing personnel in coronary care. • Interview the nurse manager/director to ascertain specific requirements for the manager/director position. In addition interview staff RN's regarding specific competencies for the coronary care unit If indicated, review a sample of training records for staff assigned to this unit. • The licensed nurse patient ratio shall be 1:2 or fewer at all times. LVNs may be 50% of the licensed nurses. No less than 2 nursing personnel present in the unit when a patient is present. One of these nursing personnel shall be a registered nurse.
§ 70467	**Coronary Care Service Equipment and Supplies.** The equipment and supplies required in Section 70497 for intensive care units shall be provided. **Survey procedures:** • If issues are identified in coronary care services regarding equipment and supplies issues and/or space, refer to 70497. The requirement for equipment and supplies and space for coronary care units is the same as intensive care units. • Verify by observation and interview the equipment and supplies and space are sufficient to meet the needs of the patients and the scope of services offered.
§ 70469	**Coronary Care Service Space.** The space requirements in Section 70499 for intensive care units shall be provided. Survey procedure: The space requirements in Section 70499 for intensive care units shall be provided.
§ 70471	**Dental Service Definition.** Dental services means the provision of diagnostic, preventive or corrective procedures performed by dentists with appropriate staff, space, equipment and supplies.

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§ 70473	**Dental Service 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 dental service to the medical staff and administration shall be defined. (c) A physician member of the medical staff shall be responsible for the care of any medical problem arising during the hospitalization of dental patients. (d) There shall be a well-defined plan for oral health care, based on patient need, the size of the hospital and the type of service provided. (e) There shall be a well-organized plan for emergency dental care. (f) There shall be a record of all dental services provided to the patient and this shall be made a part of the patient's medical record. (g) 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. **Survey procedures:** • If indicated, review applicable policies/procedures for this service. Do the medical staff and administration sign off or approve the applicable material? • Interview the appropriate person and ascertain how the dental service is accountable to the medical staff and administration. • Interview the appropriate person and ask how dental patients are seen to treat other medical problems. • Ask the appropriate person regarding the provision of oral care to patients. How is this accomplished? Is it a nursing function? If emergency dental care is needed, how is this provided? • All dental care rendered should be part of the medical record. • 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.
§ 70475	**Dental Service Staff.** (a) A dentist shall have overall responsibility for the dental service. (b) The dental service shall be staffed by a sufficient number of dentist members of the medical staff along with auxiliary personnel to render proper dental care. (c) If dental hygienists, dental assistants or dental laboratory technicians are employed, they shall work under the supervision of the director of the dental service.

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	Survey procedures: • Interview appropriate person to ascertain that a dentist has overall responsibility for the dental service. • Observe the provision of care. Is there sufficient staff to meet the needs of the service being offered? If not, interview the department manager regarding the above. • If dental hygienists, dental assistants or dental laboratory technicians are employed, interview the appropriate person and ensure they work under the supervision of the director of the dental service.
§ 70477	**Dental Service Equipment and Supplies** (a) There shall be sufficient equipment, instruments and supplies maintained to meet the needs of the services offered. (b) There shall be equipment for sterilization of instruments and supplies. (c) The following materials shall be available for immediate use wherever dental treatment is provided:(1) Oxygen. (2) appropriate drugs. (3) Resuscitation equipment. (d) The hospital library shall contain an adequate selection of dental texts, periodicals and the "Index to Dental Literature." (e) Radiographic equipment shall meet the requirements of Chapter 5, Part 1, Title 17, California Administrative Code. **Survey procedures:** • Verify by observation and interview, the equipment and supplies and space are sufficient to meet the needs of the patients and the scope of services offered. Interview manager and observe resuscitation equipment.
§ 70479	**Dental Service Space.** (a) There shall be adequate space maintained for the dental service. (b) There shall be facilities for dental radiography. Survey procedure: • Observe that there is adequate space and equipment for dental services and dental radiography.
§ 70481	**Intensive Care Newborn Nursery Service Definition.** An intensive care newborn nursery service means the provision of comprehensive and intensive care for all contingencies of the newborn infant. Infant transport services are an indispensable part of an intensive care newborn nursery service. **Guidance to Surveyors:** The NICU can be categorized into different levels depending on the level of care offered. Below are references from the American Academy of Pediatrics (AAP), GUIDELINES FOR PERINATAL CARE 7th Edition. The references are not the entire text and additional research may be

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	required based on your observations of care. Additional information can be found under CALIFORNIA CHILDREN'S SERVICES - ICNN (Intensive Care Newborn Nursery) levels of care and are termed as Regional, Community and Intermediate. Level I (basic) AAP: • Provide neonatal resuscitation at every delivery, as needed Provide care for infants born at 35-37 weeks who are physiologically stable • Stabilize infants born <35 weeks or who are ill until transfer to a higher level of care facility Level II (Specialty Care) AAP: • Provide care for infants ≥32 weeks or ≥1500 grams who have physiological immaturity (e.g. apnea, inability to feed orally) or who are moderately ill with problems that are expected resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. • Provide convalescent care after intensive care Level III (Subspecialty Care) AAP • Provide sustained life support and comprehensive care for infants <32 wk and <1500 g, and all critically ill infants • Prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists and pediatric ophthalmologists on site or at a closely related institution by pre- arranged consultative agreement • Capability to perform advanced imaging with interpretation on an urgent basis, including computed tomography, magnetic resonance imaging and echocardiography Level IV (Subspecialty Care) AAP • Located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions. • Immediate on-site access to pediatric medical and surgical subspecialists, and pediatric anesthesiologists **Survey Procedures:** • Interview the NICU RN manager/director regarding the level of care the NICU delivers • Is the standard of care based on the AAP GUIDELINES FOR PERINATAL CARE and/or California Children's Services ?
§ 70483	**Intensive Care Newborn Nursery Service General Requirements.** (a) An intensive care newborn nursery service shall provide: (1) Comprehensive care for all life-threatening or disability-producing situations. (2) Consultation service to referring perinatal units.

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	(3) Infant transport services between perinatal units and the intensive care newborn nursery. (4) A transport team consisting of at least a physician and registered nurse or respiratory care practitioner. (5) Continuing education for staff of the intensive care newborn nursery as well as referring perinatal units. (6) Review and evaluation of service programs of perinatal units. (b) There shall be written policies and procedures developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Procedures shall be approved by the medical staff and administration where such is appropriate. Such policies and procedures shall include but not be limited to: (1) Relationships to other services in the hospital. (2) Admission to the intensive care newborn nursery. (3) Consultation to perinatal units. (4) Infection control and relationship to the hospital infection committee. (5) Transfer of infants to and from perinatal units. (6) Provision for family-centered infant care by parent or surrogate. (7) Prevention and treatment of neonatal hemorrhagic disease. (8) Visiting privileges. (9) Resuscitation of the newborn. (10) Administering and monitoring of oxygen and respiratory therapy. (11) Transfusion. (12) PKU screening (13) Rhesus (Rh) hemolytic disease identification, reporting and prevention. (14) Management of hyperbilirubinemia. (15) Discharge and continuity of care with referral to community supportive services. (16) Pediatric-pathologic-radiologic conferences. (17) Routine and special care of the infant. (18) Handwashing technique. (19)Individual Bassinet technique. (20)Gavage feedings. (21) Intravenous therapy. (22) Formula preparation and storage. (23) Respiratory care procedures. (c) The responsibility and the accountability of the intensive care newborn nursery service to the medical staff and administration shall be defined.

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	(d) The hospital laboratory shall have the capability of performing blood gas analyses, pH and microtechniques. (e) Infants with diarrhea of the newborn as defined in section 2564, Title 17, California Code of Regulations, or who have draining lesions shall be isolated. (f) Infants suspected of having airborne infections shall be separated from other infants in the nursery. (g) All infections shall be reported to the hospital infection control committee promptly. (g) All infections shall be reported to the hospital infection control committee promptly. (h) Social services shall be available. (i) There shall be discharge planning and provisions for follow-up care. (j) Oxygen shall be administered to newborn infants only on the written order of a physician. The order shall include the concentration (volume percent) or desired arterial partial pressure of oxygen and be reviewed, modified or discontinued after 24 hours. (k) The intensive care newborn nursery is considered an electrically sensitive area and shall meet the requirements of section 70853 of these regulations. (l) An air-conditioned transport vehicle shall be provided which has an intercommunication system between the driver and the transport team and radio communication between the transport team and the intensive care newborn nursery. (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 1275 and 13200, Health and Safety Code. Reference: Sections 1276, 131050, 131051 and 131052, Health and Safety Code. **Survey procedures:** • Interview the manager and ask how the unit transports newborns between perinatal and ICU newborn nursery. Ensure that a physician and registered nurse or respiratory care practitioner are part of the transport team. • Interview the physician regarding the personnel's continuing education program. • If needed, interview the physician in charge of the service as how policy and procedures are adopted. See Title 22 70483 (b) for a list of 23 minimal policies and procedures required. • Interview nurse staff regarding the laboratory capability for blood gases, PH, and microtechniques. • Interview nurse staff on when and how newborns with diarrhea (Title 17 2564) or have draining lesions are isolated. Ask how newborns suspected of having airborne infection are separated from other newborns in nursery.

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	• Interview ICU nursery staff regarding how infections are reported promptly to the infection control committee. • Interview unit staff regarding how social services needs are met. • Interview unit staff regarding discharge planning and provisions for follow-up care. • Interview staff regarding the oxygen use on newborns. Ask who orders it and how often must it be reordered. • Interview the nurse manager to ensure that the ICU is classified as an electrically sensitive area**.** • Interview staff on when and how they screen for PKU, Rh identification reporting and prevention, treatment of hyperbilirubinemia**.** • Interview the nurse manager and ask what vehicle the transport team uses. The transport team must use an air conditioned vehicle, with intercommunication systems between the driver and the transport team and the transport team and the ICU newborn nursery.
§ 70485	**Intensive Care Newborn Nursery Service Staff.** (a) A physician shall have overall responsibility for the service. The physician shall be certified or eligible for certification by the American Board of Pediatrics and have additional training and experience in neonatology. (1) The pediatrician shall be responsible for: (A) Providing in-hospital pediatric service. (B) Maintaining working relationships with referring perinatal units. (C) Providing for joint staff conferences and continuing education of respective medical specialties. (D) Providing transport team availability at all times. (2) A physician who is certified or eligible for certification by the American Board of Anesthesiology shall be available to the service. (3) A surgeon experienced in neonatal surgery and a pediatric cardiologist shall be available to the service. (b) A registered nurse who has had training and experience in intensive care of the newborn shall be responsible for the nursing care in the intensive care newborn sursery. (c) A registered nurse trained in intensive care of the newborn shall be on duty on each shift. (d) A ratio of one registered nurse to two or fewer intensive care infants shall be maintained. (e) There shall be evidence of continuing education and training programs for the nursing staff in intensive care newborn nursing. (f) A registered nurse trained in intensive care of the newborn shall be available to serve on the transport

team.
(g) A respiratory care practitioner trained in the respiratory care of the newborn shall be available to the service.
Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Sections 1276, 131050, 131051 and 131052, Health and Safety Code.

Survey procedures:

- If needed, review the qualifications of the physician.
- Ask the physician in charge how the unit ensures physician and transport team accessibility at all times.
- Ask the physician in charge how an anesthesiologist, surgeons with neonatal experience, and a pediatric cardiologist are available.
- Interview the nurse manage and ask how they meet the following requirements:
  - A RN with training and experience in ICU newborn nursery manages and is responsible for nursing care provided in this service.
  - A RN trained in ICU Newborn nursery is on duty each shift.
  - The registered nurse patient ratio shall be 1:2 or fewer at all times.
  - A registered nurse is available to serve on the transport team.
- Interview physician or nurse manager and verify evidence of continuing education and training for the ICU newborn nursery staff.

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Intensive Care Newborn Nursery Service Equipment and Supplies.
(a) The intensive care newborn nursery shall include at least the following:
(1) A separate bassinet or equivalent for each infant.
(2) Enclosed storage unit for clean supplies.
(3) Diaper receptacles with a cover, foot control and disposable liner.
(4) A hamper with a disposable liner for soiled linen.
(5) A wall thermometer and hygrometer.
(6) Accurate beam scales or the equivalent.
(7) Thermostatically controlled incubators or radiant heating devices to maintain proper ambient temperature.
(8) Two oxygen and one compressed air outlets per infant station with regulating devices and administration equipment.

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	(9) Resuscitation equipment and supplies to include at least: (A) Glass trap suction device with catheter or a device which serves this function. (B) Pharyngeal airways, assorted sizes. (C) Laryngoscope, including a blade for premature infants. (D) Endotracheal catheters, assorted sizes with malleable stylets. (E) Arterial catheters, assorted sizes. (F) Ventilatory assistance bag and infant mask. (G) Bulb syringe. (H) Stethoscope. (I) Syringes, needles and appropriate drugs. (10) Suction equipment. (11) DC defibrillator (within the hospital). (12) Cardiac monitor. (13) Blanket warmer. (14) Blood gas analyzer (within the hospital). (15) Umbilical blood vessel catheterization tray. (16) Portable incubator with power pack to provide continuous temperature control and monitoring. (17) Ventilatory equipment designed for the care of newborn infants. (18) Ten or more electrical outlets for each infant bed equivalent. (19) One handwashing sink with controls not requiring direct contact of the hand for operation (wrist or elbow blade handle are not acceptable) for each four bassinets. (b) Infant transport equipment shall include at least the following: (1) Infant transport incubator with self-contained power supply to maintain a neutral thermal environment. (2) Oxygen supply with fail-safe monitor humidifier. (3) Oxygen analyzer. (4) Compressed air supply. (5) Temperature monitoring equipment. (6) Cardiopulmonary monitoring equipment. (7) Suction device. (8) Infusion pump. (9) Resuscitation equipment and supplies. (10) Intravenous fluids and supplies.
§ 70489	**Intensive Care Newborn Nursery Service Space.** (a)Sufficient floor area shall be provided so that there is at least 7.2 square meters (80 square feet) per

	bassinet. (b) A work room or control station shall be maintained which shall provide for handwashing, gowning and charting. (c) There shall be 100 foot candles of light at each bassinet. (d) A waiting room shall be maintained adjacent to the intensive care newborn nursery. (e) A treatment area with temperature control. (f) Bassinets in the intensive care newborn nursery shall be included in the total licensed bed capacity of the hospital. **Survey procedures:** • Observe the following: ▪ Is there 80 square feet per bassinet? ▪ Is there a work station which provides for handwashing, gowning, and charting? ▪ Is there sufficient lighting for the provision of care? ▪ Is there a waiting room, adjacent to the nursery? ▪ Is there a treatment room? • Interview the nurse manager and ensure that the bassinet capacity is included in the hospital's census.
§ 70491	**Intensive Care Service Definition.** An intensive care service is a nursing unit in which there are specially trained nursing and supportive personnel and diagnostic, monitoring and therapeutic equipment necessary to provide specialized medical and nursing care to critically ill patients
§ 70493	**Intensive Care Service 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. Policies and procedures shall include, but not be limited to: (1) Admission, discharge and transfer policies. (2) Staffing requirements. (3) Routine procedures. (4) Emergency procedures. (b) The responsibility and the accountability of the intensive care service to the medical staff and administration shall be defined. Intensive Care Service General Requirements. (c) Periodically, an appropriate committee of the

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	Medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration. (d) Intensive care units are classified as electrically sensitive areas and shall meet the requirements of section 70853 of these regulations. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.
§ 70495	**Intensive Care Service Staff.** (a) A physician with training in critical care medicine shall have overall responsibility for the intensive care service. This physician or his designated alternate shall be responsible for: (1) Implementation of established policies and procedures. (2) Development of a system for assuring physician coverage. (3) Final decision regarding admissions to and discharges from the unit. (4) Assuring there is continuing education for the medical staff and nursing personnel. (b) A registered nurse with training and experience in intensive care nursing shall be responsible for the nursing care and nursing management of the intensive care unit when a patient is present. (c) All licensed nurses shall have training and experience in intensive care nursing. (d) There shall be not less than two nursing personnel physically present in the intensive care unit when a patient is present. At least one of the nursing personnel shall be a registered nurse. e) The nurse:patient ratio shall be 1:2 or fewer at all times. Licensed vocational nurses may constitute up to 50 percent of the licensed nurses. (f) An inhalation therapist, physical therapist and other supportive service staff shall be available depending upon the requirements of the service. **Survey procedures:** • If needed, review the qualifications of the physician. If necessary, interview the physician and ask how he/she implements policies and procedures, ensures physician coverage, conducts coronary care education for physicians and continuing education for all nursing personnel. • Interview the nurse manager and ask how they meet the following requirements: ▪ A RN with training and experience in intensive care nursing manages and is responsible for nursing care provided in this service. ▪ All licensed nurses have training and experience in intensive care nursing. ▪ Not less than two nursing personnel are present at all times a patient is in ICU. One of those two personnel must be an RN. ▪ The registered nurse patient ratio shall be 1:2 or fewer at all times. See 70495(e) ▪ Licensed vocational nurses shall not be over 50% of licensed nurses. See70495(e) ▪ An inhalation therapist, physical therapist, or other supportive staff is available when needed.

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	See 70495(f) REFER TO LICENSED NURSE STAFFING REQUIREMENTS Section 70217, PAGE 30
§ 70497	**Intensive Care Service Equipment and Supplies.** (a) In addition to the construction requirements of Section T17-316, Title 24, California Administrative Code, the following requirements shall be met: (1) Individual bed area lighting which is controlled by a dimmer in the patient care unit shall be provided. Special lights should be provided for patient examinations. (2) Isolated power systems, if installed, shall be provided with a continuously operating line isolation monitor to warn of possible leakage or faulty current. The monitor shall contain a red signal lamp and audible warning signal activated when total current reaches a value of two (2) milliamperes. All other receptacles shall be located at least 2.4 meters (8 feet) away. (3) A minimum of four (4) duplex or eight (8) single receptacles shall be provided at the head of each bed and served by at least two separate circuits used for no other purpose. (b) General equipment shall include but not be limited to: (1) Electrocardiographic oscilloscopic monitor with writer at each bed. If a central nurses' station is equipped with a writer, a writer is not required at each bedside. (2) DC defibrillator. (3) Positive pressure breathing apparatus. (4) Oxygen mask with accessory equipment. (5) Transvenous cardiac pacemaker. (6) Emergency cart containing drugs and emergency supplies. (7) Sterile trays for parenteral therapy. (8) Tracheostomy tray. (9) Thoracentesis tray. (10) Venesection tray. (11) Irrigation equipment. (12) Intravenous fluids and plasma expanders or plasma. (13) Refrigerated storage for drugs and biologicals. (14) Laryngoscope and cuffed endotracheal tubes. (15) Equipment for blood gas analysis, immediately available. (c) Other equipment that is to be provided at each bed unless otherwise indicated: (1) Devices for holding intravenous solutions. (2) Wall clock with sweep second hand visible to each patient. (3) Wall-mounted interval clock with sweep second hand which may be activated at time of cardiac arrest.

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	(4) A sphygmomanometer. (5) Two oxygen outlets or a single outlet with a “Y” connection with sufficient oxygen delivery capability. (6) One air outlet. (7) Two piped suction inlets or a single inlet with a “Y” connection with sufficient suction capability. (d) An intercommunication system shall be provided which includes the following: (1) A call outlet at each bed which communicates to the nurses' control desk. (2) An intercommunication system connected to the nearest continuously staffed nurses' station, which will enable the nurse or physician to contact the nearby unit without leaving the intensive care unit. (3) An alarm system or other method for summoning physicians or cardiac arrest teams. **Survey procedures:** • Observe the unit and individual patient areas. Are the appropriate equipment and supplies available for the service? See 70497 for a list of 15 required items if equipment is a concern. See 70497(b)(1-15) If bedside accommodations are a concern, see 70497 for a list of 7 items required at the bedside. • Verify by observation and testing that an operating intercommunication system is present at the bedside and at the nearest continuously staffed nursing station. Verify that there is an alarm system or other method exists for summoning physicians or cardiac arrest teams.
§ 70499	**Intensive Care Service Space.** (a) In addition to the construction requirements in Section T17-316, Title 24, the following requirement shall be met: (1) An intensive care unit shall consist of not less than four (4) nor more than twelve (12) patient beds, including at least one isolation room. Multiple, interconnected units may be approved by the Department. (2) Beds in the intensive care unit shall be included in the total licensed bed capacity. (3) Each patient bed area shall contain at least 11.9 square meters (132 square feet) with no dimension less than 3.3 meters (11 feet) and with 1.2 meters (4 feet) of clearance at each side and the foot of the bed and with a minimum 2.4 meters (8 feet) between beds. (4) 1.2 meters (4 feet) shall be provided around the nurses' desk. (5) All beds shall be placed in relation to the nurses' station or work area to obtain maximum observation of patients. (6) A visitor's waiting area nearby to the unit shall be provided.

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	Survey procedures: • Observe the intensive care area. • Are there less than 4 beds or more than 12 beds? • Do the beds designated as ICU contain one isolation room? • Are there multiple interconnected units that have been approved by the Department? • Does the placement of the nurse station maximize the ability of the nurses to observe patients? • Is there a waiting room nearby?
§ 70501	**Intermediate Care Service Definition.** Intermediate care service means the provision of inpatient care to patients who have need for skilled nursing supervision and supportive care but who do not require continuous skilled nursing care. Generally you will not see this in the hospital setting, but follow below if the unit is encountered.
§ 70503	**Intermediate Care Service General Requirements.** (a) The regulations for Intermediate Care Facilities, Chapter 4, Division 5, Title 22, California Administrative Code, shall be met with the following exceptions: (1) The administrator of the hospital does not need to possess a license as a nursing home administrator and his services may be shared between the hospital and the intermediate care service. (2) The functions of the director of nurses may be shared between the hospital and the intermediate care service. The registered nurse requirement, referred to as the director of the nursing service in Section 73323 of the regulations for Intermediate Care Facilities, shall be met. (b) There shall be written policies and procedures relating to the transfer of patients between the hospital and intermediate care service that are approved by the medical staff. (c) The intermediate care services shall be provided in a distinct part. **Survey procedure:** • Verify through observation and interview that the regulations for Intermediate Care Facilities, Chapter 4, Division 5, Title 22, California Administrative Code, are met with the following exceptions: ▪ The administrator of the hospital does not need to possess a license as a nursing home administrator and his services may be shared between the hospital and the intermediate care service. • The functions of the director of nurses may be shared between the hospital and the intermediate care service. The registered nurse requirement, referred to as the director of the nursing service in Section 73323 of the regulations for Intermediate Care Facilities, shall be met. • If needed verify through document review and interview that written policies and procedures exist that relate to the transfer of patients between the hospital and intermediate care service that are approved by the medical staff.

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	Observe whether the intermediate care service is provided in a distinct part.
§ 70505	**Nuclear Medicine Service Definition.** Nuclear medicine service means those measures using internal radionuclides for the diagnosis and treatment of patients, employing specially trained personnel and providing appropriate space, equipment and supplies.
§ 70507	**Nuclear Medicine 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 nuclear medicine service to the medical staff and administration shall be defined. (c) The storage, use and disposal of radionuclides shall meet the safety standards of California Radiation Control Regulations, Subchapter 4, Chapter 5, Title 17, California Administrative Code. (d) Nuclear medicine patients shall be subject to periodic follow-up on completion of their treatment in coordination with the referring physician. (e) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make recommendations to the executive committee of the medical staff and administration. **Survey procedures:** • Verify by observation and interview that the storage, use, and disposal radionuclides meet safety standards at Title 17, Chapter 5, Subchapter 4. • Interview the service manager and ask how they provide periodic follow-up on completion of nuclear medicine patients' treatment in coordination with the referring physician.
§ 70509	**Nuclear Medicine Service Staff.** (a) A physician shall have overall responsibility for the service. This physician shall be certified or eligible for certification by the appropriate specialty board, as follows: the conjoint American Board of Nuclear Medicine or one of its parent boards: American Board of Radiology, American Board of Pathology or American Board of Internal Medicine. (b) Where appropriate, technologists with training and experience in handling radionuclides in either of the three disciplines of radiology, nuclear medicine or pathology shall be employed in sufficient number to accomplish the mission of the service. (c) A radiological physicist should be available to the nuclear medicine service. **Survey procedures:** • Interview the physician or manager in charge. Ask who has overall responsibility for the service. See

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	this regulation for accepted qualifications of the physician in charge. • Interview manager and verify that technologist with training and experience in handling radionuclides in either of three disciplines of radiology, nuclear medicine, or pathology, are employed in sufficient number to provide this service. Verify that a radiological physicist is available to the service.
§ 70511	**Nuclear Medicine Equipment and Supplies.** Equipment and supplies shall be sufficient to meet the needs of the patients and the scope of services offered. **Survey procedures:** Verify by observation and interview, the equipment and supplies and space are sufficient to meet the needs of the patients and the scope of services offered.
§ 70513	**Nuclear Medicine Space.** The space required will be dependent upon services offered. Where radiotherapy is provided from a radionuclide source, construction requirements shall meet the standards of Subchapter 4, Chapter 5, Title 17, California Administrative Code and Part 6, Division T17, Part 6, Subchapter 4, Chapter 5, Title 24, California Administrative Code.
§ 70515	**Occupational Therapy Service Definition.** (a) Occupational therapy services means those services provided to a patient by or under the supervision of an occupational therapist with appropriate staff, space, equipment and supplies. These services are used to restore the functional capacity of those individuals whose abilities to cope with tasks of daily living are threatened or impaired by developmental deficits, the aging process, physical illness or injury or psychosocial disabilities. Occupational therapy services include but are not limited to: (1) Providing the physician with an initial evaluation of the patient's level of function by diagnostic and prognostic testing. (2) Intervention in acute stages of illness or injury to minimize or prevent dysfunction. (3) Use of professionally selected self-care skills, daily living tasks and tests and therapeutic exercises to improve function. (4) Training in the performance of tasks modified to the patient's level of physical and emotional tolerance. (5) Provision of preventive and corrective equipment to promote function and to prevent deformity. (6) Reevaluating the patient as changes occur and modifying treatment goals consistent with these changes. (7) Psychological conditioning of the patient to prepare him for reentry and integration into his

community.
(8) Use of tests to determine patient's ability in areas of concentration, attention, thought organization, perception and problem solving.
(9) Prevocational evaluation through the use of specific tasks to determine the patient's potential for vocational performance.

§ 70517

Occupational Therapy Service 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 occupational therapy service to the medical staff and administration shall be defined.
(c) Occupational therapy shall be given only on the signed order of a person lawfully authorized to give such an order.
(d) Patients shall be evaluated by the occupational therapist and a treatment program shall be established to include the modalities, the frequency and duration of treatments. This program and any modifications shall be approved in writing by the referring physician.
(e) Signed notes shall be entered into the record each time occupational therapy service has been performed.
(f) Progress notes shall be written and signed at least weekly by the occupational therapist and summarized upon completion of the treatment program.
(g) Occupational therapy staff shall be involved in orientation and in-service training of hospital employees.
(h) There shall be staff representation at the multidisciplinary conferences in order to plan and review patient treatment.
(i) Procedures shall be established for outpatient treatment, home visits and referrals to appropriate community agencies.
(j) 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.

Survey procedures:

- Interview the occupational therapist manager. Ask how a patient's treatment program is established to include the modalities, the frequency and duration of treatments.
- Review a patient's occupational therapy record. Is the treatment ordered by the physician? Are there

	signed notes each time occupational therapy service has been performed. Are progress notes written and signed at least weekly by the occupational therapist and summarized upon completion of the treatment program. • Interview the manager or staff and ask how occupational therapy staff is involved in orientation and in-service training of hospital employees. • Interview the manager or staff. Ask how the occupational therapy service is involved in patients' multidisciplinary conferences to plan and review treatment. If necessary, review the policy and procedures regarding outpatient treatment, home visits, and referrals to appropriate community agencies.
§ 70519	**Occupational Therapy Service Staff.** (a) An occupational therapist shall have overall responsibility for the service. (b) The occupational therapy director shall be responsible for the coordination of activity therapies which may include but not be limited to recreation, dance, art, music, poetry and drama. (c) There shall be sufficient staff to meet the needs of the patients and scope of the services offered. The staff shall consist of occupational therapist(s) and may additionally consist of occupational therapy assistants, occupational therapy aides and other supportive personnel. (d) The occupational therapist shall supervise treatment rendered by aides and occupational therapy assistants. When occupational therapy aides are providing treatment, an occupational therapist shall provide direct supervision of the treatment rendered. **Survey procedures:** • Observe care being delivered and verify that there is sufficient staffing to ensure the needs of the patients and scope of the services offered are met. The staff consists of occupational therapist(s) and may additionally consist of occupational therapy assistants, occupational therapy aides and other supportive personnel. • During observations, ensure that an occupational therapist supervises treatments rendered by aides and occupational therapy assistants. When occupational therapy aides are providing treatment, an occupational therapist provides direct supervision of the treatment rendered.
§ 70521	**Occupational Therapy Service Equipment and Supplies.** (a) There shall be sufficient equipment and supplies appropriate to the needs of the services offered. In addition there shall be: (1) A telephone. (2) A handwashing sink in the treatment area.

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	(3) Equipment made accessible to patients in wheelchairs, on crutches, or when using other adaptive equipment. This shall include but not be limited to: (A) Adequate width of door openings. (B) Toilets with grab bars on both sides of the commode. (C) Over-sink mirrors. (D) Drinking fountains. (E) Adjustable tables. **Survey procedures:** • Observe whether the equipment and supplies and space are sufficient to meet the needs of the patients and the scope of services offered. • Observe for the presence of a telephone and a handwashing sink in the treatment area. • Observe that equipment is made accessible to patients in wheelchairs, on crutches, or using adaptive equipment. • Observations should include an observation that there is adequate width of door openings, toilets with grab bars on both sides of the commode, over-sink mirrors, drinking fountains, and adjustable tables.
§ 70523	**Occupational Therapy Service Space.** (a) Adequate space shall be maintained for the equipment and supplies necessary to provide occupational therapy service. The minimum floor area for occupational therapy service shall be 28 square meters (300 square feet), no dimension of which shall be less than 4 meters (12 feet). (b)Office space, separate from the treatment area, shall be provided. (c) There shall be adequate ventilation and lighting, and sufficient power outlets, both 110 V and 220 V, for equipment. (d) Floor finishes shall be of a nonslip variety to minimize hazard. (e) Architectural barriers, as defined by the American National Standards, A117.1, 1961 (reaffirmed 1971), including thresholds and stairways shall be provided with alternate means of access such as ramps. (f) Suitable waiting space shall be provided. **Survey procedures:** • Observe that there is an office separate from the treatment area. • Observe that floors have a nonslip aspect to them to prevent hazards. • Is a waiting areas available?

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§ 70525	**Outpatient Service Definition.** Outpatient service means the rendering of nonemergency health care services to patients who remain in the hospital less than 24 hours with the appropriate staff, space, equipment and supplies.
§ 70527	**Outpatient Service 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 outpatient service to the medical staff and administration shall be defined. (c) If outpatient surgery is performed, the written policies and procedures shall make provision for at least the following: (1) The types of operative procedures that may be performed. (2) Types of anesthesia that may be used. (3) Preoperative evaluation of the patient, meeting the same standards as apply to inpatient surgery. (4) Informed operative consent. (5) The delivery of all anatomical parts, tissues and foreign objects removed to a pathologist designated by the hospital and a report of findings to be filed in the patient's medical record. (6) Written preoperative instructions to patients covering: (A) Applicable restrictions upon food and drugs before surgery. (B) Any special preparations to be made by the patient. (C) Any postoperative requirements. (D) An understanding that admission to the hospital may be required in the event of an unforeseen circumstance. (7) Examination of each patient by a licensed practitioner whose scope of licensure permits prior to discharge. (d) A medical record shall be maintained for each patient receiving care in the outpatient service. The completed medical record shall include the following, if applicable: (1) Identification sheet to include but not be limited to the following patient information: (A) Name. (B) Address. (C) Identification number (if applicable). 1. Hospital number. 2. Social Security. 3. Medicare.

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	4. Medi-Cal. (D) Age. (E) Sex. (F) Marital status. (G) Religious preference. (H) Date and time of arrival. (I) Date and time of departure. (J) Name, address and telephone number of person or agency responsible for the patient. (K) Initial diagnostic impression. (L) Discharge or final diagnosis. (2) Medical history including: (A) Immunization record. (B) Screening tests. (C) Allergy record. (D) Nutritional evaluation. (E) Neonatal history for pediatric patients. (3) Physical examination report. (4) Consultation reports. (5) Clinical notes including dates and time of visits. (6) Treatment and instructions, including: (A) Notations of prescriptions written. (B) Diet instructions, if applicable. (C) Self-care instructions. (7) Reports of all laboratory tests performed. (8) Reports of all X-ray examinations performed. (9) Written record of preoperative and postoperative instructions. (10) Operative report on outpatient surgery including preoperative and postoperative diagnosis, description of findings, techniques used and tissue removed or altered, if appropriate. (11) Anesthesia record including preoperative diagnosis, if anesthesia is administered. (12) Pathology report, if tissue or body fluid was removed. (13) Clinical data from other providers. (14) Referral information from other agencies. (15) All consent forms. (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.

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	Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275, Health and Safety Code; and Section 2725, Business and Professions Code. **Survey procedures:** • Interview the outpatient manager. Ask if outpatient surgery is performed. If yes, and if necessary, review policies and procedures for at least the following: ▪ Types of anesthesia that may be used ▪ Preoperative evaluation of the patient (same as inpatient) ▪ Types of operative procedures that may be performed ▪ Informed operative consent ▪ Delivery of all anatomical parts, tissue or foreign objects to the pathologist and report filed in medical record. ▪ Written preoperative instructions regarding food allowed, special preparations, postoperative requirements, and an understanding that admission to the hospital may be required for unforeseen circumstances. • Review outpatient records to ensure that an examination by a licensed practitioner prior to discharge was performed. Review applicable policy and procedure regarding discharge criteria. • During record review ensure that the outpatient medical records are complete. See Title 22 70527 for a detailed list of what is required in an outpatient medical record.
§ 70529	**Outpatient Service Staff.** (a) The outpatient service shall have a person designated to direct and coordinate the service. (b) All physicians, dentists and podiatrists providing services in the outpatient unit shall be members of the organized medical staff. All other health care professionals providing services in outpatient settings shall meet the same qualifications as those professionals providing services in inpatient services. (c) A registered nurse shall be responsible for the nursing service in the outpatient service. (d) There shall be sufficient nursing and other personnel to provide the scope of services offered. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** • Interview the outpatient manager. How does the outpatient service ensure that all physicians; dentists and podiatrists providing services in the outpatient unit are members of the organized medical staff

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	and all other health care professionals providing services in outpatient settings meet the same qualifications as those professionals providing services in inpatient services. • Observe the provision of care. Is there sufficient nursing and other personnel to provide the scope of services offered?
§ 70531	**Outpatient Service Equipment and Supplies.** There shall be sufficient and appropriate equipment and supplies related to the scope and nature of the anticipated needs and services.
§ 70533	**Outpatient Service Space.** (a) The number of examination and treatment rooms shall be adequate in relation to the volume and nature of work performed. (b) Waiting areas shall be readily accessible to patients and personnel. Rest rooms, drinking fountain and a public telephone shall be provided. (c) Laboratory, radiology and pharmacy services shall be readily available to the outpatient service. (d) If outpatient surgery is performed in the outpatient service area, the basic facilities shall include: (1) Appropriately equipped and staffed operating room and postanesthesia recovery area. (2) Appropriate means of control against the hazards of infection, electrical or mechanical failure, fire and explosion. (3) Provision for sterilizing equipment and supplies and for maintaining sterile technique. (4) Appropriate equipment and instrumentation for anesthesia, emergency cardiopulmonary resuscitation and other life support systems. (5) The operating room shall be so located that it does not directly connect with a corridor used for general through traffic. Entry and exit shall be controlled with respect to personnel, patients and materials handling. (6) Construction of the operating room shall be in conformity with provisions of Division T17, Title 24, California Administrative Code. (e) If beds are provided in the outpatient unit, they shall not be included in the licensed bed capacity. (1) Inpatients shall not be allowed to occupy an outpatient bed. (2) Outpatients shall not be allowed to remain over 24 hours in outpatient beds. **Survey procedures:** • Observe that there are sufficient equipment/supplies for the service. • Are there an adequate number of exam and treatment rooms for the service? • Is there a waiting room, restroom, drinking fountain, and public phone? • Are laboratory, radiology, and pharmacy readily available to the outpatients?

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	• If the outpatient area is a surgery area, refer to Title 22 70533 for specific requirements of the space. • If there are beds in the outpatient area, ensure that they are not listed in the hospital's bed capacity. By record review, ensure that outpatients are not kept over 24 hours.
§ 70535	**Pediatric Service Definition.** Pediatric service means the observation, diagnosis and treatment (including preventive treatment) of children and their illnesses, injuries, diseases and disorders by appropriate staff, space, equipment and supplies.
§ 70537	**Pediatric Service General Requirements.** (a) There shall be written policies and procedures developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. These policies and procedures shall be based upon the standards and recommendations of the American Academy of Pediatrics (Care of Children in Hospitals, 1971). Policies shall be approved by the governing body. Procedures shall be approved by the medical staff and administration where such is appropriate. These policies and procedures shall include but not be limited to: (1) Admission policies. (2) Visiting privileges and parent participation. (3) Accidents. (4) Patient emergencies. (5) Reporting of child abuse or neglect. (6) Consultation requirements. (7) Infection control and isolation procedures. (8) Drug reactions and interactions. (b) The responsibility and the accountability of the pediatric service to the medical staff and administration shall be defined. (c) A pediatric nursing unit shall be provided if the hospital has eight or more licensed pediatric beds. (d) Patients beyond the age of 13 shall not be admitted to or cared for in spaces approved for pediatric beds unless approved by the pediatrician in unusual circumstances and the reason documented in the patient's medical record. (e) An activity program appropriate to the needs of the patients and the scope of the service shall be provided. Participation in such program shall be with the approval of the attending physician. The activity program shall be under the direction of a designated member of the hospital staff. (f) The hospital shall inform the parent or guardian as soon as possible of any accident affecting the child. (g) Periodically, an appropriate committee of the medial staff shall evaluate the services provide and make appropriate recommendations to the executive committee of the medical staff and administration.

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	Survey procedures: • If needed, review required written policies and procedures regarding , admission policies, visiting privileges and parent participation, accidents, patient emergencies, reporting of child abuse and neglect, consultation requirements, infection control and isolation procedures, drug reactions and interactions. • A pediatric nursing unit shall be provided when there are 8 or more licensed pediatric beds. • Does the pediatric unit have patient s over the age of 13? Interview the nurse manager and discuss the unusual circumstances and verify by record review the reason as documented in the medical record. • Observe the activity program provided. Does it meet the pediatric needs? Is the participation in an activity program by the physician's approval? • Interview the nurse manager regarding informing a parent as soon as possible of any accident affecting the child. How is this done and where is it recorded?
§ 70539	**Pediatric Service Staff.** (a) A physician shall have overall responsibility for the pediatric service. This physician shall be certified or eligible for certification by the American Board of Pediatrics. If such a pediatrician is not available, a physician with training and experience in pediatrics may administer the service. In this circumstance, a pediatrician, qualified as above, shall provide consultation at a frequency which will assure high quality service. (b) A registered nurse who has had training and experience in pediatric nursing shall be responsible for the nursing care and nursing management in the pediatric service. (c) In addition to the above, there shall be a registered nurse present on each shift with responsibility for patient care. (d) There shall be sufficient other staff to provide adequate care. (e) There shall be evidence of continuing education and training for the nursing staff in pediatric nursing. **Survey procedures:** • If needed, verify that the physician in charge is qualified. See this regulation for accepted qualifications of the physician. • Interview the nurse manager. Ask about her training and experience in pediatric nursing. • Verify with the nurse manager that a RN trained in pediatric nursing is on duty each shift and has patient responsibilities.

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	• Observe the provision of care. Is there sufficient nursing and other personnel to provide the scope of services offered? • Review by interview with the nurse manager or nursing staff and by record review that continuing education and training is provided for the pediatric nursing staff. Nurse to patient ratios are 1:4 or fewer at all times. REFER TO LICENSED NURSE STAFFING REQUIREMENTS Section 70217, PAGE 30
§ 70541	**Pediatric Service Equipment and Supplies.** Sufficient equipment and supplies shall be provided to adequately care for pediatric patients. This shall include a full range of sizes and modifications suitable for use with infants and small children.
§ 70543	**Pediatric Service Space.** (a) Beds in the pediatric unit, including bassinets, cribs and youth beds, shall be included in the total licensed bed capacity of the hospital. (b) The rooms for pediatric patients shall be located to provide adequate observation by nursing and other personnel. (c)The rooms for infants under the age of three years shall be separate from older children. (d) A private room shall be available for any pediatric patient in need of physical separation as defined by the infection control committee. (e) An examination and treatment room shall be located in or adjacent to the pediatric unit. (f) A play area of sufficient size should be provided. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** • Verify by observation that the pediatric beds' location provides maximum surveillance by nursing staff. • Observe whether children under 3 are housed separately from older children. • Is a room available for isolation if needed? • Does the unit have an examination unit, treatment room and play area?
§ 70545	**Perinatal Unit Definition.** A perinatal unit means a maternity and newborn service of the hospital for the provision of care during pregnancy, labor, delivery, postpartum and neonatal periods with appropriate staff, space, equipment and supplies.
§ 70547	**Perinatal Unit General Requirements.** (a) A perinatal unit shall provide: (1) Care for the patient during pregnancy, labor, delivery and the postpartum period.

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	(2) Care for the normal infant and the infant with abnormalities which usually do not impair function or threaten life. (3) Care for mothers and infants needing emergency or immediate life support measures to sustain life up to 12 hours or to prevent major disability. (4) Formal arrangements for consultation and/or transfer of an infant to an intensive care newborn nursery, or a mother to a hospital with the necessary services, for problems beyond the capability of the perinatal unit. (b) There shall be written policies and procedures developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. These policies and procedures shall reflect the standards and recommendations of the American College of Obstetricians and Gynecologists “Standard for Obstetric-Gynecologic Hospital Services,” 1969, and the American Academy of Pediatrics “Hospital Care of Newborn Infants,” 1971. Policies shall be approved by the governing body. Procedures shall be approved by the medical staff and administration where such is appropriate. Such policies and procedures shall include but not be limited to: (1) Relationships to other services in the hospital. (2) Admission policies, including infants delivered prior to admission and infants transferred from an intensive care newborn nursery. (3) Arrangements for maternity patient overflow. (4) Consultation from an intensive care newborn nursery. (5) Infection control and relationship to the hospital infection committee. (6) Transfer of mothers to appropriate care services and/or infants to and from an intensive care newborn nursery. (7) Provision, where deemed necessary, for family centered perinatal care, including rooming-in and care of infants by parent or surrogate. (8) Prevention and treatment of neonatal hemorrhagic disease. (9) Care of the premature or low birth weight infant. (10) Visiting privileges. (11) Resuscitation of newborn. (12) Administering and monitoring of oxygen and respiratory therapy. (13) Transfusion. (14) PKU screening. (15) Rhesus (Rh) hemolytic disease identification, reporting and prevention. (16) Management of hyperbilirubinemia. (17) Induction of labor and administration of oxytocic drugs. (18) Provision for parent education regarding childbirth, child care and family planning.

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	(19) Discharge and continuity of care with referral to community supportive services. (20) Obstetric-pediatric-pathologic-radiologic conferences. (21) Patient identification system. (22) Care routines for the mother and infant. (23) Handwashing technique. (24) Individual bassinet technique. (25) Credo treatment of eyes of newborn. (26) Breast feeding. (27) Gavage feedings. (28) Formula preparation and storage. (c) The responsibility and the accountability of the perinatal service to the medical staff and administration shall be defined. (d) The hospital laboratory should have the capability of performing blood gas analyses, pH and microtechniques. (e) The hospital shall have the capability for operative delivery including caesarean section at all times. (f) The Infection Control Committee shall develop and implement policies for the management, including physical separation from other infants, of infants with diarrhea of the newborn or draining lesions. (g) All infections shall be reported to the hospital infection control committee promptly. (h) All persons in the delivery room shall wear clean gowns, caps and masks during a delivery. (i) Oxygen shall be administered to newborn infants only on the written order of a physician. The order shall include the concentration (volume percent) or desired arterial partial pressure of oxygen and be reviewed, modified, or discontinued after 24-hours. (j) All patients shall be attended by a physician or licensed nurse when under the effect of anesthesia or regional analgesia, when in active labor, during delivery or in the immediate postpartum period. (k) Rooming-in should be permitted if requested by the family. (l) Smoking shall be prohibited in delivery rooms and nurseries. (m) The delivery room is considered an electrically sensitive area and shall meet the requirements of section 70853 of these regulations. (n) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of medical staff and administration. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** • Observe the provision of care. Can the facility care for a normal infant or an infant with abnormalities

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	that usually do not impair function or threaten life? • Interview the nurse manager and ask how mothers and infants who need emergency care or immediate life support to prevent major disability are handled. • Interview the nurse manager. Ask how formal arrangements for consultation and transfer of an infant to ICU newborn nursery or a mother to a hospital that can handle her situation are accomplished. • If needed, review the required written policies and procedures. See Title 22 70547(b) for a list of 28 minimal policies and procedures. • Ask staff how the laboratory capability for blood gases, PH, and microtechniques is accomplished. • Observe/interview that the hospital has capability of operative delivery, including caesarean sections at all times. • If needed, review with the nurse manager, their policies for the management of infants with diarrhea (Title 17 2564) or draining lesions, including separation from other infants. Ensure that all infections are reported promptly to the infection control committee. • Based on hospital policy, the only individual in the delivery room who must have PPE is the practitioner delivering the baby. This is to avoid getting splashed during the delivery. All others may be in street clothing. • Review the medical record documentation for a newborn. Verify that oxygen use is by physician order, which includes concentration and oxygen saturation level. Are these oxygen orders renewed or revised every 24 hours? • By observation, establish that all patients under anesthesia, including regional, when in active labor, during delivery or immediately postpartum are attended by a physician or licensed nurse. • Verify through observation and signage that rooming- in is allowed and smoking is prohibited. • If needed, interview the nurse manage to ensure that the perinatal unit is treated as an electrically sensitive area. • Interview the nurse manager or staff to assess the handling and storage of breast milk and other feeding formulas.
§ 70549	**Perinatal Unit Staff.** (a) A physician shall have overall responsibility of the unit. This physician shall be certified or eligible for certification by the American Board of Obstetrics and Gynecologists or the American Board of Pediatrics. If a physician with one of the above qualifications is not available, a physician with training and experience in obstetrics and gynecology or pediatrics may administer the service. In this circumstance, a

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	physician with the above qualifications shall provide consultation at a frequency which will assure high quality service. He shall be responsible for: (1) Providing continuous obstetric, pediatric, anesthesia, laboratory and radiologic coverage. (2) Maintaining working relationships with intensive care newborn nursery. (3) Providing for joint staff conferences and continuing education of respective medical specialties. (b) A physician who is certified or eligible for certification by the American Board of Pediatrics shall be responsible for the nursery. (c) There shall be one registered nurse on duty on each shift assigned to the labor and delivery suite. In addition, there shall be sufficient trained personnel to assist the family, monitor and evaluate labor and assist with the delivery. (d) There shall be one registered nurse on duty for each shift assigned to the antepartum and postpartum areas. In addition, there shall be sufficient trained personnel to assess and provide care, assist the family and provide family education. (e) A registered nurse who has had training and experience in neonatal nursing shall be responsible for the nursing care in the nursery. (1) A registered nurse trained in infant resuscitation shall be on duty on each shift. (2) A ratio of one licensed nurse to eight or fewer infants shall be maintained for normal infants. (f) There shall be evidence of continuing education and training programs for the nursing staff in perinatal nursing and infection control. **Survey procedures:** • If needed, verify that the physician in charge is qualified. See this regulation for accepted qualifications of the physician. • Interview the physician in charge or nurse manager and ask how they provide joint staff conferences and continuing education for respective medical specialties. • Interview the nurse manager of the nursery. Ask about her training and experienced in neonatal nursing. Ask how she ensures that an RN, trained in infant resuscitation, is on duty each shift in the nursery. By a review of the schedule ensure that the licensed nurse patient ratio is 1:8 or fewer at all times for normal infants in the nursery. • Interview the nurse manager and review schedules. Is an RN on duty each shift for the labor and delivery suite? In addition, observe the provision of care. Is there sufficient trained staff to assist and provide care in labor and delivery areas? • Interview the nurse manager and review schedules. Is an RN on duty each shift for the antepartum

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	and postpartum areas. In addition, observe the provision of care. Is there sufficient trained staff to assist and provide care in the antepartum and postpartum? • Review by interview with the nurse manager or nursing staff and by record review that continuing education and training is provided for the pediatric nursing staff. REFER TO LICENSED NURSE STAFFING REQUIREMENTS Section 70217, PAGE 30
§ 70551	**Perinatal Unit Equipment and Supplies.** (a) General equipment shall include at least the following: (1) Amniocentesis tray. (2) DC defibrillator immediately available. (3) Blanket warmer. (4) Solutions and supplies for intravenous fluids, blood, plasma and blood substitutes or fractions. (b) A fetal heart rate monitor should be available. (c) Labor rooms shall contain at least the following equipment: (1) Oxygen and suction outlets. (2) A labor bed with adjustable side rails. (3) Foot stool. (4) One or more comfortable chairs. (5) Handwashing facilities. (6) Toilet and handwashing facilities shall be in or immediately adjacent to labor room and shall be shared by no more than two patients. (7) Adjustable examination light. (8) Sphygmomanometer. (9) Regular and fetal stethoscope. (d) Delivery rooms shall have at least the following equipment: (1) Adjustable delivery table. (2) Surgical light. (3) Equipment for inhalation anesthesia and regional analgesia. (4) Clock with sweep second hand. (5) An elapsed time clock. (6) Emergency supplies such as packings, syringes, needles and drugs. (7) Emergency call button. (8) Provision for oxygen and suction for mother and infant. (9) Thermostatically controlled incubator or radiant heating device. (10) Sterile one percent silver nitrate and irrigating solutions for prophylactic Crede treatment of the

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	eyes. (11) Sterile clamps or ties for umbilical cord. (12) Resuscitation equipment and supplies to include at least: (A) Glass trap suction device with catheter. (B) Pharyngeal airways, assorted sizes. (C) Laryngoscope, including a blade for premature infants. (D) Endotracheal catheters, assorted sizes with malleable stylets. (E) Arterial catheters, assorted sizes. (F) Ventilatory assistance bag and infant mask. (G) Bulb syringe. (H) Stethoscope. (I) Syringes, needles and appropriate drugs. (e) Nursery equipment shall include at least the following: (1) A separate bassinet for each infant made of easily cleanable material such as metal or clear plastic. (2) Enclosed storage unit for clean supplies for each infant. (3) Diaper receptacles with a cover, foot control and disposable liner. (4) A hamper with a disposable liner for soiled linen. (5) A wall thermometer and hygrometer. (6) Accurate beam scales or the equivalent. (7) Thermostatically controlled incubators or radiant heating devices to maintain proper ambient temperature. (8) Oxygen and compressed air supply, regulating devices and administration equipment. (9) Resuscitation equipment as required in delivery rooms. (10) Suction equipment. (11) At least one duplex electrical outlet for every two bassinets. (12) One handwashing sink with controls not requiring direct contact of the hands for operation (wrist or elbow blade handles are not acceptable) for each six bassinets. **Survey procedures:** • Observe the provision of care. Is there appropriate equipment and supplies available for the labor rooms, delivery rooms, postpartum rooms, and nursery? • See Title 22 70551 for a very detailed and extensive list of items required for this service area.
§ 70553	**Perinatal Unit Space.** (a) General:

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	(1) A storage room for supplies and equipment used in labor and delivery areas shall be maintained. (2) Dressing room for staff personnel should be provided. (b) Labor rooms: (1) At least one labor room, having a minimum of 9.3 square meters (100 square feet) of floor space shall be provided. (2) Labor room beds shall not be included in the licensed bed capacity of the hospital. (3) A labor room shall contain no more than two beds. (c) Delivery rooms: (1) Delivery rooms shall be provided which are used for no other purpose. The operating room may serve as the delivery room in rural area hospitals having a licensed bed capacity of 25 or less. (2) Delivery rooms shall have a minimum floor area of 30 square meters (324 square feet) with no dimension less than 5.5 meters (18 feet). (d) Nurseries: (1) Sufficient floor area shall be provided so that there is at least 2.3 square meters (25 square feet) per bassinet with at least 1 meter (3 feet) between bassinets. (2) A workroom or control station shall be maintained which shall provide for handwashing, gowning and charting. (3) There shall be 100 foot candles of light at each bassinet. (4) Bassinets in the normal newborn nursery are not included in the total licensed bed capacity of the hospital. **Survey procedures:** • Observe the storage space for the perinatal unit. Is it adequate? Is there a dressing area for staff? • By observation ensure that a labor room has no more than two beds. • By observation, ensure that a delivery room is used only for deliveries. In a rural area, the operating room may serve as a delivery room for hospitals with 25 or under beds • By observation, ensure that a nursery has a workroom or station with provisions for handwashing, gowning, and charting.
§ 70555	**Physical Therapy Service Definition.** (a) Physical therapy service means those services to a patient by or under the supervision of a physical therapist to achieve and maintain the highest functional level with appropriate staff, space, equipment and supplies. Physical therapy services include but are not limited to: (1) Providing the physician with an initial written evaluation of the patient's rehabilitation potential. (2) Applying muscle, nerve, joint and functional ability tests.

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	(3) Treating patients to relieve pain, develop or restore function. (4) Assisting patients to achieve and maintain maximum performance using physical means such as exercise, massage, heat, sound, water, light, ice, and electricity.
§ 70557	**Physical Therapy Service 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 physical therapy service to the medical staff and administration shall be defined. (c) Physical therapy shall be given only on the signed order of a person lawfully authorized to give such an order. (d) When physical therapy is ordered, the patient shall be evaluated by the physical therapist and a treatment program shall be established to include the modalities, frequency and duration of treatments. This program and any modifications shall be approved by the person who signed the order for service. (e) Signed notes shall be entered into the record each time physical therapy service has been performed (f) Progress notes shall be written and signed at least weekly by the physical therapist and summarized upon completion of the treatment program. (g) Physical therapy service staff shall be involved in orientation and in-service training of hospital employees. (h) There shall be written techniques for cleaning and culturing of hydrotherapy equipment. (i) Procedures shall be established for outpatient treatment, home visits and referrals to appropriate community agencies. (j) 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: Section 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** • By medical record review, ensure that treatments are ordered by a person lawfully authorized to give such an order; patients are evaluated by the physical therapist and a treatment program is established to include the modalities, the order contains the frequency and duration of treatments; the treatment is approved by the physician, there are signed notes are entered into the record each time physical therapy service has been performed; progress notes are written and signed at least weekly by the physical therapist and summarized upon completion of the treatment program; physical therapy staff

	attend multidisciplinary conferences to plan and review treatment. • Interview the person responsible for physical therapy. Is the service involved in orientation and in-service training of hospital employees? • If needed, review the policy and procedures established for cleaning and culturing of hydrotherapy equipment. • If needed, review the policy and procedures established for outpatient treatment, home visits, and referrals to appropriate community agencies. Interview staff related to the process of how infection control is accomplished in the physical therapy area.
§ 70559	**Physical Therapy Service Staff.** (a) A physical therapist shall have overall responsibility for the physical therapy service. (b) There shall be sufficient staff to meet the needs of the patients and scope of the services offered. The staff shall consist of physical therapists and may additionally consist of physical therapist assistants, physical therapy aides and other supportive personnel. (c) The physical therapist shall supervise treatment rendered by aides and assistants. When physical therapy aides are providing treatment, a physical therapist shall provide direct supervision of the treatment rendered. **Survey procedures:** • Verify that a physical therapist has overall responsibility for the service. • Interview the manager of physical therapy and ask how they ensure sufficient staffing to ensure the needs of the patients and scope of the services offered are met. The staff may consist of physical therapist(s) and may additionally consist of physical therapy assistants, physical therapy aides and other supportive personnel. • Observe the provision of care. Does a physical therapist supervise treatments rendered by aides and physical therapy assistants? When physical therapy aides are providing treatment, is a physical therapist providing direct supervision of the treatment rendered?
§ 70561	**Physical Therapy Service Equipment and Supplies.** (a) There shall be sufficient equipment and supplies appropriate to the needs and the services offered. In addition there shall be: (1) A telephone. (2) A handwashing sink in the treatment area. (3) Equipment accessible to patients in wheelchairs, on crutches, or when using other adaptive

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	equipment. This shall include but not be limited to: (A) Adequate width of door openings. (B) Toilets with grab bars on both sides of the commode. (C) Over sink mirrors. (D) Drinking fountains. (E) Adjustable tables. **Survey procedures:** • Observe whether the equipment and supplies are sufficient to meet the needs of the patients and the scope of services offered. See 70561(a) • Observe for the presence of a telephone and a handwashing sink in the treatment area. • Observe that equipment is made accessible to patients in wheelchairs, on crutches, or using adaptive equipment. • Observations should include an observation that there is adequate width of door openings, toilets with grab bars on both sides of the commode, over-sink mirrors, drinking fountains, and adjustable tables.
§ 70563	**Physical Therapy Service Space.** (a) Adequate space shall be maintained for the equipment and supplies necessary to provide physical therapy service. The minimum floor area for physical therapy service shall be 28 square meters (300 square feet), no dimension of which shall be less than 4 meters (12 feet). (b) Office space, separate from the treatment area, shall be provided. (c) Floor finishes shall be of a nonslip variety to minimize hazard. (d) Architectural barriers as defined in Specifications for Making Buildings and Facilities Accessible and Usable by the Physically Handicapped, A-117.1 1961 (reaffirmed 1971) by the American National Standards Institute, Inc., 1430 Broadway, New York, NY 10018, shall have alternate means of access such as ramps. (e) A suitable waiting area shall be provided. **Survey procedures:** • Observe the physical therapy area. Is it 300 sq feet or more? • Does it have office space that is separate from the treatment area? • Observe that floors have a nonslip aspect to them to prevent hazards. • Is a waiting area available?
§ 70565	**Podiatric Service Definition.** Podiatric service means the diagnosis and treatment of disorders of the foot by podiatrists with the

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	appropriate staff, space, equipment and supplies.
§ 70567	**Podiatric Service 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 podiatric service to the medical staff and administration shall be defined. (c) A physician member of the medical staff shall be responsible for the care of any medical problem arising during the hospitalization of podiatric patients. (d) There shall be a record of all podiatric services provided for the patient and this shall be made a part of the patient's medical record. (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. **Survey procedures:** • Interview the director of the podiatry service. How does the service handle the care of a medical problem arising during the hospitalization of podiatry patients? • Using medical record review, does the podiatry care given become part of the medical record?
§ 70569	**Podiatric Service Staff.** A podiatrist shall have overall responsibility for the service. **Survey procedures:** Verify that a podiatrist has overall responsibility for the service**.**
§ 70571	**Podiatric Service Equipment and Supplies.** There shall be sufficient equipment, instruments, and supplies for the scope of services provided.
§ 70573	**Podiatric Service Space.** There shall be adequate space maintained to meet the needs of the service. **Survey procedures:** Observed that the equipment, instruments, and supplies and space are sufficient to meet the needs of the patients and the scope of services offered.
§ 70575	**Psychiatric Unit Definition.** A psychiatric unit means a service, department or division of a hospital which is organized, staffed and

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	equipped to provide inpatient and outpatient care for mentally disordered or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with 6000) of the Welfare and Institutions Code.
§ 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 he 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. 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. (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. (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.

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	(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,Division5 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 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 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 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 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1255, 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

Survey procedures:

- Verify with the nurse manager that all patients have a mental illness or disorder. A mental disorder is defined as any psychiatric illness or disease, whether functional or organic in origin.
- Review medical records and verify the following:
- Psychiatrists or clinical psychologists are responsible for the diagnostic formulation and the development and implementation of each patient's treatment plan.
- Medical examinations are conducted as needed and are in the patient's medical record.
- Each record contains legal authorization for admission and the release of information follows guidance in Article 7, 5325 and 5328 and W & I Part 1 Division 5.
- Interview the nurse manager and review the availability of psychiatrists at all times for psychiatric emergencies.
- Are equipment and supplies are available for emergency medical problems? Verify with observation

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	and interview. • Interview the nurse manager and verify the following: ▪ A plan is developed for the handling and referral of patients with emergency medical problems. ▪ The circumstances regarding electroconvulsive therapy (ECT) are determined. • 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. Consult with CDPH pharmacist. • Interview nurse manager or staff and ask how and when a social worker is available. • Does the unit care for school age children? If yes, are there therapeutic activities in place for each unit and school programs in place for school age children? • Observe for patients in restraint or isolation. Restraints may be used only when alternative methods are not sufficient, used only with a physician's order, document the reason and type of restraint, restrained patients are observed at least every 15 minutes, easily removable, and restraint events are comprehensively documented in the patient record. In an emergency, an RN may place a patient in restraints and then obtain a physician order. Verify that the policy for restraint is consistent with the practice. Interview staff related to the policy and actions required to initiate restraints or isolation. • Interview patients. Are they afforded their rights, which include, being informed of the provisions of law regarding complaints and of procedures for registering complaints confidentially with the address and telephone number of the complaint receiving unit of the Department? A physician or approved practitioner may deny a patient his or her rights as specified in 70577 (k) (2). Are the rights posted? • Interview the nurse manager. How does the facility accomplish their orientation and in-service training of hospital employees?
§ 70579	**Psychiatric Unit Staff.** (a) If a psychiatrist is not the administrative director of the psychiatric unit, a psychiatrist who is certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology, shall be responsible for the medical care and services of the unit, including all those acts of diagnosis, treatment, or prescribing or ordering of drugs which may only be performed by a licensed physician. (b) A clinical psychologist shall be available on a full-time, part-time or consulting basis. The clinical psychologist shall function on such terms and conditions as the facility shall establish. (c) A registered nurse with two years experience in psychiatric nursing shall be responsible for the nursing care and nursing management of the psychiatric unit. (d) There shall be registered nurses with training and experience in psychiatric nursing on duty in the unit at all times. (e) There shall be sufficient nursing staff, including registered nurses, licensed vocational nurses, psychiatric technicians and mental health workers to meet the needs of the patients.

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	(f) A qualified therapist should be employed to conduct the therapeutic activity program. Therapists that may be involved in the program include occupational, music, art, dance and recreation therapist. (g) A social worker shall be employed on a full-time, regular part-time or consulting basis. Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Sections 1255, 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code. **Survey procedures:** • Interview the unit's manager and ascertain that a psychiatrist is in charge of the service. How are medical issues addressed? Do they have psychologists? Do the psychologists work FT, PT, or on a consulting basis? Is there a social worker FT, PT, or on a consulting basis? • Interview the nurse manager of the unit. Ask about training and experience in psychiatric nursing. Ask how the unit is staffed with an RN, trained in psychiatric nursing at all times. In addition, verify there is sufficient trained staff to assist and provide care to meet the needs of the patients. • Review the patient's program schedule, is there a qualified therapist employed to conduct the therapeutic activities program, such as OT, Rec, Music, Art, Dance, etc.? REFER TO LICENSED NURSE STAFFING REQUIREMENTS PAGE 10
§ 70581	**Psychiatric Unit Equipment and Supplies.** (a) Sufficient equipment and supplies shall be provided to meet the needs of the patients, including that necessary for the rehabilitative therapy program. (b) Resuscitative and cardiac monitoring equipment shall be in or readily available to the unit.
§ 70583	**Psychiatric Unit Space.** (a) A psychiatric unit shall meet the following space requirements: (1) Consultation room for interviewing patients. (2) Facilities for physical examination and a treatment room for medical procedures. (3) At least one observation room for acutely disturbed patients. This room shall have facilities for visual observation and be located near the nursing station and a bathroom. (4) Separate dining room. (5) Facilities for occupational therapy. (6) Indoor and outdoor facilities for therapeutic activities. (7) A separate nursing station for the psychiatric unit. No beds for patients on the unit shall be located more than 90 feet away from the nursing station. (8) Windows, modified to prevent patients from leaving the unit by way of a window. (9) There shall be a principal entrance to the unit which could be locked if necessary. (b) A unit which treats children of school age over a substantial period of time (one month or more) shall have physical facilities for an educational program, such as a classroom and an office for the teacher.

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	(c) Beds in a psychiatric unit shall be counted in the total licensed bed capacity of the hospital. **Survey procedures:** • Observe the physical environment. Is there sufficient equipment and supplies available to meet the needs of the patients, including that necessary for the rehabilitative therapy program? • During the observation, is the resuscitative and cardiac monitoring equipment readily available and in working order? Have staff demonstrate function of equipment. • Tour the unit and observe for areas of potential hazards. • Is there an isolation/seclusion room? Does it have a means for visual observation? Are patient rooms within 90 feet of a nursing station? Observe for a separate dining room, consultation room, physical exam, treatment room, observation, occupational therapy space, and indoor and outdoor room for activities. • Are the windows modified to prevent patients from leaving?
§ 70585	**Radiation Therapy Service Definition.** Radiation therapy service means the use of external ionizing radiation including X-rays and teletherapy and brachytherapy using sealed sources of radioactive material in the treatment of human illnesses with appropriate staff, space, equipment and supplies.
§ 70587	**Radiation Therapy Service 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 radiation therapy service to the medical staff and administration shall be defined. (c) Radiation therapy shall be given only under the direction of a radiation therapist. (d) All cancer cases accepted for curative radiation shall have adequate histologic substantiation of diagnosis unless convincing alternative evidence for diagnosis is presented. (e) Documentation of the initial evaluation, treatment plan, dosimetry, and clinical, technical and follow-up notes shall be maintained. (f) Adequate communication shall be maintained with referring physicians. (g) There should be periodic review of case management, complications and treatment results. (h) There shall be a tumor board, a tumor registry, and/or cancer committee in which the radiation therapy staff shall participate. i) There shall be provided: (1) Continuing radiological physics support for radiation therapy in cancer management.

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	(2) Calibration and operation of radiation therapy equipment according to California Radiation Control Regulations, Subchapter 4, Chapter 5, Title 17, California Administrative Code. (3) Appropriate radiation treatment localization, simulation and verification. (4) Isodose treatment planning with complex analyses generated in appropriate cases. (5) Treatment record quality control through independent review of records of patients undergoing treatment. The record shall be signed by the reviewer. (6) Radiation protection for patients and staff in accordance with requirements of California Radiation Control Regulations, Subchapter 4, Chapter 5, Title 17, California Administrative Code. (j) Periodic follow-up of patients following completion of treatment shall be coordinated with the referring physician. (k) The hospital shall have on file and open to inspection by the Department evidence of any and all affiliations currently in effect. These may include but are not limited to: (1) Joint directorship and/or physician collaboration and coordination among several institutions. (2) Interhospital collaboration for professional and administrative management. (l) 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. **Survey procedures:** If a concern exists here, consult with your district office and appropriate consultants and refer to Title 22 at 70585 through70593
§ 70589	**Radiation Therapy Service Staff.** (a) A physician shall have overall responsibility for the service. This physician shall be certified or eligible for certification in therapeutic radiology by the American Board of Radiology or be certified or eligible for certification in radiology by the American Board of Radiology and have two (2) years of additional full-time experience in radiation therapy. (b) In remote communities where the population and number of cancer cases are insufficient to require a full-time radiation therapist, a general radiologist may provide radiation treatment of limited scope for those patients whose transportation to larger centers would be undesirable. He shall have an established mechanism to provide the consultation, physics and treatment planning support and referral availability of a radiation therapist. (c) Other personnel who shall be available full-time, part-time or on a consultative basis, depending upon the activity of the department are: (1) A radiological physicist who is either certified in radiological physics or in therapeutic radiological physics by the American Board of Radiology. (2) A dosimetrist (treatment plan technologist) who is a qualified and experienced radiation therapy technologist with a minimum of one year of additional clinical training in dosimetry under the direction

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	of an experienced dosimetrist and a physicist. (3) A certified therapeutic radiological technologist. (4) Appropriate support personnel including licensed nurses, where patient load requires.
§ 70591	**Radiation Therapy Service Equipment and Supplies.** (a) Equipment and supplies shall include: (1) Megavoltage (supervoltage) treatment unit capable of delivering x or gamma rays of effective energy 500 KeV or more and conforming to the requirements of California Radiation Control Regulations, Subchapter 4, Chapter 5, Title 17, California Administrative Code. (2) Access to medium voltage or superficial treatment unit delivering 500 KeV or less, but otherwise having the same functional characteristics as the above megavoltage units and conforming to the requirements of California Radiation Control Regulations, Subchapter 4, Chapter 5, Title 17, California Administrative Code. (3) Access to brachytherapy equipment which shall meet the requirements of California Radiation Control Regulations, Subchapter 4, Chapter 5, Title 17, California Administrative Code. (4) Appropriate examination room equipment. (5) Emergency trays and medications. (6) Access to radiation measurement and calibration equipment including a calibration constancy instrument and access to a secondary standard dose meter.
§ 70593	**Radiation Therapy Service Space.** (a) Rooms accommodating radiation therapy machines shall be of adequate size to permit easy use of stretcher patients. Shielding of the rooms shall meet the requirements of California Radiation Control Regulations, Subchapter 4, Chapter 5, Title 17, California Administrative Code. (b) Sufficient examination rooms of adequate size. (c) Patient reception, waiting and dressing areas with conveniently located toilets shall be provided. (d) Space sufficient for medical and physics staff functions shall be provided.
§ 70595	**Rehabilitation Center Definition.** Rehabilitation center means a functional unit for the provision of those rehabilitation services that restore an ill or injured person to the highest level of self-sufficiency or gainful employment of which he is capable in the shortest possible time, compatible with his physical, intellectual and emotional or psychological capabilities and in accord with planned goals and objectives.
§ 70597	**Rehabilitation Center 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. These policies and procedures shall include but not be limited to:

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	(1) Goals and objectives. (2) General eligibility and admission criteria. (3) Geographic area to be served. (4) Scope of services to be provided. (5) Rehabilitation staff eligibility requirements. (6) Relationships between the hospital and other health facilities in the community. (7) Sources and forms used for referral of patients. (b) The responsibility and the accountability of the rehabilitation service to the medical staff and administration shall be defined. (c) As a minimum, physical therapy, occupational therapy and speech therapy shall be provide and the requirements for these individual services, as stated elsewhere in these regulations, shall be met. (d) There shall be preadmission patient screening done by an appropriate individual who may be the director of the service or his designee. Such screening shall include but not be limited to: (1) Medical review. (2) Rehabilitative potential evaluation. (3) Review of future placement resources. (e) An outpatient service shall be part of the rehabilitation center. This service shall provide continuity of care to patients who have completed inpatient rehabilitation care and will provide comprehensive, integrated care for patients not requiring hospitalization. This service shall have available all of the resources of the rehabilitation center. (1) A coordinated system of patient scheduling and appointments that serves to minimize waiting time shall be established. (2) An outpatient medical record shall be maintained for each patient receiving care in the outpatient service. The completed medical record shall include the information required for treatment of all hospital outpatients (Section 70367). (f) There shall be a written utilization review plan that outlines the: (1) Organization and composition of the utilization review committee, which shall include at least two physicians who shall be responsible for the utilization review functions. (2) Requirement that the committee shall meet at least once each month. (3) Selection of cases, both inpatient and outpatient, for review on a scientifically selected basis. (4) Summary of the number and types of cases reviewed and the findings on each. (5) Actions to be taken by the rehabilitation center based on the findings and recommendations of the utilization review committee. (g) Staff conferences shall be held regularly and include representation and participation by all disciplines involved in the program to assist in the organization and coordination of services offered.

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	(h) Patient case conferences shall be held regularly to determine need for modification of treatment plans. (1) There shall be a case conference plan and written minutes of each case conference held. (2) One member of the rehabilitation service team shall be designated as the patient service coordinator. (i) 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. **Survey procedures:** • If needed, review the following required policies and procedures: ▪ Goals and Objectives ▪ General eligibility and admission criteria ▪ Geographic area to be served ▪ Scope of services provided ▪ Rehab staff's eligibility requirements ▪ Relations between hospital and other health facilities in the community ▪ Sources and forms used for referral of patients • Interview the nurse manager. Verify that, at a minimum, there is physical therapy, occupational therapy, and speech therapy. Their requirements are found under the respective Title 22 section. • Review medical records. Is there a pre- admission screening process by an appropriate individual? Screening contains, but is not limited to: medical review, rehab potential eval, and future placement resources. • Interview the nurse manager. Is there an outpatient component of rehabilitative services operating and using all services of the rehab center? • During record review, ensure that an outpatient record is used and fulfills all the requirements of an outpatient service medical record. • Interview staff to ascertain how often patient care meeting are held. How often are staff conferences held? Who attends these meetings? Interview the unit director. Discuss and review the written utilization review plan. Does it outline organization and composition of its committee, which includes at least two physicians, who meet monthly, select review using a scientific basis, provide a summary of the number and type of cases reviewed, provide findings on the cases reviewed, and provide the actions/recommendations to be taken based on the reviews?
§ 70599	**Rehabilitation Center Staff.** (a) A physician experienced in rehabilitation medicine shall have overall responsibility for the service. (b) A registered nurse with training and at least one year of experience in rehabilitation nursing shall be

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	responsible for nursing care and nursing management of rehabilitation services. (c) Sufficient registered nurses experienced in rehabilitation nursing shall be employed to meet the needs of the service. (d) Other personnel experienced in rehabilitation shall be provided to meet the needs of the service and shall include but not be limited to the following: (1) Full-time physical therapists. (2) Full-time occupational therapists. (3) Speech pathologists. (4) The following personnel shall be available on a consultation or referral basis: (A) Audiologist. (B) Orthotist. (C) Prosthetist. (D) Vocational rehabilitation counselor. (E) Recreational therapist. (F) Psychiatrist. (G) Psychologist. (H) Registered nurse with public health nursing certificate. (I) Learning disability specialist. (J) Social worker. **Survey procedures:** • Identify the physician who has overall responsibility for the service. • Interview the nurse manager of the unit. Ask about her training and experienced in rehabilitation nursing (1 year required). Verify that there is sufficient registered nursing staff to assist and provide care to meet the needs of the patients. • Review scheduling with the nurse manager to ensure there are full-time physical therapists and full-time occupational therapists. Ensure there is a speech therapist. Other staff must be available to include, but not limited to: audiologist, orthotist, prosthetist, vocational counselor, recreational therapist, psychiatrist, psychologist, public health RN, learning disability specialist, and social worker.
§ 70601	**Rehabilitation Center Equipment and Supplies.** (a) There shall be sufficient equipment and supplies to fulfill the needs of the services provided. (b) The equipment shall be of a type, quantity and quality that will provide safe and effective patient care.
§ 70603	**Rehabilitation Center Space.** (a)Rehabilitation beds shall be in a designated area of the hospital and shall be included in the licensed bed capacity of the hospital.

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	(b) The following structural features shall be provided in the rehabilitation service area: (1) Flooring in rehabilitation areas, while selected for appearance, durability and ease of cleaning and maintenance, shall also be selected and maintained to minimize slipping hazards. (2) Architectural barriers as defined in Specifications for Making Buildings and Facilities Accessible and Usable by the Physically Handicapped, A-117.1 1961 (reaffirmed 1971) by the American National Standards Institute, Inc., 1430 Broadway, New York, NY 10018, shall have alternate means of access such as ramps. (3) Sturdy handrails shall be provided on both sides of ramps and stairs in areas used by physically handicapped patients. (4) Grab bars on both sides of toilets and supports shall be provided in patient bathrooms so that physically disabled patients may use toilet, handwashing and bathing facilities with minimal or no assistance. (5) Doors and doorways. (A) Doors to be used by ambulatory and wheelchair patients shall be at least 1.1 meters (three feet, eight inches) wide. Doors 0.9 meter (three feet) wide may be permitted at individual toilet rooms adjacent to patient bedrooms. (B) Thresholds at doorways shall be flush with the floor. (C) There should be at least two doors of entry and exit from group activity areas, i.e., craft and workshops. All such exit doors shall be equipped with panic bars. (D) Doors shall not obstruct wheelchair patients' access to toilets and other patient areas. (6) Bathing facilities. (A) Bathtubs shall be of standard height. There shall be access on both sides and one end of bathtub to allow personnel to work on either side or end of tub. (B) Shower stalls shall have minimum dimensions of at least 1.2 meters (four feet), be equipped with handrails and curtains and be designed for easy accessibility. The floor shall be sloped to provide drainage. (7) There shall be at least one training toilet area in each patient unit with minimum dimensions of 1.5 meters (five feet) and 1.8 meters (six feet). (8) Drinking fountains shall be located conveniently in nursing units, treatment areas and the lobby. Fountains shall be usable by wheelchair patients. (9) Telephones shall be accessible to and usable by wheelchair patients. (10) All rooms shall contain a minimum of 10 square meters (110 square feet) of usable floor space per bed with greater space provided for special needs such as circ-o-lectric beds. (11) Beds of adjustable height, preferably electrically operated, adequate to the needs of the service shall be provided. Beds shall be adjustable to the heights of wheelchair seats for use in patient

transfer.
(12) A mirror with overhead light, so arranged as to be easily usable by handicapped patients in wheelchairs, shall be provided in patient rooms.
(13) Dining and lounge or recreation area.
(A) Space for group dining shall be provided in a minimum amount of at least 2 square meters (20 square feet) per licensed bed for adults and/or children beyond the crib age.
(B) Space for group recreation or patients lounge shall be provided in the same space ratio as the dining area.
(C) Dining and recreation areas shall be equipped with appropriate height tables to accommodate patients in wheelchairs.
(14) Suitable space shall be provided for staff conferences, patient evaluation and progress reports.
(15) Classroom space.
(16) An examining room equipped with furnishings, equipment and supplies adjacent or readily accessible to the office of the physician in charge of the outpatient service.
(17) A waiting room area with coat or locker space, drinking fountain, telephone and men and women toilet facilities in or adjacent to the rehabilitation outpatient service area.
(18) Access to an outside area to be used in therapeutic procedures for patients.

Survey procedures:
Observe the rehabilitation areas. Is the appropriate space, equipment, and resources are available to meet the needs of the patient population served?

§ 70605	**Renal Transplant Center Definition.** Renal transplant center means a specialized unit of a hospital for the treatment of patients with end-stage renal disease who manifest the accumulation of excessive nitrogenous waste products. The scope of services offered is comprehensive and includes acute dialysis, renal transplantation and may include peritoneal dialysis or other means for removing toxic or excessive waste products from the blood.
§ 70607	**Renal Transplant Center 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 the 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 renal transplant center to the medical staff and administration shall be defined. (c) The hospital shall: (1) Perform a sufficient number of transplants per annum to demonstrate a capability to perform with

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	high quality. Fifteen (15) transplants should be performed per annum. (2) Offer both living related donor and cadaver donor transplant services. (3) Contribute to a coordinated system of care by arrangements with other facilities providing care for patients with end-stage renal disease. (4) Make renal transplant services available to patients with end-stage renal disease referred from facilities that do not provide renal transplant services. (5) Participate in the development and use of a registry of prospective recipient patients. (6) Participate in kidney procurement, preservation and transport program. (7) Cooperate with other facilities for the timely transfer of medical data on patients with end-stage renal disease. (d) There shall be a written hepatitis control program incorporating the recommendations of Report 33, January 1971, of the Hepatitis Surveillance Program of the Center for Disease Control, Public Health Services, Atlanta, GA 30333. (e) There shall be in-service training and continuing education for all medical, nursing and other personnel. (f) The particular requirements for renal transplant and acute dialysis patients shall be accommodated in the disaster and fire plans of the hospital. (g) The hospital shall provide directly: (1) Inpatient acute dialysis. (2) Respiratory therapy. (3) Angiography. (4) Nuclear medicine. (5) Twenty-four hour laboratory capability of performing, as a minimum, the following determinations: C.B.C., B.U.N., creatinine, platelet count, blood typing and cross matching, blood gas analysis, blood pH, electrolytes, serum glucose, coagulation tests, spinal fluid examination, and urinalysis. (6) Immunofluorescence studies. (h) The hospital shall provide directly or by arrangement: (1) Microbiological studies for rickettsiae, fungi, bacteria and viruses. (2) Electron microscopy. (3) Outpatient follow-up care of patients with renal transplants. (4) Tissue culture. (5) Tissue typing and immunologic testing. (6) Cadaver kidney preservation. (7) Chronic dialysis. (i) Periodically, a committee of the medical staff shall evaluate the services provided and make

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	appropriate recommendations to the executive committee of the medical staff and administration. **Survey procedures:** • If the transplant service exists, seek consultation from appropriate CDPH resources. • If this service is in place verify the service is completing a minimum of 15 procedures per year/annum.
§ 70609	**Renal Transplant Center Staff.** (a) A physician shall have overall responsibility for the center. This physician shall be certified or eligible for certification by the American Board of Surgery, American Board of Urology, American Board of Internal Medicine or American Board of Pediatrics and shall have a minimum of one year's training or experience in the care of patients with renal transplantation. (b) The surgeons performing the transplantation procedures shall be certified or eligible for certification by the American Board of Surgery or American Board of Urology and shall have at least one year's training or experience in renal transplantation. (c) Children (13 years of age or under) receiving transplant services shall be under the care of a physician who is certified or eligible for certification by the American Board of Pediatrics. (d) Where appropriate, the hospital shall provide timely evaluation and consultation for its patients with renal transplants by the following specialists: (1) Physicians certified or eligible for certification in cardiology, endocrinology, hematology, or infectious disease by the American Board of Internal Medicine. (2) A physician certified or eligible for certification in neurology by the American Board of Psychiatry and Neurology. (3) A physician certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology. (4) A physician certified or eligible for certification in orthopaedic surgery by the American Board of Orthopaedic Surgery. (5) A physician certified or eligible for certification by the American Board of Pathology. (6) A physician certified or eligible for certification by the American Board of Urology. (e) There shall be a registered nurse responsible for the nursing service who has had at least 12 months' general nursing experience or six months' experience in the care of patients with renal transplants. (f) There shall be sufficient other licensed nurses and skilled personnel to provide the required patient care. (g) A dietician shall provide diet management and counseling to meet the needs of patients with renal transplants. (h) A social worker shall provide the social services and counseling needs of patients with renal transplants.

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§ 70611	**Renal Transplant Center Equipment and Supplies.** (a) Equipment and supplies shall include at least the following if chronic dialysis is provided: (1) A dialysis machine or equivalent (with appropriate monitoring equipment) for each bed or station. (2) Dialysis equipment appropriate for pediatric patients, if treated. (3) Cardiac monitoring equipment. (4) Resuscitative equipment.
§ 70613	**Renal Transplant Center Space.** (a) There shall be a minimum of 10 square meters (110 square feet) of floor space per bed. Beds in the renal transplant center shall be included in the total licensed bed capacity of the hospital. (b) The following areas shall be provided and maintained if chronic dialysis is provided: (1) Patient waiting area. (2) Conference room. (3) Nurses' station. (4) Isolation room. (5) Segregated area for home dialysis training. (6) Machine storage room. (7) Supplies storage room. (8) Utility room.
§ 70615	**Respiratory Care Service Definition.** (a) Respiratory care service means those diagnostic and therapeutic procedures for ventilatory support and associated services to patients with appropriate staff, space, equipment and supplies. These diagnostic and therapeutic procedures include but are not limited to: (1) Measurement of pulmonary function testing and blood gas analyses. (2) Procedures to reverse or prevent further physiological abnormalities. (3) Treatment or prevention of airway problems of respiratory therapy origin. (4) Positive pressure ventilatory therapy. (5) Respiratory monitoring. (6) Cardiopulmonary resuscitation. (7) Physical therapy of the chest including bronchial drainage and percussion. (8) Patient instruction. (9) Care of the intubated and tracheostomy patient. (10) Constant consideration of infection control.

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§ 70617	**Respiratory Care Service 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 respiratory care service to the medical staff and administration shall be defined. (c) There shall be clear delineation as to who may perform the various procedures, under what circumstances and under whose supervision, with the important undesirable side effects noted if an emergency arises. (d) All services shall be provided on the order of a person lawfully authorized to give such an order and shall specify the type, frequency of treatment, the dose and type of medication, appropriate dilution ratios and which diagnostic procedures are requested. (e) A copy of the order shall be available within the respiratory care files in addition to the patient's health record. (f) Diagnostic studies and treatment modalities shall be recorded in the patient's medical record including the type of diagnostic or therapeutic procedures, the dates and times of their occurrence and their effects including any adverse reactions. (g) Normal range and acceptable deviations from normal will be clearly delineated. Reactions outside the acceptable usual disease range shall be brought to the attention of the referring physician and the nursing service. (h) Respiratory care staff shall be involved in orientation and in-service training of hospital employees. (i) 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: Section 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.
§ 70619	**Respiratory Care Service Staff.** (a) A physician shall have overall responsibility for the service. This physician should be certified or eligible for certification by the American Board of Internal Medicine or the American Board of Anesthesiology. His responsibilities shall include: (1) Coordinating with other services. (2) Making services available. (3) Assuring the quality of respiratory care personnel. (4) Developing measures to control nosocomial infections. (b) The day-to-day operation of the service shall be under the immediate supervision of a technical director who shall be a respiratory care practitioner, respiratory care technician, cardiopulmonary or

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	pulmonary technologist or a registered nurse with specialized training and/or advanced experience in respiratory care, who shall be responsible for: (1) Supervising the clinical application of respiratory care. (2) Supervising the technical procedures used in pulmonary function testing and blood gas analysis. (3) Supervising the maintenance of equipment. (4) Assuring that national and local safety standards are met. (c) Other personnel may include registered nurses, licensed vocational nurses and physical therapists trained in respiratory care, respiratory care practitioners, respiratory care technicians, cardiopulmonary or pulmonary technologists and students. Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Sections 1276, 131050, 131051 and 131052, Health and Safety Code.
§ 70621	**Respiratory Care Service Equipment and Supplies.** (a) There shall be sufficient types and quantity of equipment to provide the appropriate inhalation of the several gases, aerosols and such other modalities required for the anticipated nature and variety of procedures. (b) Equipment shall be calibrated in accordance with manufacturer's instructions and records of such calibrations shall be kept.
§ 70623	**Respiratory Care Service Space.** (a) There shall be sufficient space maintained for: (1) Storage of necessary equipment. (2) Work areas for cleaning, sterilizing and repairing equipment. (3) Pulmonary function studies and blood gas analysis, if performed in the unit. (4) Office space. Survey procedure: Respiratory care service means those diagnostic and therapeutic procedures for ventilatory support and associated services to patients with appropriate staff, space, equipment and supplies. These diagnostic and therapeutic procedures include but are not limited to: (1) Measurement of pulmonary function testing and blood gas analyses. (2) Procedures to reverse or prevent further physiological abnormalities. (3) Treatment or prevention of airway problems of respiratory therapy origin. (4) Positive pressure ventilatory therapy. (5) Respiratory monitoring. (6) Cardiopulmonary resuscitation. (7) Physical therapy of the chest including bronchial drainage and percussion. (8) Patient instruction.

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	(9) Care of the intubated and tracheostomy patient. (10) Follows hospital's policies on infection control. **Survey Procedures:** • Interview the service manager. Review the delineation as to who may perform the various procedures, under what circumstances and under whose supervision, with the important undesirable side effects noted if an emergency arises. • Review medical records. Does the respiratory care order specify the type, frequency of treatment, the dose and type of medication, appropriate dilution ratios, and which diagnostic procedures are requested? Does the staff notify the referring physician and nursing if there are abnormal reactions or complications during the course of treatment? • Interview the unit manager and respiratory care staff. Ask about orientation and in-service training of hospital employees. • Verify that the physician who has overall responsibility for the service is certified or eligible for certification by the American Board of Internal Medicine or the American Board of Anesthesiology. • Interview the appropriate individual/s regarding the developing and implementation of infection control measures and practices. • Verify that the day-to-day operation of the service is under the immediate supervision of a technical director who is a respiratory therapist, respiratory therapy technician, cardiopulmonary or pulmonary technologist or a registered nurse with specialized training and/or advanced experience in respiratory care. • Interview this manager and ask how they supervise the clinical application of respiratory care, the technical procedures used in pulmonary function and blood gas analysis, and the maintenance of equipment. • Ask the manager what national and local standards are used in the service. • If a staffing concern is raised, realize that other personnel can include, RNs, LVNs, physical therapists trained in respiratory care, respiratory therapist, respiratory therapy technicians, cardiopulmonary or pulmonary technologist, and students. • Through observation, does the service have the appropriate space, equipment, and resources available to meet the needs of the patient population served? • Interview the manager. How is the equipment calibrated with manufacturers' instructions? How are the records of calibration kept? • Are bronchoscopes used? Who is responsible for the processing and cleaning? • • Does the respiratory service have areas for storage, work areas for cleaning, sterilizing, and

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	repairing equipment and office space?
§ 70625	**Skilled Nursing Service Definition.** Skilled nursing service means the provision of skilled nursing care and supportive care to patients whose primary need is for the availability of skilled nursing care on a long-term basis. There is provision for 24-hour inpatient care and as a minimum includes medical, nursing, dietary, pharmaceutical services and an activity program. Skilled Nursing Service will be done yearly as a SNF survey. It will not be part of the GACH licensing survey.
§ 70627	**Skilled Nursing Service General Requirements.** (a) The regulations for Skilled Nursing Facilities, Chapter 3, Division 5, Title 22, California Administrative Code, shall be met with the following exceptions: (1) The administrator of the hospital does not need to possess a license as a nursing home administrator and his services may be shared between the hospital and the skilled nursing service. (2) The functions of the director of nurses may be shared between the hospital and the skilled nursing service. The registered nurse requirement, referred to as director of the nursing service, in Section 72323 of regulations for Skilled Nursing Facilities. (b) There shall be written policies and procedures relating to the transfer of patients between the hospital and skilled nursing service that are approved by the medical staff. (c) The skilled nursing service shall be provided in a distinct part.
§ 70629	**Social Service Definition.** Social service means assisting patients and their families to understand and cope with the emotional and social problems which affect their health status, with appropriately organized staff, space, equipment and supplies. problems of patients.
§ 70631	**Social Service General Requirements.** (a) The social service to be provided shall be planned and developed in consultation with the administration, medical staff, nursing staff and other staff as appropriate. (b) The responsibility and the accountability of the social service to administration and medical staff shall be defined. (c) 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. (d) When the patient receives social service appropriate entries and progress notes shall be included in the patient's medical record. (e) Social service staff shall be involved in orientation and in -service training of the staff to assist in

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	identifying social and emotional problems of patients. (f) Periodically, an appropriate committee of the medical staff shall evaluate the service provided and make appropriate recommendations to the executive committee of the medical staff and administration. **Survey procedures:** Interview the social worker. Ask how she/he coordinates and develops services in consultation with administration, medical staff, nursing staff and other staff. Does a physician or nursing staff send a request? How long does it take to respond? Does social service attend care conferences?
§ 70633	**Social Service Staff.** (a) A social worker shall have overall responsibility for the service. (b) The social service staff shall be sufficient in number and qualifications to effectively provide the service needed. Such personnel may include social work assistants, social work aides and support staff. **Survey procedures:** Interview the social worker manager. Ask how many staff she/he has and how many referrals does she/he receive? Does social services use assistants, aides, and support staff. How does the manager effectively cover the needs of the hospital?
§ 70635	**Social Service Equipment and Supplies.** Equipment and supplies shall be provided as needed for performance of social service.
§ 70637	**Social Service Space.** There shall be sufficient office space and privacy for interviewing and conducting social service. **Survey procedures:** Through observation and interview with the social service workers, verify that appropriate space, equipment, and resources are available to meet the needs of the patient population served. Is there privacy for interviewing?
§ 70639	**Speech Pathology and/or Audiology Service Definition.** Speech pathology and/or audiology service means diagnostic evaluation, screening, testing and rehabilitation services for individuals with speech, hearing and/or language disorders with appropriate staff, space, equipment and supplies.
§ 70641	**Speech Pathology and/or Audiology Service 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.

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	(b) The responsibility and accountability of the speech pathology and/or audiology service to the medical staff and administration shall be defined. (c) 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. **Survey procedures:** If needed, verify that written policies and procedures are developed and maintained by the person responsible for the speech therapy service.
§ 70643	**Speech Pathology and/or Audiology Service Staff.** (a) A speech pathologist, audiologist or otolaryngologist shall have overall responsibility for the service. (b) There shall be sufficient trained staff to meet the needs of the patients and the scope of the services provided. (c) All unlicensed personnel shall work under the direct supervision of a speech pathologist or audiologist. (d) There shall be arrangements for consultation with the patient's physician, a physician who is certified or eligible for certification by the American Board of Otolaryngology or other physician specialists as deemed appropriate. **Survey procedures:** • Interview the manager. Ask about their qualifications. Are there a speech pathologist, audiologist, or otolaryngologist worker? • If there is unlicensed staff working in the speech therapy service, are they under direct supervision of a speech pathologist or audiologist? • Interview the manager. How are arrangements made to consult with the patient's physician?
§ 70645	**Speech Pathology and/or Audiology Service Equipment and Supplies.** (a) At least the following equipment shall be provided: (1) An appropriate clinical audiometer. (2) Diagnostic tests and materials. (3) Other equipment and materials deemed necessary by the person having overall responsibility for the service. (b) Audiometric equipment shall be calibrated in accordance with Standard S-3.6, 1969, Specifications for Audiometer, of the American National Standards Institute, Inc., 1430 Broadway, New York, NY 10018. Evidence of such calibration shall be available on request.
§ 70647	**Speech Pathology and/or Audiology Service Space.** (a) There shall be at least one two-room testing suite that meets Standard S-3.1, 1960 (R-1971), Criteria

for Background Noise in Audiometer Rooms, of the American National Standards Institute, Inc., 1430 Broadway, New York, NY 10018.
(b) There shall be the space necessary for the tables and chairs to conduct interviews, consultations, treatment and to accommodate patients in wheelchairs or on stretchers.

Survey procedures:

- If needed, observe speech therapy's equipment. At the minimum, the service has a clinical audiometer, diagnostic tests and materials, other equipment as deemed by the person responsible for the service.
- Interview the manager. Ask how the equipment is calibrated.
- Observe the speech therapy space. Is there a two room testing suite? Are there appropriate tables and chairs to conduct interviews, consultations, and treatment sessions? Does the space used accommodate wheelchairs or stretchers? See 70647(a)

§ 70649

Standby Emergency Medical Service, Physician on Call, Definition.
Standby emergency medical service, physician on call, means the provision of emergency medical care in a specifically designated area of the hospital which is equipped and maintained at all times to receive patients with urgent medical problems and capable of providing physician service within a reasonable time.

§ 70651

Standby Emergency Medical Service, Physician on Call, 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 emergency medical service to the medical staff and administration shall be defined.
(c) There shall be a roster of names of physicians and their telephone numbers who are available to provide emergency service.
(d) A communication system employing telephones, radiotelephone or similar means shall be in use to establish and maintain contact with the police department, rescue squads and other emergency services of the community.
(e) The emergency medical service shall have a defined emergency and mass casualty plan in concert with the hospital's capabilities and the capabilities of the community served.
(f) The hospital shall require continuing education of all emergency medical service personnel.
(g) Medical records shall be maintained on all patients presenting themselves for emergency medical care. These shall become part of the patient's hospital medical record. Past hospital records shall be

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	available to the emergency medical service. (h) An emergency room log shall be maintained and shall contain at least the following information relating to the patient: name, date, time and means of arrival, age, sex, record number, nature of complaint, disposition and time of departure. The name of those dead on arrival shall also be entered in the log. (i) Each standby emergency medical service shall be identified to the public by an exterior sign, clearly visible from public thoroughfares. The wording of such signs shall state STANDBY EMERGENCY MEDICAL SERVICE, PHYSICIAN ON CALL. (j) Standardized emergency nursing procedures shall be developed by an appropriate committee of the medical staff. (k) A list of referral services shall be available in the emergency service. This list shall include the name, address and telephone number of the following: (1) Police department (2) Blood bank (3) Antivenin service (4) Burn center (5) Drug abuse center (6) Poison control information center (7) Suicide prevention center (8) Director of the State Department of Health or his designee (9) Local health department (10) Clergy (11) Emergency psychiatric service (12) Chronic hemodialysis service (13) Renal transplant center (14) Intensive care newborn nursery (15) Emergency maternity service (16) Radiation accident management service (17) Ambulance transport and rescue services (18) County coroner or medical examiner. (l) 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. **Survey procedures:** • Interview the nurse manager. Review the physician roster with the manager. Is it current with names

and telephone numbers of physicians available to provide emergency care?

- Observe the standby emergency area. Is there a communications system to establish and maintain contact with the police department, rescue squads and other emergency services of the community?
- Interview the physician in charge or the nurse manager. Review their emergency and mass casualty plan. Is the plan in concert with the parent hospital's capabilities and the capabilities of the community served?
- Interview the nurse manager. Review the continuing education records of all emergency medical service personnel. Interview staff and ask about their inservices.
- Interview the nurse manager. Ask when a medical record is instituted. Medical Records are to be maintained on all presenting patients and become part of the health record. How are emergency room staff able to access past medical records.
- Review the emergency room log. Does it contain, at least, name, date, time, means of arrival, sex, record number, nature of complaint, disposition, and time of departure of the presenting patient?. Does it contain the name of those dead on arrival?
- Observe the exterior signage. Is it visible from a public thoroughfare and contains wordage that states: STANDBY EMERGENCY MEDICAL SERVICE, PHYSICIAN ON CALL?
- Interview the nurse manager or emergency room staff. Do they use standardized emergency nursing procedures? If yes, how are the procedures developed?

Interview emergency room staff. Do they have referral services available? See section 70651 (k), for a lengthy example list of referral services required.

§ 70653

Standby Emergency Medical Service, Physician on Call, Staff.

(a) A physician shall have overall responsibility for the service. He or his designee shall be responsible for:

(1) Implementation of established policies and procedures.

(2) Development of a system for assuring physician coverage on call 24 hours a day to the emergency medical service.

(3) Assurance that physician coverage is available within a reasonable length of time, relative to the patient's illness or injury.

(4) Development of a roster of specialty physicians available for consultation at all times.

(5) Assurance of continuing education for the medical and nursing staff.

(b) All physicians, dentists and podiatrists providing services in the emergency room shall be members of the organized medical staff.

(c) A registered nurse shall be immediately available within the hospital at all times to provide emergency nursing care.

(d) There shall be sufficient other personnel to support the services offered.

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	Survey procedures: • Interview the physician in charge. How does the physician coordinate the implementation of policies and procedures? • Interview the physician regarding physician coverage 24 hours a day. There must be physician coverage is available within a reasonable length of time, relative to the patient's illness or injury. Who are their specialty physicians and how is their availability at all times coordinated? Are all physicians, podiatrists, or dentists working in the emergency service members of the medical staff? • Interview the physician and review the continuing education for the medical and nursing staff. • Review the registered nursing schedule for three months. Is an RN immediately available within the hospital at all times to provide emergency nursing care? Observe the provision of care. Is there sufficient other personnel to support the services offered?
§ 70655	**Standby Emergency Medical Service, Physician on Call, Equipment and Supplies.** All equipment and supplies necessary for life support shall be available. Equipment shall include, but need not be limited to, airway control and ventilation equipment, suction devices, cardiac monitor defibrillator, intravenous fluids and administering devices and including blood expanders.
§ 70657	**Standby Emergency Medical Service, Physician on Call, Space.** (a) The following space provisions and designations shall be met: (1) Designated emergency room area (2) Reception area (3) Observation room (b) Observation beds in the emergency medical service shall not be counted in the total licensed bed capacity of the hospital **Survey procedures:** • Observe the standby emergency area. Is there appropriate equipment, supplies and space necessary for life support? Ensure that, at the minimum, airway control, ventilation equipment, suction devices, cardiac monitor defibrillator, IV fluids, administering devices, and blood expanders are available. Interview staff regarding the availability of above. • By observation and interview, are the equipment and supplies and space sufficient to meet the needs of the patients and the scope of services offered? Is there a dedicated emergency room area, reception area, and observation area? Observation beds may not be counted in the census.

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§ 70701	**Governing Body.** (a) The governing body shall: (1) Adopt written bylaws in accordance with legal requirements and its community responsibility which shall include but not be limited to provision for: (A) Identification of the purposes of the hospital and the means of fulfilling them. (B) Appointment and reappointment of members of the medical staff. (C) Appointment and reappointment of one or more dentists, podiatrists, and/or clinical psychologists to the medical staff respectively, when dental, podiatric, and/or clinical psychological services are provided. (D) Formal organization of the medical staff with appropriate officers and bylaws. (E) Membership on the medical staff which shall be restricted to physicians, dentists, podiatrists, and clinical psychologists competent in their respective fields, worthy in character and in professional ethics. No hospital shall discriminate with respect to employment, staff privileges or the provision of professional services against a licensed clinical psychologist within the scope of his/her licensure, or against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O. or D.P.M. degree. Wherever staffing requirements for a service mandate that the physician responsible for the service be certified or eligible for certification by an appropriate American medical board, such position may be filled by an osteopathic physician who is certified or eligible for certification by the equivalent appropriate American Osteopathic Board. (F) Self-government by the medical staff with respect to the professional work performed in the hospital, periodic meetings of the medical staff to review and analyze at regular intervals their clinical experience and requirement that the medical records of the patients shall be the basis for such review and analysis. (G) Preparation and maintenance of a complete and accurate medical record for each patient. (2) Appoint an administrator whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body. (3) The Department shall be notified in writing whenever a change of administrator occurs. (4) Provide appropriate physical resources and personnel required to meet the needs of the patients and shall participate in planning to meet the health needs of the community. (5) Take all reasonable steps to conform to all applicable federal, state and local laws and regulations,

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	including those relating to licensure, fire inspection and other safety measures. (6) Provide for the control and use of the physical and financial resources of the hospital. (7) Require that the medical staff establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical staff be required to demonstrate their ability to perform surgical and/or other procedures competently and to the satisfaction of an appropriate committee or committees of the staff, at the time of original application for appointment to the staff and at least every two years thereafter. (8) Assure that medical staff by-laws, rules and regulations are subject to governing body approval, which approval shall not be withheld unreasonably. (9) These by-laws shall include an effective formal means for the medical staff, as a liaison, to participate in the development of all hospital policy. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code. **Survey procedures:** • Governing Body Bylaws/Granting of Privileges/Reappointment/ Minutes for last year of meetings of Governing Body and Quality Committees. Interview administration: What makes up the Governing Body for this hospital? Is there a remote GB and a local leadership team that jointly fulfil the role? • When reviewing a year of minute meetings, it is not necessary to read all of the year's minutes. Pick 3 or 4 to review for documentation of the performance of the duties of the committee and expand the sample if indicated. • Review a sample of physician credentialing file to include primary verification of license, NPDB, DEA, Letters of reference (by hospital policy), Do not spend a lot of time on going back in time in these files. • Written statement, adopted by the governing body, of the appointment, qualifications, authority, and duties of the administrator. • Provision of appropriate physical resources and personnel to meet the communities and the patients' needs. Interview administration: ED wait times, OR availability? Review three year capital budget if indicated as noted below. • Physician/approved disciplines demonstrate competency to perform surgery/ procedures at the time of original application and every 2 years. Ask about new technology, robots, teleradiology, sedation. • Review medical staff policies/procedures governing credentialing, current clinical comperency measures. Observe medical staff follows bylaws and P & Ps. • Look for approval of Medical Staff appointment and reappointment/approval of minutes or report by Quality, Med Exec., Infection Control, Nursing, Surgical services, as well as hospital administration. • List of Medical Staff officers, and Medical Staff Department heads, committees.

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	• Minutes of Medical staff Executive Committee. • Policies on peer review. • Look at the privileges. Review policy and procedure for reappointments (may be in bylaws) • Check that they are approved by the Medical Staff and Governing Body as per their hospital policy and that all specialized procedures by the provider are included. • Review 3-5 year capital budget to verify resources. • Interview staff during survey if their needs are met in terms of equipment, personnel, etc. • Medical Staff Bylaws and Rule and Regulations/ Approval by hospital's policy.
§ 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 care rendered to patients. (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, 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 D.D.S. degree or clinical psychology license. (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

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	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. (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 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1315, 1316, 1316.5, 131050, 131051 and 131052, Health and Safety Code. **Survey procedures:** • Review in bylaws who may be member of the Medical Staff based on the type of professionals who work in the hospital. • Review policy for psychologists, dentists, podiatrists, nurse practitioners, physician assistants, nurse first assists, nurse anesthetists; • Review minutes of meetings of medical staff for past year. May be an annual meeting. • Quarterly or more often if necessary, reports to the governing body and executive committee of medical staff functions, activities, and recommendations. • Verify teleradiologists and other remote providers have been granted privileges by the by-laws. (See AFL 11-33 January 25, 2012) • Policies for availability of physician coverage for inpatient emergency in the event that the attending physician and/or his alternate is unavailable. Medical staff participates in continuing education, also using the retrospective review evaluations for the basis of need.
§ 70705	**Medical Staff, Residents, Interns and Students.**

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	(a)The hospital shall not permit any physician, dentist, podiatrist, or clinical psychologist or any medical, dental, podiatric or clinical psychology resident, intern or student to perform any service for which a license, certificate of registration or other form of approval is required unless such person is licensed, registered, approved or is exempted therefrom under the provisions of the State Medical Practice Act, the State Dental Practice Act, the State Podiatric Practice Act, or the State Psychology Licensing Law and, further, unless such services are performed under the direct supervision of licensed practitioner whenever so required by law. (b) If patient care is provided by residents, interns and medical students, such care shall be in accordance with the provisions of a program approved by and in conformity with: the Council on Education of the American Medical Association, the American Osteopathic Association Board of Trustees through the Committee on postdoctoral training and the Bureau of Professional Education, the American Dental Association, the American Podiatry Association, or the Education and Training Board of the American Psychological Association and/or the residency training programs of the respective specialty boards. (c) Except in an emergency, all other patient care by interns, house officers, residents or persons with equivalent titles, not provided as specified in subdivision (b) of this section, must be provided by a practitioner with a current license to practice in California. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code. **Survey procedures:** Verify these practitioners are approved/credentialed for the services they render and under direct supervision if required.
§ 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

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	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 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code. **Survey procedures:** • Registered nurses that 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 • A Committee on Interdisciplinary Practice has been established and accountable to the Governing Body, for establishing policies and procedures for interdisciplinary medical practice. • 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. Licensed or certified health professionals other than registered nurses who are performing or will perform these functions. • The Committee on Interdisciplinary Practice will establish written policies and procedures for the conduct of its business. Policies and procedures shall include but not be limited to: ▪ 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. ▪ 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 of designee and a majority of the physician members and a majority of the registered nurse members would be

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	required and that prior to such approval, consultation shall be obtained from facility staff in the medical and nursing specialties under review. ▪ 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. • Intended line of approval for each committee recommendation.
§ 70706.1	**Granting of Nonphysician Privileges.** (a) Registered Nurses. The Committee on Interdisciplinary Practice shall be responsible for recommending policies and procedures for the granting of expanded role privileges to registered nurses, whether or not employed by the facility, to provide for the assessment, planning, and direction of the diagnostic and therapeutic care of a patient in a licensed health facility. These policies and procedures will be administered by the Committee on Interdisciplinary Practice which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges. (b) Physician's Assistant. A physician's assistant who practices in a licensed facility shall be supervised by a physician approved by the Division of Allied Health Professions of the Medical Board of California who is a member of the active medical staff of that facility. Physician's assistants shall apply to and be approved by the Executive Committee of the medical staff of the facility in which the physician's assistant wishes to practice. Note: Authority cited: Section 1275 and 131200, Health and Safety Code. Reference: Sections 1276, 131050, 131051 and 131052, Health and Safety Code. **Survey procedures:** • Healthcare professional/healthcare extenders such as RNs/physician's assistant have been afforded privileges through the designated means of approval. • Review associated policies if concerns arise. Committee on Interdisciplinary Practice shall be responsible for recommendations and policy of each professional.
§ 70706.2	**Standardized Procedures.** (a) The Committee on Interdisciplinary Practice shall be responsible for: (1) Identifying functions and/or procedures which require the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the facility, and initiating the preparation of such standardized procedures in accordance with this section. (2) The review and approval of all such standardized procedures covering practice by registered nurses in the facility. (3) Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be

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	administered by the Committee on Interdisciplinary Practice or by delegation to the director of nursing. (b) Each standardized procedure shall: (1) Be in writing and show date or dates of approval including approval by the Committee on Interdisciplinary Practice. (2) Specify the standardized procedure functions which registered nurses are authorized to perform and under what circumstances. (3) State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure. (4) Specify any experience, training or special education requirements for performance of the functions. (5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the functions. (6) Provide for a method of maintaining a written record of those persons authorized to perform the functions. (7) Specify the nature and scope of review and/or supervision required for the performance of the standardized procedure functions; for example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated. (8) Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition. (9) State any limitations on settings or departments within the facility where the standardized procedure functions may be performed. (10) Specify any special requirements for procedures relating to patient recordkeeping. (11) Provide for periodic review of the standardized procedure. (c) If nurses have been approved to perform procedures pursuant to a standardized procedure, the names of the nurses so approved shall be on file in the office of the director of nursing. Note: Authority cited: Section 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** • The Committee on Interdisciplinary Practice shall be responsible for the following: ▪ Identifying functions and/or procedures which require the formulation and adoption of standardized procedures. ▪ The review and approval of all such standardized procedures covering practice by registered nurses in the facility.

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	▪ Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee on Interdisciplinary Practice or by delegation to the director of nursing. • Each standardized procedure shall: ▪ Be in writing and show date or dates of approval including approval by the Committee on Interdisciplinary Practice. ▪ Specify the standardized procedure functions which registered nurses are authorized to perform and under what circumstances. ▪ State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure. ▪ Specify any experience, training or special education requirements for performance of the functions. ▪ Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the functions. ▪ Provide for a method of maintaining a written record of those persons authorized to perform the functions. ▪ Specify the nature and scope of review and/or supervision required for the performance of the standardized procedure functions; for example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated. ▪ Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition. ▪ State any limitations on settings or departments within the facility where the standardized procedure functions may be performed. ▪ Specify any special requirements for procedures relating to patient recordkeeping. • Provide for periodic review of the standardized procedure.
§ 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, disability, medical condition, marital status, registered domestic partner status, or the source of payment for care.

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	(2) Considerate and respectful care. (3) Knowledge of the name of the 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 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 nontreatment 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. (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/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, marriage, or registered domestic partner status, 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

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	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 and 131200, Health and Safety Code. Reference: Section 51, Civil Code; Sections 297 and 297.5, Family Code; and Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code. **Guidance for the above regulations:** The 19 elements of patient rights are simple and straightforward. By reviewing the specific elements of patient rights the surveyor can develop pertinent questions to ask the patient or staff. **Survey procedures:** • The posting of patient rights are displayed in the facility in English and Spanish and in languages common to the community. If indicated, review the policy regarding the distribution and posting of patient rights information. See 70707(b) • Interview the hospital administration regarding the handling of patient complaints. Administration contacts for this task may be the risk department director or quality department director. • Ask for and review the policy associated with the processing of patient complaints. After reviewing the policy request a sample of patient complaints that have been acted upon. • Review the associated documentation to ensure the process is consistent with the policy. See 70707(c)
§ 70707.1 – §70707.8 **Criteria for the Performance of Sterilization, Informed**	**Criteria for the Performance of Sterilization.** (a) A sterilization shall be performed only if the following conditions are met: (1) The individual is at least 18 years old at the time the consent is obtained, or the individual is under 18 and: (A) Has entered into a valid marriage, whether or not such marriage was terminated by dissolution; or

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Consent, Certification of Informed Consent, Hyster-ectomy, Additional Requirements for Informed Consent when Specified Federal Funds are used, Verification of Informed Consent, Noncom-pliance **§ 70707.3**	(B) Is on active duty with the United States armed services; or (C) Is over 15 years old, lives apart from his or her parents or guardian(s) manages, his or her own financial affairs; or (D) Has received a declaration of emancipation pursuant to Section 64 of the Civil Code. (2) The individual is able to understand the content and nature of the informed consent process as specified in 70707.3. (3) The individual has voluntarily given informed consent in accordance with all the requirements prescribed in Sections 70707.1 through 70707.6. (4) At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the following instances. (A) Sterilization may be performed at the time of emergency abdominal surgery if the following requirements are met: 1. The written informed consent to be sterilized was given at least 30 days before the individual intended to be sterilized. 2. At least 72 hours have passed after written informed consent to be sterilized was given. (B) Sterilization may be performed at the time of premature delivery if the following requirements are met: 1. The written informed consent was given at least 30 days before the expected date of the delivery. 2. At least 72 hours have passed after written informed consent to be sterilized was given. (C) The patient voluntarily requests in writing that the procedure be performed in less than 30 days. However, in no case shall a sterilization be performed in less than 72 hours following the signing of the consent form. Note: Authority cited: Sections 208, 1275, 1276, Health and Safety Code. Reference: Sections 1250 et seq., Health and Safety Code; Sections 25.6, 25.7, 34.6, and 63, Civil Code. **Informed Consent Process for Sterilization.** (a) An individual has given informed consent only if: (1) The person who obtained consent for the sterilization procedure: (A) Offered to answer any questions the individual to be sterilized may have concerning the procedure. (B) Provided the individual with a copy of the consent form and the booklet on sterilization published by the Department. (C) Provided orally all of the following to the individual to be sterilized: 1. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or

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	withdrawal of any federally funded program benefits to which the individual might be otherwise entitled. 2. A full description of available alternative methods of family planning and birth control. 3. Advice that the sterilization procedure is considered to be irreversible. 4. A thorough explanation of the specific sterilization procedure to be performed. 5. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used. 6. A full description of the benefits or advantages that may be expected as a result of the sterilization. 7. Approximate length of hospital stay. 8. Approximate length of time for recovery. 9. Financial cost to the patient. 10. Information that the procedure is established or new. 11. Advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in Section 70707.1. 12. The name of the physician performing the procedure. If another physician is to be substituted, the patient shall be notified, prior to administering pre-anesthetic medication of the physician's name and the reason for the change in physician. (2) Suitable arrangements were made to ensure that the information specified in (a)(1) was effectively communicated to any individual who is blind, deaf, or otherwise handicapped. (3) An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent. (4) The individual to be sterilized was permitted to have a witness of the individual's choice present when consent was obtained. (5) The sterilization operation was requested without fraud, duress, or undue influence. (6) The consent form requirements of Section 70707.4 were met. (b) Informed consent may not be obtained while the individual to be sterilized is: (1) In labor or within 24 hours postpartum or postabortion. (2) Seeking to obtain or obtaining an abortion. (A) Seeking to obtain means that period of time during which the abortion decision and the arrangement for the abortion are being made. (B) Obtaining an abortion means that period of time during which the individual is undergoing the abortion procedure, including any period during which preoperative medication is administered. (3) Under the influence of alcohol or other substances that affect the individual's state of awareness.

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§ 70707.4	(c) The informed consent process may be conducted either by a physician or by the physician's designee. (d) A copy of the signed consent form shall be: (1) Provided to the patient. (2) Retained by the physician and the hospital in the patient's medical records. (e) No person shall by reason of mental retardation alone be prevented from consenting to sterilization under this section. Note: Authority cited: Sections 208(a), 1275, and 1276, Health and Safety Code. Reference: Section 1250, Health and Safety Code. **Certification of Informed Consent for Sterilization.** (a) The Consent Form, provided by the Department in English and Spanish, shall be the only approved form and shall be signed and dated by the: (1) Individual to be sterilized. (2) Interpreter, if one is provided. (3) Person who obtained the consent. (4) Physician who performed the sterilization procedure, or an alternate physician. (b) The person securing consent shall certify, by signing the Consent Form, that he or she: (1) Advised the individual to be sterilized before the individual to be sterilized signed the Consent Form, that no federal benefits may be withdrawn because of the decision not to be sterilized. (2) Explained orally the requirements for informed consent to the individual to be sterilized as set forth on the Consent Form and in Section 70707.3. (3) Determined to the best of his/her knowledge and belief that the individual to be sterilized appeared to understand the content and nature of the informed consent process as specified in 70707.3 and knowingly and voluntarily consented to be sterilized. (c) The physician performing the sterilization, or an alternate physician shall certify, by signing the Consent Form, that: (1) The physician or an alternate physician, shortly before the performance of the sterilization, advised the individual to be sterilized that federal benefits shall not be withheld or withdrawn because of a decision not to be sterilized. (2) The physician or an alternate physician explained orally the requirements for informed consent as set forth on the Consent Form. (3) To the best of the physician's or an alternate physician's knowledge and belief, the individual to be sterilized appeared to knowingly and voluntarily consent to be sterilized. (4) At least 30 days have passed between the date of the individual's signature on the Consent Form and the date upon which the sterilization was performed, except in the following instances:

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	(A) Sterilization may be performed at the time of emergency abdominal surgery if the physician: 1. Certifies that the written informed consent to be sterilized was given at least 30 days before the individual intended to be sterilized. 2. Certifies that at least 72 hours have passed after written informed consent to be sterilized was given. 3. Describes the emergency on the Consent Form. (B) Sterilization may be performed at the time of premature delivery if the physician certifies that: 1. The written informed consent was given at least 30 days before the expected date of the delivery. The physician shall state the expected date of the delivery on the Consent Form. 2. At least 72 hours have passed after written informed consent to be sterilized was given. (C) The patient voluntarily requests in writing that the procedure be performed in less than 30 days. However, in no case shall a sterilization be performed in less than 72 hours following the signing of the Consent Form. (d) The interpreter, if one is provided, shall certify that he or she: (1) Transmitted the information and advice presented orally to the individual to be sterilized. (2) Read the Consent Form and explained its contents to the individual to be sterilized. (3) Determined to the best of his/her knowledge and belief that the individual to be sterilized understood that the interpreter told the individual.
§ 70707.5	(e) The person who obtains consent shall provide the individual to be sterilized with a copy of the booklet on sterilization, provided by the Department in English and Spanish before obtaining consent. (f) For the purposes of this section, shortly before means a period within 72 hours prior to the time the patient receives any preoperative medication. Note: Authority cited: Sections 208(a), 1275 and 1276, Health and Safety Code. Reference: Section 1250, Health and Safety Code. **Hysterectomy.** (a) Except for a previously sterile woman, a hysterectomy may be performed or arranged for by a physician only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile. (2) The individual and the individual's representative, if any, has signed a written acknowledgement of receipt of the information in (1). (3) The individual has been informed of the rights to consultation with a second physician. (b) A copy of the signed statement shall be: (1) Provide to the patient.
§ 70707.6	(2) Retained by the physician and the hospital in the patient's medical records.

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	(c) For previously sterile women the physician shall discuss with the patient her pre-existing sterility and certify in the patient's health record that the individual was previously sterile and the cause of sterility. Note: Authority cited: Sections 208, 1275 and 1276, Health and Safety Code. Reference: Sections 1275, 1276 and 1294, Health and Safety Code.
§ 70707.7	**The Additional Requirements for Informed Consent Process When Specified Federal Funds Are Used.** Pursuant to Title 22, California Administrative Code Sections 51163 and 51305.1 through 51305.7 the following Additional Requirements for Informed Consent Process shall be met When Specified Federal Funds are Used: (a) When Medi-Cal funds are used: (1) Sterilization shall be performed only if the following conditions are met: (A) The individual is at least twenty-one years old at the time consent is obtained. (B) The individual is not a mentally incompetent individual. (C) The individual is not an institutionalized individual. (2) A hysterectomy shall not be covered if: (A) Performed solely for the purpose of rendering an individual permanently sterile. (B) There is more than one purpose to the procedure, and the hysterectomy would not be performed except for the purpose of rendering the individual permanently sterile. (3) The hospital may not honor any request that the sterilization be performed earlier than 30 days as may non-Medi-Cal patients under Sections 70707.1(4)(C) and 70707.4(4)(C). (b) For the purposes of this section the following definitions apply: (1) Mentally incompetent individual means an individual who has been declared mentally incompetent by a Federal, State, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization. (2) Institutionalized individual means an individual who is: (A) Involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness. (B) Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness. Note: Authority cited: Sections 208, 1275, 1276, Health and Safety Code. Reference: Sections 1250 et seq. , Health and Safety Code.
§ 70707.8	**Verification of Informed Consent.** (a) For the purposes of the hospital in complying with these regulations, signature of the patient,

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	physician, physician's designee (if any) and auditor-witness (if applicable) on the Sterilization Consent Document shall be sufficient evidence that the informed consent procedure has taken place. Note: Authority cited: Sections 208, 1275, 1276, Health and Safety Code. Reference: Sections 1250 et seq. , Health and Safety Code. **Noncompliance.** Noncompliance with Sections 70707.1 through 70707.7 may result in a revocation or an involuntary suspension of the hospital's license as delineated in Section 70135. The facility shall report to the Medical Board of California the name of any physician who performs a sterilization procedure which was not in compliance with Sections 70707.1 through 70707.7 of this chapter. Note: Authority cited: Sections 1275, 1276 and 131200, Health and Safety Code. Reference: Sections 1276, 131050, 131051 and 131052, Health and Safety Code. **Survey procedures:** Review these sections if sterilizations are performed at the facility. • Very exact and detailed criteria for informed consent is provided at 70707.1 regarding sterilization. See 70707.1 • Obtaining informed consent for sterilization is provided at 70707.3. See 70707.3 • Informed consents are certified. See 70707.4 • Specific requirements exist at 70707.5 for a woman to consent to a hysterectomy. See 70707.5 • Additional requirements for informed consent when Federal monies, such as Medicaid is used at 70707.6. See 70707.6 • Signature of the physician, patient, physician's assistant, responsible party, auditor, witness is evidence that all the requirements are met and informed consent took place. See 70707.7 • 70707.8 states that noncompliance with 70707.1 through 70707.7 may result in a revocation or involuntary suspension of the hospital's license. See 70707.8 • The facility reports any physician performing sterilization not in compliance with these requirements is reported to the state MD Board. See 70707.8 • Also see 70715 (c) for nondiscrimination polices regarding sterilization. • Also see 70735 (a) for sterilization reporting to the Department.
§ 70708	**Clinical Research.** Research projects involving human subjects shall have the prior approval of a broadly represented committee which shall assure maximum patient safety and understanding. **Survey procedures:**

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	Verify that clinical research projects involving human subjects have received prior approval by the enitity to "assure maximum patient safety and understanding." Approving committee(s) (bodies or groups) would minimally include **Governing Body** (see §70701) and may include other organized hospital committees, and/or groups, such as the **Pharmacy and Therapeutics Committee** (see §70263) or **Organized Medical Staff** (see §70703), etc. Patients have inherent rights (see **Patient Rights** §**70707)** to adequate information regarding any proposed treatment or procedure, and the right to refuse such treatment.
§ 70709	**Emotional and Attitudinal Support.** Hospitals shall have a written plan for the provision of those components of total patient care that relate to the spiritual, emotional and attitudinal health of the patient, patients' families, visitors designated by patients pursuant to Section 70707(b)(17) and hospital personnel. Note: Authority cited: Sections 1275 and 100275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** Verify the existence of a written plan for the provision of those components of total patient care that relate to the spiritual, emotional and attitudinal health of the patient, patients' families, visitors designated by patients pursuant to Section 70707(b)(17) and hospital personnel. See 70709
§ 70711	**Social Services.** (a) Hospitals shall have a written plan for providing social services to those patients with social problems. This service may be provided through: (1) An organized social service within the hospital, or (2) A social worker employed on a part-time basis, or (3) Social work consultant services from a community agency. **Survey procedures:** Verify that the hospital has a written plan for providing social services for patients with social services problems. The service may be provided through an organized social service within the hospital, a social worker employed on a part-time basis, or a social work consultant service from a community agency. See 70711(a)(1-3)
§ 70713	**Use of Outside Resources.** If a hospital does not employ a qualified professional person to render a specific service to be provided by the hospital, there shall be arrangements for such a service through a written agreement with an outside resource -which meets the standards and requirements of these regulations. The responsibilities, functions, objectives and terms of agreement, including financial arrangements and charges of each such outside resource, shall be delineated in writing and signed by an authorized representative of the hospital

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	and the person or the agency providing the service. The agreement shall specify that the hospital retains professional and administrative responsibility for the services rendered. The outside resource, when acting as a consultant, shall apprise the administrator of recommendations, plans for implementation and continuing assessment through dated and signed reports which shall be retained by the administrator for follow-up action and evaluation of performance. **Survey procedures:** • If the hospital does not employ a qualified professional person to render a specific service to be provided by the hospital, verify the following: ▪ Arrangements for such a service through a written agreement with an outside resource--which meets the standards and requirements of these regulations. ▪ The responsibilities, functions, objectives and terms of agreement, including financial arrangements and charges of each such outside resource, shall be delineated in writing and signed by an authorized representative of the hospital and the person or the agency providing the service. ▪ The agreement shall specify that the hospital retains professional and administrative responsibility for the services rendered. ▪ The outside resource, when acting as a consultant, shall apprise the administrator of recommendations, plans for implementation and continuing assessment through dated and signed reports which shall be retained by the administrator for follow-up action and evaluation of performance. See 70713
§ 70715	**Nondiscrimination Policies.** (a) No hospital shall discriminate against any person based on sex, race, color, religion, ancestry, national origin, sexual orientation, disability, medical condition, marital status, or registered domestic partner status, except as provided herein. This provision shall apply to the appointment of the medical staff, hiring of hospital employees, and the admission, housing, or treatment of patients. (b) 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. Such policies shall not be construed as a violation of the first paragraph of this section. Any admission of nonmembers or nonadherents shall be subject to the first paragraph of this section. (c) No hospital which permits sterilization operations for contraceptive purposes nor any member of its medical staff shall require of the patient any special nonmedical qualifications which are not imposed upon individuals seeking other types of operations. Prohibited nonmedical qualifications shall include, but not be limited to, age, marital status, registered domestic partner status, and number of natural

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	children. This prohibition does not affect requirements relating to the physical or mental condition of the patient, physician counseling of the patient or existing law pertaining to individuals below the age of majority. Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Section 51, Civil Code; Sections 297 and 297.5, Family Code; and Sections 1276, 131050, 131051 and 131052, Health and Safety Code. **Survey procedures:** Verify the hospital policy provides language related to discrimination against any person based on sex, race, color, religion, ancestry or national origin, except as provided herein. This provision shall apply to the appointment of the medical staff, hiring of hospital employees and the admission, housing or treatment of patients.
§ 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. 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

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	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 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 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 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1285, 1315, 1316.5, 131050, 131051 and 131052, Health and Safety Code. **Survey procedures:** • If indicated, obtain and review a copy of the Conditions of Admission and associated written policies for: • 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

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	agreements and other financial considerations, discharge of patients and other related functions. • Hospitals offering emergency and/or outpatient services make available, upon request of a patient, a schedule of hospital charges. • A member of the medical staff admits patients and at the time of admission establishes the patient's condition and provisional diagnoses. • For every patient, in the health record, there is a complete history and physical examination within 24 hours after admission, or immediately before, providing the condition of the patient permits. • See 70717 (e) for details regarding detaining patients and minors against their will. In no event is a patient to be detained solely for nonpayment of a hospital bill. • No patient shall be transferred or discharged solely for the purposes of effecting a transfer from a hospital to another health facility unless arrangements were made in advance, the physician determines that the discharge would cause no medical hazard to the patient, and the patient and legally responsible person have been notified, including attempts over a 24 hour period. • Unemancipated minors are discharged only to the custody of their parents/legal guardians, unless addressed in writing by the parents/legal guardians. • Each patient receives a wristband identification tag. • No admissions to a distinct part (DP) unless, the DP is appropriate for the patient's level of care. • Patients with critical burns are treated in a burn center unless contraindicated by the physician.
H & S Code 1262.5 **Written Discharge Planning Policy and Process**	1262.5. (a) Each hospital shall have a written discharge planning policy and process. (b) The policy required by subdivision (a) shall require that appropriate arrangements for posthospital care, including, but not limited to, care at home, in a skilled nursing or intermediate care facility, or from a hospice, are made prior to discharge for those patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. If the hospital determines that the patient and family members or interested persons need to be counseled to prepare them for posthospital care, the hospital shall provide for that counseling. (c) As part of the discharge planning process, the hospital shall provide each patient who has been admitted to the hospital as an inpatient with an opportunity to identify one family caregiver who may assist in posthospital care, and shall record this information in the patient's medical chart. (A) In the event that the patient is unconscious or otherwise incapacitated upon admittance to the hospital, the hospital shall provide the patient or patient's legal guardian with an opportunity to designate a caregiver within a specified time period, at the discretion of the attending physician, following the patient's recovery of consciousness or capacity. The hospital shall promptly document the attempt in the patient's medical record. (B) In the event that the patient or legal guardian declines to designate a caregiver pursuant to this section, the hospital shall promptly document this declination in the patient's medical record, when

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	appropriate. (d) The policy required by subdivision (a) shall require that the patient's designated family caregiver be notified of the patient's discharge or transfer to another facility as soon as possible and, in any event, upon issuance of a discharge order by the patient's attending physician. If the hospital is unable to contact the designated caregiver, the lack of contact shall not interfere with, delay, or otherwise affect the medical care provided to the patient or an appropriate discharge of the patient. The hospital shall promptly document the attempted notification in the patient's medical record. (e) The process required by subdivision (a) shall require that the patient and family caregiver be informed of the continuing health care requirements following discharge from the hospital. The right to information regarding continuing health care requirements following discharge shall also apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient, if the patient is unable to make those decisions for himself or herself. The hospital shall provide an opportunity for the patient and his or her designated family caregiver to engage in the discharge planning process, which shall include providing information and, when appropriate, instruction regarding the posthospital care needs of the patient. This information shall include, but is not limited to, education and counseling about the patient's medications, including dosing and proper use of medication delivery devices, when applicable. The information shall be provided in a culturally competent manner and in a language that is comprehensible to the patient and caregiver, consistent with the requirements of state and federal law, and shall include an opportunity for the caregiver to ask questions about the posthospital care needs of the patient. (f) (1) A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of the hospital. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan, and shall be signed by the physician. (2) A copy of the transfer summary shall be given to the patient and the patient's legal representative, if any, prior to transfer to a skilled nursing or intermediate care facility. (g) A hospital shall establish and implement a written policy to ensure that each patient receives, at the time of discharge, information regarding each medication dispensed, pursuant to Section 4074 of the Business and Professions Code. (h) A hospital shall provide every patient anticipated to be in need of long-term care at the time of discharge with contact information for at least one public or nonprofit agency or organization dedicated to providing information or referral services relating to community-based long-term care options in the patient's county of residence and appropriate to the needs and characteristics of the patient. At a minimum, this information shall include contact information for the area agency on aging serving the patient's county of residence, local independent living centers, or other information appropriate to the

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	needs and characteristics of the patient. (i) A contract between a general acute care hospital and a health care service plan that is issued, amended, renewed, or delivered on or after January 1, 2002, may not contain a provision that prohibits or restricts any health care facility's compliance with the requirements of this section. (j) Discharge planning policies adopted by a hospital in accordance with this section shall ensure that planning is appropriate to the condition of the patient being discharged from the hospital and to the discharge destination and meets the needs and acuity of patients. (k) This section does not require a hospital to do either of the following: (1) Adopt a policy that would delay discharge or transfer of a patient. (2) Disclose information if the patient has not provided consent that meets the standards required by state and federal laws governing the privacy and security of protected health information. (*l*) This section does not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg). (m) For the purposes of this section, "family caregiver" means a relative, friend, or neighbor who provides assistance related to an underlying physical or mental disability but who is unpaid for those services.
§ 70719	**Personnel Policies.** (a) Each hospital shall adopt written personnel policies concerning qualifications, responsibilities and conditions of employment for each type of personnel, which shall be available to all personnel. Such policies shall include but not be limited to: (1) Wage scales, hours of work and all employee benefits. (2) A plan for orientation of all personnel to policies and objectives of the hospital and for on-the-job training where necessary. (3) A plan for at least an annual evaluation of employee performance. (b) Personnel policies shall require that employees and other persons working in or for the hospital familiarize themselves with these and such other regulations as are applicable to their duties. (c) Hospitals shall furnish written evidence of a plan for growth and development of the hospital staff through: (1) Designation of a staff member qualified by training and experience who shall be responsible for staff education. (2) Reference material relevant to the services provided by the hospital which shall be readily accessible to the staff. **Survey procedures:**

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	Verify the following: • Written personnel policies, available to all personnel, concerning qualifications, responsibilities, and conditions of employment for each type of personnel The policies include a plan for orientation of all personnel to policies and objectives of the hospital and for on-the-job training where necessary, wages work hours, employee benefits, and at least, an annual evaluation of employee performance. • Personnel policies require that employees and other persons working in or for the hospital familiarize themselves with these and such other regulations as are applicable to their duties. • Hospitals furnish written evidence of a plan for growth and development of the hospital staff through: ▪ Designation of a staff member qualified by train9ng and experience who is responsible for staff education. ▪ Reference material relevant to the services provided by the hospital readily accessible to the staff
§ 70721	**Employees.** (a) The hospital shall recruit qualified personnel and provide initial orientation of new employees, a continuing in-service training program and competent supervision designed to improve patient care and employee efficiency. (b) If language or communication barriers exist between hospital staff and a significant number of patients, arrangements shall be made for interpreters or for the use of other mechanisms to insure adequate communications between patients and personnel. (c) The hospital shall designate a member of the staff as a patient discharge planning coordinator. (d) All employees of the hospital having patient contact, including students, interns and residents, shall wear an identification tag bearing their name and vocational classification. (e) Appropriate employees shall be given training in methods of hospital infection control and cardiopulmonary resuscitation. (f) Uniform rules shall be established for each classification of employees concerning the conditions of employment. A written statement of all such rules shall be provided each employee upon commencing employment. **Survey procedures:** Verify the following: • Initial orientation of new employees, a continuing in-service training program and competent supervision designed to improve patient care and employee efficiency. • If language or communication barriers exist between hospital staff and a significant number of patients, arrangements shall be made for interpreters or for the use of other mechanisms to insure adequate communications between patients and personnel. • The hospital shall designate a member of the staff as a patient discharge planning coordinator. • All employees of the hospital having patient contact, including students, interns and residents, wear

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	an identification tag bearing their name and vocational classification. • Appropriate employees shall be given training in methods of hospital infection control and cardiopulmonary
§ 70723	**Employee Health Examinations and Health Records.** (a) Personnel evidencing signs or symptoms indicating the presence of an infectious disease shall be medically screened prior to having patient contact. Those employees determined to have infectious potential as defined by the Infection Control Committee shall be denied or removed from patient contact until it has been determined that the individual is no longer infectious. (b) A health examination, performed by a person lawfully authorized to perform such an examination, shall be required as a requisite for employment and must be performed within one week after employment. Written examination reports, signed by the person performing the examination, shall verify that employees are able to perform assigned duties. (1) Initial examination for tuberculosis shall include a test for tuberculosis infection that is recommended by the federal Centers for Disease Control and Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA). If the result is positive, a chest X-ray shall be obtained. If a person has a previously documented positive tuberculosis test result, a test for tuberculosis infection need not be done but a baseline chest X-ray shall be obtained. (2) Policies and Procedures that address the identification, employment utilization and medical referral of persons with positive tuberculosis tests including those who have converted from negative to positive shall be written and implemented. (3) An annual tuberculosis test shall be performed on those individuals with a previously documented negative tuberculosis test. If an individual with a previously documented negative tuberculosis test has a subsequent positive tuberculosis test result, a chest X-ray shall be obtained. (4) Less frequent testing for tuberculosis, but never less than every four years, may be adopted as hospital policy when documented in writing as approved by the Infection Control Committee, the medical staff and the health officer of the health jurisdiction in which the facility is located. (c) Employee health records shall be maintained by the hospital and shall include the records of all required health examinations. Such records shall be kept a minimum of three years following termination of employment. (d) Personnel shall be made aware of recommended vaccinations for preventable diseases that can be prevented by vaccination. Note: Authority cited: Sections 1275, 121357 and 131200, Health and Safety Code. Reference: Sections 1250, 1276, 121362, 131050, 131051 and 131052, Health and Safety Code.

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	Survey procedures: • No patient contact is allowed if an employee displays signs of an infectious disease, until such time, as the employee is no longer infectious. • A health exam is a prequisite for employment, and not to exceed 1 week after employment. The following are part of that health exam: ▪ TB testing ▪ Policies and procedures for those employees with a positive skin reaction, including the conversion of a negative to positive ▪ Annual TB testing on all employees with a negative test result. ▪ Less frequent testing for TB can be adopted if adopted by the hospital, such as every 4 years, with written approval from the infection control committee, the medical staff and the community public health officer. • Employee health records are available and kept for 3 years following termination. • Employees are aware of recommended preventative vaccinations.
§ 70725	**Employee Personnel Records.** All hospitals shall maintain personnel records of all employees. Such records shall be retained for at least three years following termination of employment. The record shall include the employee's full name, Social Security number, the license or registration number, if any, brief resume of experience, employment classification, date of beginning employment and date of termination of employment. Records of hours and dates worked by all employees during at least the most recent six-month period shall be kept on file at the place of employment. **Survey procedures:** • Employee personnel records are maintained for at least 3 years following termination. • Records, available onsite, which contain full name, s.s. number, license or registration number, brief resume, hire date, termination date, and hours and dates worked (within the last 6 month period). • If necessary review a sample of employee personnel files for content as outlined in this section.
§ 70727	**Descriptions.** Job descriptions detailing the functions of each classification of employee shall be written and shall be available to all personnel. **Survey procedures:** Verify that Job descriptions for all positions are available upon request.
§ 70729	**Advertising.** No hospital shall make or disseminate any false or misleading statement or advertise by any manner or

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	means any false claims regarding services provided by the hospital. **Survey procedures:** Verify that advertising of hospital services is not false or misleading by statement or claim and is consistent with services available.
§ 70731	**Alcoholic and/or Tubercular Patients.** (a) Any licensee who holds out or advertises, by any means, the capability of providing specialized treatment of alcoholics and/or tubercular patients shall: (1) Establish a distinct part for each type of patient treated. (2) Obtain Department approval. **Survey procedures:** If the service exists, verify it is a distinct part and that the Department (CDPH) has approved of the service.
§ 70733	**Records and Reports.** (a) Each hospital shall maintain copies of the following applicable documents on file in the administrative offices of the hospital: (1) Articles of incorporation or partnership agreement. (2) Bylaws or rules and regulations of the governing body. (3) Bylaws and rules and regulations of the medical staff. (4) Minutes of the meetings of the governing body and the medical staff. (5) Reports of inspections by local, state and federal agents. (6) All contracts, leases and other agreements required by these regulations. (7) Patient admission roster. (8) Reports of unusual occurrences for the preceding two years. (9) Personnel records. (10) Policy manuals. (11) Procedure manuals (12) Minutes and reports of the hospital Infection Control Committee. (13) Any other records deemed necessary for the direct enforcement of these regulations by the Department. (b) The records and reports mentioned or referred to above shall be made available for inspection by any duly authorized officer, employee or agent of the Department. **Survey procedures:**

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	• If needed, the aforementioned records/reports shall be available from the hospital administration. • Be judicious when requesting to see the reports. Do not access the reports with the intention of finding non- compliance issues, but to validate concerns that have arisen based on observations, interviews and other records reviewed. • Providers may h at your request and cite the California Evidence Code 1156. You may counter point with the citing of section 70733 and state the items need to be reviewed to ensure compliance. • Copying of the documents is usually not allowed or provided. This may vary depending on the relationship with the provider.
§ 70735	**Annual Reports.** All hospitals shall submit annual reports to the Department on forms supplied by the Department and by the date specified on the form. **Survey procedures:** All hospitals submit annual reports using forms supplied by the Department, by the specified date on the form, to the Department.
§ 70736	**Sterilization Reporting Requirements.** (a) All hospitals performing tubal ligations, vasectomies, and hysterectomies shall submit to the Department a quarterly report containing the following information: (1) The total number of such sterilizations performed, including diagnoses and types of procedures employed. (2) The number and type of such sterilizations performed by each physician on the medical staff preserving the anonymity of the physicians and patient. (3) Demographic and medical data as required by the Department. Note: Authority cited: Sections 208, 1275, 1276, Health and Safety Code. Reference: Sections 1250 et seq. , Health and Safety Code. **Survey procedures:** Submits to the Department a quarterly report for all performed tubal ligations, vasectomies, and hysterectomies, which includes the total number of sterilizations performed, including diagnoses, and type of procedures, number of procedures per physician.
§ 70737	**Reporting.** (a) Reportable Disease or Unusual Occurrences. All cases of reportable diseases shall be reported to the local health officer in accordance with Section 2500, Article 1, Subchapter 4, Chapter 4, Title 17, California Administrative Code. Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or

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	health of patients, personnel or visitors shall be reported as soon as reasonably practical, either by telephone or by telegraph, to the local health officer and to the Department. The hospital shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require. (b) Testing for Phenylketonuria. Hospitals to which maternity patients or infants 30 days of age or under may be admitted shall comply with the requirements governing testing for phenylketonuria (PKU) contained in Section 6500 of Title 17, California Administrative Code. (c) (c) Rhesus (Rh) Hemolytic Disease of the Newborn. Hospitals to which maternity patients may be admitted shall comply with the requirements for the determination and reporting of the rhesus (Rh) blood type of maternity patients and the reporting of rhesus (Rh) hemolytic disease of the newborn contained in Section 6510 of Title 17, California Administrative Code. (d) (d) Child Placement. Hospitals shall report to the Department on forms supplied by them, within 48 hours, the name and address of any person other than a parent or relative by blood or marriage, or the name and address of the organization or institution into whose custody a child is given on discharge from the hospital. The release of children for adoption shall be in conformity with the state law regulating adoption procedure. **Survey procedures:** Verify the following: • All reportable diseases are reported to the local public health officer. • An occurrence, such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophic or unusual occurrences which threatens welfare, safety of health of patients, personnel, or visitors. Also see 70746 (b) for reporting a discontinuance or disruption of service by the administrator. • Newborn, up to 30 days of age, reported for testing for phenylketonia. • Newborn reported for rhesus hemolytic disease Placement of a child with other than the parent/legal guardian are reported.
§ 70738	**Infant Security.** Written policies and procedures shall be adopted and implemented to accurately identify infants and to protect infants from removal from the facility by unauthorized persons. The policies and procedures shall be reviewed and updated by the facility every two years. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** • Verify the existence of an infant security program, updated every 2 years.

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	• Review written policies related to infant security • Interview staff related to the above.
§ 70739	**Infection Control Program.** (a) A written hospital infection control program for the surveillance, prevention and control of infections shall be adopted and implemented. The program shall include policies and procedures that: (1) Define and require methods to handle all patients, all blood and body fluids and all materials that are soiled with blood and/or body fluids from all patients. The methods prescribed shall be designed to reduce the risk of transmission of potentially infectious etiologic agents from patient to patient and between patient and healthcare worker. The methods shall include handwashing, the use of gloves, the use of other barriers, the handling of needles/sharps and the disposal of materials that are soiled with or contain blood and/or body fluids. (2) Define practices to reduce the risk of transmission of airborne infectious etiologic agents including tuberculosis and addressing the assignment of rooms and/or roommates. (3) Provide for and document the education of all personnel. (A) Each new employee shall receive training appropriate to his/her job classification and work activities to acquaint him/her with infection control policies and procedures of the healthcare facility. (B) Training material shall be kept current and conform to new information pertaining to the prevention and control of infectious diseases. Revised training material shall be presented to all healthcare workers. (4) Provide a plan for the surveillance and control of nosocomial infections including procedures for the investigation and management of outbreaks. (5) Define the equipment, instruments, utensils and disposable materials that are to be identified as biohazardous. (b) The oversight of the infection surveillance, prevention and control program shall be vested in a multi-disciplinary committee which shall include representatives from the medical staff, administration, nursing department and infection control personnel. This committee shall provide advice on all proposed construction and shall be responsible for the provision of current, updated information on infection control policy and procedures for the facility. (c) Hospitals having a licensed bed capacity of 200 or more shall have a full-time infection control employee who shall coordinate the activities of the program. (d) Hospitals having a licensed bed capacity of 199 or less shall have a designated part-time infection control employee who shall coordinate activities of the program. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

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	Survey procedures: Verify the following: • Written policies and procedures defining and adopting methods to handle all patients, all blood and body fluids, and materials that are soiled by blood or body fluids. The policies include: ▪ Methods to reduce the risk of transmission from patient to patient and between patient and staff. Methods include handwashing, glove use, barrier use, sharps/needles, and disposal of soiled materials. ▪ Methods to reduce airborne infectious pathogens, including tuberculosis. ▪ Methods for assigning room and roommates ▪ Provisions for the education of all personnel. Each new employee gets training appropriate to their position and work activities. Training content is current to new, accepted information. ▪ The plan to surveil and control nosocomial (hospital acquired) infections with procedures to investigate and manage outbreaks. ▪ Identify the equipment, instruments, utensils, and disposable material that are biohazardous (biological substances that pose a threat to health). • Oversight of the program is a multidisciplinary committee. Including medical staff, administration, nursing, and infection control personnel. • This committee provides advice on all proposed construction and responsible for providing updated infection control information. Hospitals over 200 beds have a full time infection control employee who coordinates the activities of the program. Hospitals under 199 have a designated part time infection control employee who coordinates the activities of the program.
From the PSLS **H & S 1255.8**	**1255.8** (a) For purposes of this section, the following terms have the following meanings: (1) “Colonized” means that a pathogen is present on the patient’s body, but is not causing any signs or symptoms of an infection. (2) “Committee” means the Healthcare Associated Infection Advisory Committee established pursuant to Section 1288.5. (3) “Health facility” means a facility as defined in subdivision (a) of Section 1250. (4) “Health-care-associated infection,” “health-facility-acquired infection,” or “HAI” means a health care associated infection as defined by the National Healthcare Safety Network of the federal Centers for Disease Control and Prevention, unless the department adopts a definition consistent with the recommendations of the committee or its successor. (5) “MRSA” means Methicillin-resistant Staphylococcus aureus.

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	(b) (1) Each patient who is admitted to a health facility shall be tested for MRSA in the following cases, within 24 hours of admission: (A) The patient is scheduled for inpatient surgery and has a documented medical condition making the patient susceptible to infection, based either upon federal Centers for Disease Control and Prevention findings or the recommendations of the committee or its successor. (B) It has been documented that the patient has been previously discharged from a general acute care hospital within 30 days prior to the current hospital admission. (C) The patient will be admitted to an intensive care unit or burn unit of the hospital. (D) The patient receives inpatient dialysis treatment. (E) The patient is being transferred from a skilled nursing facility. (2) The department may interpret this subdivision to take into account the recommendations of the federal Centers for Disease Control and Prevention, or recommendations of the committee or its successor. (3) If a patient tests positive for MRSA, the attending physician shall inform the patient or the patient's representative immediately or as soon as practically possible. (4) A patient who tests positive for MRSA infection shall, prior to discharge, receive oral and written instruction regarding aftercare and precautions to prevent the spread of the infection to others. (c) Commencing January 1, 2011, a patient tested in accordance with subdivision (b) and who shows evidence of increased risk of invasive MRSA shall again be tested for MRSA immediately prior to discharge from the facility. This subdivision shall not apply to a patient who has tested positive for MRSA infection or colonization upon entering the facility. (d) A patient who is tested pursuant to subdivision (c) and who tests positive for MRSA infection shall receive oral and written instructions regarding aftercare and precautions to prevent the spread of the infection to others. (e) The infection control policy required pursuant to Section 70739 of Title 22 of the California Code of Regulations, at a minimum, shall include all of the following: (1) Procedures to reduce health care associated infections. (2) Regular disinfection of all restrooms, countertops, furniture, televisions, telephones, bedding, office equipment, and surfaces in patient rooms, nursing stations, and storage units. (3) Regular removal of accumulations of bodily fluids and intravenous substances, and cleaning and disinfection of all movable medical equipment, including point-of-care testing devices such as glucometers, and transportable medical devices. (4) Regular cleaning and disinfection of all surfaces in common areas in the facility such as elevators, meeting rooms, and lounges. (f) Each facility shall designate an infection control officer who, in conjunction with the hospital infection control committee, shall ensure implementation of the testing and reporting provisions of this section and other hospital infection control efforts. The reports shall be presented to the appropriate committee within

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	the facility for review. The name of the infection control officer shall be made publicly available, upon request. (g) The department shall establish a health care acquired infection program pursuant to this section. **Survey procedures:** For infection control, interview infection control nurse • What policies and procedures does the hospital have in place to meet statutory requirements? • For which patients does the hospital require MRSA testing? • How does the hospital ensure that newly admitted patients who require MRSA testing are tested within 24 hours of admission? • When a patient tests positive for MRSA, how does the hospital ensure that the patient or patient's representative is informed by the attending physician in a timely manner? • Note: The definition of attending physician is per usual facility practice. . When a patient tests positive for MRSA, what is the hospital's process for providing the patient or patient's representative with instructions before discharge? This does not limit the evaluator in conducting a full investigation as needed. For the Infection Control Officer: • Does the GACH have a designated infection control officer? What is that person's name? • How does the infection control officer ensure infection control requirements for testing and reporting are implemented? • How does the infection control officer ensure other hospital infection control efforts (such as the requirements above) are implemented? • What infection control reports are provided to which committees? This does not limit the evaluator in conducting a full investigation as needed. For each patient admitted, they are tested for MRSA within 24 hours when: ▪ Discharged from a GACH within 30 days of the current admission. ▪ Admitted to ICU or Burn unit. ▪ Receiving inpatient dialysis ▪ Transfer from a skilled nursing facility • If found positive for MRSA, physician informs patient/responsible party immediately or asap • If found positive receives, prior to discharge, Oral and written instructions for aftercare and precautions to prevent the spread to others.

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	• In addition to requirements above at 70739, includes: ▪ Procedures to reduce health care associated infections ▪ Regular disinfection of all restrooms, countertops, furniture, televisions, telephones, office equipment, and surfaces in patient rooms, nurses stations and storage rooms. ▪ Regular removal of accumulation of bodily fluids and IVs, cleaning of moveable medical equipment, including point of care testing devices such as glucometer and transportable medical devices. Regular cleaning and disinfection of all common areas, such as elevators, meeting rooms, and lounges.
From the PSLS **H & S 1279.7** **Hand washing**	**1279.7** (a) A health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, shall implement a facility-wide hand hygiene program. (b) Commencing January 1, 2016, a health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, is prohibited from using an epidural connector that would fit into a connector other than the type it was intended for, unless an emergency or urgent situation exists and the prohibition would impair the ability to provide health care. (c) Commencing January 1, 2016, a health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, is prohibited from using an intravenous connector or an enteral feeding connector that would fit into a connector other than the type it was intended for, unless an emergency or urgent situation exists and the prohibition would impair the ability to provide health care. (d) The Advanced Medical Technology Association shall, on January 1 of each year until the standards are developed, provide the Legislature with a report on the progress of the International Organization for Standardization in developing new design standards for connectors for intravenous, epidural, or enteral applications. (e) A health facility that is required to develop a patient safety plan pursuant to Section 1279.6 shall include in the patient safety plan measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines. This subdivision shall become inoperative as to epidural connectors upon the operative date of subdivision (b) and as to intravenous and enteral connectors upon the operative date of subdivision (c). **Survey procedures:** Hospital must implement a facility-wide hand hygiene program. ▪ Has the hospital developed a system to implement a hand hygiene program? ▪ How does the hospital ensure staff availability of resources needed to implement the hand hygiene program? ▪ Does the hospital provide training on the hand hygiene program?

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	▪ Are there adequate resources such as sinks and hand washing supplies to implement the hand hygiene program? ▪ How is the hospital's hand hygiene program incorporated into staff education/training and orientation? ▪ Do staff and healthcare providers wash their hands or perform hand hygeine prior to performing treatments or delivering care? ▪ Do Clinical staff/Healthcare personnel implement hand hygiene measures of the hand hygiene program? ▪ Is there adequate availability of hand hygiene resources such as sinks, soap, alcohol-based hand cleaners, etc.? ▪ This does not limit the evaluator in conducting a full investigation as needed.
From the PSLS **H & S 1288.6** **Infection Control Report**	**1288.6** (a) (1) Each general acute care hospital, in collaboration with infection prevention and control professionals, and with the participation of senior health care facility leadership shall, as a component of its strategic plan, at least once every three years, prepare a written report that examines the hospital's existing resources and evaluates the quality and effectiveness of the hospital's infection surveillance and prevention program. (2) The report shall evaluate and include information on all of the following: (A) The risk and cost of the number of invasive patient procedures performed at the hospital. (B) The number of intensive care beds. (C) The number of emergency department visits to the hospital. (D) The number of outpatient visits by departments. (E) The number of licensed beds. (F) Employee health and occupational health measures implemented at the hospital. (G) Changing demographics of the community being served by the hospital. (H) An estimate of the need and recommendations for additional resources for infection prevention and control programs necessary to address the findings of the plan. (3) The report shall be updated annually, and shall be revised at regular intervals, if necessary, to accommodate technological advances and new information and findings contained in the triennial strategic plan with respect to improving disease surveillance and the prevention of HAI. (b) Each general acute care hospital that uses central venous catheters (CVCs) shall implement policies and procedures to prevent occurrences of health care associated infection, as recommended by the Centers for Disease Control and Prevention intravascular bloodstream infection guidelines or other evidence-based national guidelines, as recommended by the advisory committee. A general acute care hospital that uses CVCs shall internally report CVC associated blood stream infection rates in intensive care units, utilizing device days to calculate the rate for each type of intensive care unit, to the appropriate

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	medical staff committee of the hospital on a regular basis. Verify the following • Hospital, in collaboration with infection prevention and control professionals, and with the participation of senior health care facility leadership prepares a written report that examines the hospital's existing resources and evaluates the quality and effectiveness of the hospital's infection surveillance and prevention program as a component of its strategic plan, at least once every three years. The report includes information and evaluation of: ▪ The risk and cost of the number of invasive patient procedures performed at the hospital. ▪ The number of intensive care beds. ▪ The number of emergency department visits to the hospital. ▪ The number of outpatient visits by departments. ▪ The number of licensed beds. ▪ Employee health and occupational health measures implemented at the hospital. ▪ Changing demographics of the community being served by the hospital. ▪ An estimate of the need and recommendations for additional resources for infection prevention and control programs necessary to address the findings of the plan. The report is updated annual and revised at regular intervals. • If hospital uses central venous catheters (CVCs), they implement policies and procedures to prevent occurrences of health care associated infection, as recommended by the Centers for Disease Control and Prevention intravascular bloodstream infection guidelines or other evidence-based national guidelines, as recommended by the advisory committee. A general acute care hospital that uses CVCs internally reports CVC associated blood stream infection rates in ICUs, utilizing device days to calculate the rate for each type of ICU, to the appropriate medical staff committee of the hospital on a regular basis. • How are central venous catheter (CVC) associated blood stream infection rates tracked and reported in the hospital for intensive care units? • How are these reports directed to the appropriate medical staff committee for review? • What practices has the hospital adopted to prevent occurrence of bloodstream infections related to CVC use? ▪ What is the hospital's internal CVC process or method to prevent Blood Stream Infections? This does not limit the evaluator in conducting a full investigation as needed.
From the PSLS	**1288.7** By July 1, 2007, the department shall require that each general acute care hospital, in accordance with the Centers for Disease Control guidelines, take all of the following actions: (a) Annually offer onsite influenza vaccinations, if available, to all hospital employees at no cost to the

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H & S 1288.7 **Influenza, Respiratory Etiquette, Pandemic Plan Component**	employee. General acute care hospitals shall require its employees to be vaccinated, or if the employee elects not to be vaccinated, to declare in writing that he or she has declined the vaccination. (b) Institute respiratory hygiene and cough etiquette protocols, develop and implement procedures for the isolation of patients with influenza, and adopt a seasonal influenza plan. (c) Revise an existing or develop a new disaster plan that includes a pandemic influenza component. The plan shall also document any actual or recommended collaboration with local, regional, and state public health agencies or officials in the event of an influenza pandemic. **Survey procedures:** Verify the following: • The hospital annually offers onsite no cost influenza vaccinations to all hospital employees If the employee elects not to have the required vaccination, declare in writing declining the vaccination. • The hospital has instituted respiratory hygiene and cough etiquette protocols, develop and implement procedures for the isolation of patients with influenza, and adopt a seasonal influenza plan. • The hospital has revised an existing or develop a new disaster plan that includes a pandemic influenza component. The plan shall also document any actual or recommended collaboration with local, regional, and state public health agencies or officials in the event of an influenza pandemic. • Are influenza vaccinations offered to employees on an annual basis? How much does it cost the employee? • Does the hospital have a seasonal influenza plan? Does it cover pandemics, including pandemic influenza? • Has the hospital instituted respiratory hygiene and cough etiquette protocols? • How influenza vaccination and declination rates are reported to CDPH. • How are influenza vaccinations handled for employees? • Do you have the opportunity to get one here? How much does it cost? • What happens if you want to refuse a vaccination? This does not limit the evaluator in conducting a full investigation as needed.
From the PSLS **H & S 1288.8** **Protection against Hospital**	(a) By January 1, 2008, the department shall take all of the following actions to protect against HAI in general acute care hospitals statewide: (1) Implement an HAI surveillance and prevention program designed to assess the department's resource needs, educate health facility evaluator nurses in HAI, and educate department staff on methods of implementing recommendations for disease prevention. (2) Revise existing and adopt new administrative regulations, as necessary, to incorporate current federal Centers for Disease Control and Prevention (CDC) guidelines and standards for HAI prevention. (3) Require that general acute care hospitals develop a process for evaluating the judicious use of

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Acquired Infection (HAI)	antibiotics, the results of which shall be monitored jointly by appropriate representatives and committees involved in quality improvement activities. (b) On and after January 1, 2008, each general acute care hospital shall implement and annually report to the department on its implementation of infection surveillance and infection prevention process measures that have been recommended by the federal Centers for Disease Control and Prevention Healthcare Infection Control Practices Advisory Committee, as suitable for a mandatory public reporting program. Initially, these process measures shall include the CDC guidelines for central line insertion practices, surgical antimicrobial prophylaxis, and influenza vaccination of patients and healthcare personnel. In consultation with the advisory committee, the department shall make this information public no later than six months after receiving the data. (c) The advisory committee shall make recommendations for phasing in the implementation and public reporting of additional process measures and outcome measures by January 1, 2008, and, in doing so, shall consider the measures recommended by the CDC. (d) Each general acute care hospital shall also submit data on implemented process measures to the National Healthcare Safety Network of the CDC, or to any other scientifically valid national HAI reporting system based upon the recommendation of the federal Centers for Disease Control and Prevention Healthcare Infection Control Practices Advisory Committee or to another scientifically valid reporting database, as determined by the department based on the recommendations of the HAI-AC. Hospitals shall utilize the federal Centers for Disease Control and Prevention definitions and methodology for surveillance of HAI. Hospitals participating in the California Hospital Assessment and Reporting Task Force (CHART) shall publicly report those HAI measures as agreed to by all CHART hospitals. (e) In addition to the requirements in subdivision (a), the department shall establish an infection surveillance, prevention, and control program to do all of the following: (1) Designate infection prevention professionals to serve as consultants to the licensing and certification program. (2) Provide education and training to department health facility evaluator nurses and consultants to effectively survey hospitals for compliance with infection surveillance, prevention, and control recommendations, as well as state and federal statutes and regulations. (3) By January 1, 2011, in consultation with the HAI-AC, develop a scientifically valid statewide electronic reporting system or utilize an existing scientifically valid database system capable of receiving electronically transmitted reports from hospitals related to HAI. (4) Provide current infection prevention and control information to the public on the Internet. (5) Beginning January 1, 2011, provide to the Governor, the Legislature, and the Chairs of the Senate Committee on Health and Assembly Committee on Health, and post on the department's Web site, an annual report of publicly reported HAI infection information received and reported pursuant to this article.

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	Survey procedures: Verify the following: • The hospital has actions to protect against HAI in general acute care hospitals statewide, which include: ▪ Developing a process for evaluating the judicious use of antibiotics, with the results monitored jointly by appropriate representatives and committees involved in quality improvement activities. ▪ The hospital provides an annual report on its implementation of infection surveillance and infection prevention process measures, recommended by the CDC and the Prevention Healthcare Infection Control Practices Advisory Committee, for a mandatory public reporting program. Initially, these process measures shall include the CDC guidelines for central line insertion practices, surgical antimicrobial prophylaxis, and influenza vaccination of patients and healthcare personnel. ▪ Submitting data on implemented process measures to the National Healthcare Safety Network of the CDC, or to any other scientifically valid national HAI reporting system based upon the recommendation of the CDC and Prevention Healthcare Infection Control Practices Advisory Committee or to another scientifically valid reporting database, as determined by the department based on the recommendations of the HAI-AC. ▪ Utilizing the CDC and Prevention definitions and methodology for surveillance of HAI. Hospitals participating in the California Hospital Assessment and Reporting Task Force (CHART) shall publicly report those HAI measures as agreed to by all CHART hospitals.
Commenced 1-1-2015 H&S Code 1288.85. Antimicrobial Stewardship policy	Each general acute care hospital, as defined in subdivision (a) of Section 1250, shall do all of the following by July 1, 2015: (a) Adopt and implement an antimicrobial stewardship policy in accordance with guidelines established by the federal government and professional organizations. This policy shall include a process to evaluate the judicious use of antibiotics in accordance with paragraph (3) of subdivision (a) of Section 1288.8. (b) Develop a physician supervised multidisciplinary antimicrobial stewardship committee, subcommittee, or workgroup. (c) Appoint to the physician supervised multidisciplinary antimicrobial stewardship committee, subcommittee, or workgroup, at least one physician or pharmacist who is knowledgeable about the subject of antimicrobial stewardship through prior training or attendance at continuing education programs, including programs offered by the federal Centers for Disease Control and Prevention, the Society for Healthcare Epidemiology of America, or similar recognized professional organizations. (d) Report antimicrobial stewardship program activities to each appropriate hospital committee undertaking clinical quality improvement activities.
From the	(a) Require each general acute care hospital to develop, implement, and periodically evaluate compliance

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PSLS **H & S Code 1288.9** **Prevention of secondary Surgical Site Infections (SSI), Ventilator Associated Pneu-monias, Hospital Acquired Infections (HAI)**	with policies and procedures to prevent secondary surgical site infections (SSI). The results of this evaluation shall be monitored by the infection prevention committee and reported to the surgical committee of the hospital. (b) Require each general acute care hospital to develop policies and procedures to implement the current Centers for Disease Control and Prevention guidelines and Institute for Healthcare Improvement (IHI) process measures designed to prevent ventilator associated pneumonia. (c) During surveys, evaluate the facility's compliance with existing policies and procedures to prevent HAI, including any externally or internally reported HAI process and outcome measures. **Survey procedures:** Verify the following: • The hospital has developed, implemented, and periodically evaluated compliance with policies and procedures to prevent secondary surgical site infections (SSI). The results of this evaluation are monitored by the hospital's infection prevention committee and reported to the surgical committee of the hospital. • The hospital has developed policies and procedures to implement the current Centers for Disease Control and Prevention guidelines and Institute for Healthcare Improvement (IHI) process measures designed to prevent ventilator associated pneumonia. • The hospital complies with existing policies and procedures to prevent HAI, including any externally or internally reported HAI process and outcome measures.
From the PSLS **H & S Code 1288.95** **Infection Control Program Continuing Medical Education**	(a) No later than January 1, 2010, a physician designated as a hospital epidemiologist or infection surveillance, prevention, and control committee chairperson shall participate in a continuing medical education (CME) training program offered by the federal Centers for Disease Control and Prevention (CDC) and the Society for Healthcare Epidemiologists of America, or other recognized professional organization. The CME program shall be specific to infection surveillance, prevention, and control. Documentation of attendance shall be placed in the physician's credentialing file. (b) Beginning January 2010, all staff and contract physicians and all other licensed independent contractors, including, but not limited to, nurse practitioners and physician assistants, shall be trained in methods to prevent transmission of HAI, including, but not limited to, MRSA and Clostridium difficile infection. (c) By January 2010, all permanent and temporary hospital employees and contractual staff, including students, shall be trained in hospital-specific infection prevention and control policies, including, but not limited to, hand hygiene, facility-specific isolation procedures, patient hygiene, and environmental

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	sanitation procedures. The training shall be given annually and when new policies have been adopted by the infection surveillance, prevention, and control committee. (d) Environmental services staff shall be trained by the hospital and shall be observed for compliance with hospital sanitation measures. The training shall be given at the start of employment, when new prevention measures have been adopted, and annually thereafter. Cultures of the environment may be randomly obtained by the hospital to determine compliance with hospital sanitation procedures. **Survey procedures:** Verify the following: • A physician has been designated as a hospital epidemiologist or infection surveillance, prevention, and control committee chairperson participates in a continuing medical education (CME) training program offered by the CDC and the Society for Healthcare Epidemiologists of America, or other recognized professional organization. The CME program shall be specific to infection surveillance, prevention, and control. Documentation of attendance shall be placed in the physician's credentialing file. • Beginning January 2010, all staff and contract physicians and all other licensed independent contractors, including, but not limited to, nurse practitioners and physician assistants, shall be trained in methods to prevent transmission of HAI, including, but not limited to, MRSA and Clostridium difficile infection. • That all permanent and temporary hospital employees and contractual staff, including students, are trained in hospital-specific infection prevention and control policies, including, but not limited to, hand hygiene, facility-specific isolation procedures, patient hygiene, and environmental sanitation procedures. The training required annually and when new policies have been adopted by the infection surveillance, prevention, and control committee. • That environmental services staff are trained by the hospital and observed for compliance with hospital sanitation measures. The training is given at the start of employment, when new prevention measures have been adopted, and annually thereafter. Cultures of the environment may be randomly obtained by the hospital to determine compliance with hospital sanitation procedures.
§ 70741	**Disaster and Mass Casualty Program.** (a) A written disaster and mass casualty program shall be developed and maintained in consultation with representatives of the medical staff, nursing staff, administration and fire and safety experts. The program shall be in conformity with the California Emergency Plan of October 10, 1972 developed by the State Office of Emergency Services and the California Emergency Medical Mutual Aid Plan of March 1974 developed by the Office of Emergency Services, Department of Health. The program shall be approved by the medical staff and administration. A copy of the program shall be available on

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	the premises for review by the Department. (b) The program shall cover disasters occurring in the community and widespread disasters. It shall provide for at least the following: (1) Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials. (2) An efficient system of notifying and assigning personnel. (3) Unified medical command. (4) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care. (5) Prompt transfer of casualties, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definite care. (6) A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved. (7) Procedures for the prompt discharge or transfer of patients already in the hospital at the time of the disaster who can be moved without jeopardy. (8) Maintaining security in order to keep relatives and curious persons out of the triage area. (9) Establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will be made to provide organized dissemination of information. (c) The program shall be brought up-to-date, at least annually, and all personnel shall be instructed in its requirements. There shall be evidence in the personnel files, e.g., orientation checklist or elsewhere, indicating that all new employees have been oriented to the program and procedures within a reasonable time after commencement of their employment. (d) The disaster plan shall be rehearsed at least twice a year. There shall be a written report and evaluation of all drills. The actual evacuation of patients to safe areas during the drill is optional. **Survey procedures:** Verify the following: • Written disaster and mass casualty program plan is approved by the medical staff and administration, and includes: ▪ Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials. ▪ An efficient system of notifying and assigning personnel. ▪ Unified medical command. ▪ Conversion of all usable space into clearly defined areas for efficient triage, for patient observation

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	and for immediate care. ▪ Prompt transfer of casualties, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definite care. ▪ A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved. ▪ Procedures for the prompt discharge or transfer of patients already in the hospital at the time of the disaster who can be moved without jeopardy. ▪ Maintaining security in order to keep relatives and curious persons out of the triage area. ▪ Establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will be made to provide organized dissemination of information. • The program is brought up-to-date, at least annually, and all personnel instructed in its requirements. Requires evidence in the personnel files, e.g., orientation checklist or elsewhere, indicating that all new employees have been oriented to the program and procedures within a reasonable time after commencement of their employment. The disaster plan is rehearsed at least twice a year. There is a written report and evaluation of all drills. The actual evacuation of patients is optional.
§ 70743	**Fire and Internal Disasters.** (a) A written fire and internal disaster program, incorporating evacuation procedures, shall be developed with the assistance of fire, safety and other appropriate experts. A copy of the program shall be available on the premises for review by the Department. (b) The written program shall include at least the following: (1) Plans for the assignment of personnel to specific tasks and responsibilities. (2) Instructions relating to the use of alarm systems and signals. (3) Information concerning methods of fire containment. (4) Systems for notification of appropriate persons. (5) Information concerning the location of fire fighting equipment. (6) Specification of evacuation routes and procedures. (7) Other provisions as the local situation dictates. (c) Fire and internal disaster drills shall be held at least quarterly for each shift of hospital personnel and under varied conditions. The actual evacuation of patients to safe areas during a drill is optional. (d) The evacuation plan shall be posted throughout the facility and shall include at least the following: (1) Evacuation routes. (2) Location of fire alarm boxes. (3) Location of fire extinguishers.

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	Survey procedures: Verify the following: • Written fire and internal disaster program is available. • Written program includes: ▪ Assignment plan for personnel with specific tasks and responsibilities. ▪ Instructions on use of alarm system and signals. ▪ Information on methods of fire containment. ▪ Specific evacuation routes and procedures ▪ Other provisions as local situation dictates. • Verify fire and internal disaster drills are held at least quarterly and for each shift under varied conditions. The actual evacuation of patients is optional. • Evacuation plan is posted throughout the facility with routes, location of fire alarm boxes, and location of fire extinguishers.
§ 70745	**Fire Safety.** All hospitals shall be maintained in conformity with the regulations adopted by the State Fire Marshal for the prevention of fire and for the protection of life and property against fire and panic. All hospitals shall secure and maintain a clearance relative to fire safety from the State Fire Marshal. **Survey procedures:** Maintained in conformity with regulations. Has a clearance from the state fire marshal. If there are concerns in this area, consult with our life and safety code unit.
§ 70746	**Disruption of Services.** (a) Each hospital shall develop a written plan to be used when a discontinuance or disruption of services occurs. (b) The administrator shall be responsible for informing the Department, via telephone, immediately upon being notified of the intent of the discontinuance or disruption of services or upon the threat of a walkout of a substantial number of employees, or earthquake, fire, power outage or other calamity that causes damage to the facility or threatens the safety or welfare of patients or clients.
§ 70747	**Medical Records Service.** (a) The hospital shall maintain a medical record service which shall be conveniently located and adequate in size and equipment to facilitate the accurate processing, checking, indexing and filing of all medical records. (b) The medical records service shall be under the supervision of a registered health information administrator or registered health information technician. The registered health information

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	administrator or registered health information technician shall be assisted by such qualified personnel as are necessary for the conduct of the service. Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Sections 1276, 131050, 131051 and 131052, Health and Safety Code. **Survey procedures:** Verify the following: • The service is conveniently located and is of suitable size to facilitate accurate processing, checking indexing, and filing of all medical records. • Medical record service is under the supervision of a qualified person and is assisted by qualified personnel as necessary to meet the needs of the service.
§ 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) Martial 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. (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.

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	(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 diagnoses, description of findings, technique used, tissue removed or altered, if surgery was performed. (13) 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 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code. **Survey Procedure:** Refer to Tittle 22 above for 16 specific items required to be in the medical record.
§ 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 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.

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	(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 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 signature by a licensed healthcare practitioner acting within the scope of his or her professional licensure, only when that 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 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 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

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	Survey procedures: Verify the following: • Records are kept on all patients and maintained to be readily available to physicians, the Department, or anyone else authorized to make such a request. • Records are hospital property and is safeguarded against loss, defacement, tampering, or use by unauthorized persons. • Preserved safely for 7 years. See 70751 for specific rules regarding a minor's record. • If a facility ceases operation, notification to Department how the facility will preserve the records as above. If the owners change, notify the Department how the records will be preserved. • Are easily accessible, either in the hospital or in a storage unit. • Records are completed within 2 weeks after a patient's discharge. • Indexed according to patient, disease, operation, and physician. • Inpatient, outpatient, and emergency records are part of the patient's health record.
§ 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 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. **Survey procedures:** Verify a transfer summary has been completed when applicable (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). Content should 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.
§ 70754	**Special Hospital Transfer Agreement.** A special hospital shall have an effective written agreement with a general acute care hospital in the same geographic area for the provision of surgical and anesthesia services and any other service which may be required and which the special hospital does not provide. Note: Authority cited: Section 208 and 1250, Health and Safety Code. Reference: ACR 67, Chapter 83, Statutes of 1977. **Survey procedures:**

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	Verify the special hospital has a written agreement with another general acute care hospital in the immediate vicinity/region for the provision of services which the special hospital does not provide.
§ 70755	**Patients' Monies and Valuables.** (a) No licensee shall use patients' monies or valuables as his own or mingle them with his own. Patients' monies and valuables shall be separate, intact and free from any liability the licensee incurs in the use of his own or the institutions' funds and valuables. (b) Each licensee shall maintain adequate safeguards and accurate records of patients' monies and valuables entrusted to his care. (1) Records of patients' monies which are maintained as a drawing account shall include a control account for all receipts and expenditures, an account for each patient and supporting vouchers filed in chronological order. Each account shall be kept current with columns for debits, credits and balance. (2) Records of patients' monies and other valuables entrusted to the licensee for safekeeping shall include a copy of the receipt furnished to the patient or to the person responsible for the patient. (c) Patients' monies not kept in the hospital shall be deposited in a demand trust account in a local bank authorized to do business in California, the deposits of which are insured by the Federal Deposit Insurance Corporation. A county hospital may deposit such funds with the county treasurer. (d) When the amount of money entrusted to a licensee for patients exceeds $500, all money in excess of $500 shall be deposited in a demand trust account as specified in (c) above, unless a fireproof safe is provided on the premises for the protection of monies and valuables. If a fireproof safe is kept and the licensee desires the protection accorded by Civil Code Section 1860, he shall give notice as provided by that section. (e) Upon discharge of the patient, all refunds due and all money and valuables of that patient which have been entrusted to the licensee shall be surrendered to the patient or the person responsible for the patient in exchange for a signed receipt. Money and valuables kept within the hospital must be surrendered upon demand and those kept in a demand trust account or with the county treasurer must be made available within three normal banking days. (f) Following the death of a patient, except in a coroner or medical examiner's case, all money and valuables of that patient which have been entrusted to the licensee shall be surrendered to the person responsible for the patient, the executor or the administrator of the estate in exchange for a signed receipt, within 30 days. Immediate written notice of the death of a patient without an agent or known heirs shall be given to the public administrator of the county as specified by Section 1145 of the Probate Code. (g) Upon change of ownership of a hospital, a written verification by a public accountant of all patients' monies which are being transferred to the custody of the new owners shall be obtained by the new owner in exchange for a signed receipt.

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	Survey procedure: If the hospital takes possession of monies and valuables, assure the following: • No comingling with hospital funds or accounts. • Adequate safeguards and records of patient's monies or items that are entrusted to the facility's care. • Verify monies and items have been returned the patient or responsible party upon discharge with a signed receipt. • Upon a patient's death, monies and valuable will be given to the legal responsible party within 30 days.
§ 70757	**First Aid and Referrals.** (a) If a hospital does not maintain an emergency medical service, its employees shall exercise reasonable care to determine whether an emergency exists, render necessary lifesaving first aid and shall direct the persons seeking emergency care to the nearest hospital which can render the needed services and shall assist the persons seeking emergency care in obtaining such services, including transportation services, in every way reasonable under the circumstances. (b) Hospitals not providing emergency medical service shall not advertise or make any other representation to the public that may convey or connote the availability of such service. The posting of signs to designate entrances for use by outpatients and ambulances such as ambulance entrance, referred patients, outpatient service or other words of similar connotation is not prohibited. Such hospitals may represent to the public in any form or manner and only in its entirety, the phrase first aid and referral service. **Survey procedures:** If a hospital does not maintain emergency services, the employees will exercise reasonable care, lifesaving first aid, directions to the nearest hospital which can render emergency care, and assist in obtaining such services, including transportation.
§ 70759	**Exercise Stress Testing.** Where exercise stress testing is performed, there shall be appropriate monitoring and resuscitative equipment and persons trained in cardiopulmonary resuscitative techniques physically present. **Survey procedures:** If applicable, where exercise stress testing is performed, there shall be appropriate monitoring and resuscitative equipment and persons trained in cardiopulmonary resuscitative techniques physically present.
§ 70761	**Medical Library.** (a) Each hospital shall maintain a medical library consistent with the needs of the hospital.

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	(b) The medical library shall be located in a convenient location, and its contents shall be organized, easily accessible and available through authorized personnel at all times. (c) The library shall contain modern textbooks in basic sciences and other current textbooks, journals and magazines pertinent to the clinical services maintained in the hospital. **Survey procedures:** Verify the facility maintains a medical library.
§ 70763	**Medical Photography.** The hospital shall have a policy regarding the obtaining of consent for medical photography. **Survey procedures:** Verify policies exist regarding obtaining consent for medical photography.
§ 70765	**Conference Room.** Suitable space for conferences shall be provided in the hospital. **Survey procedures:** Verify the facility has suitable place for conferences.

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§ 70801	**Alterations to Existing Buildings or New Construction.** (a) Alterations to existing buildings licensed as hospitals or new constructions shall be in conformance with Chapter 1, Division T17, Part 6, Title 24, California Administrative Code. (b) Hospitals licensed and in operation prior to the effective date of changes in these regulations shall not be required to institute corrective alterations or construction to comply with such changes except where specifically required or where the Department determines that a definite hazard to health and safety exists. Any hospital for which preliminary or working drawings and specifications have been approved by the Department prior to the effective date of changes to these regulations shall not be required to comply with such changes provided substantial, actual construction is commenced within one year after the effective date of such changes.
§ 70803	**Application for Architectural Plan Review.** (a) Drawings and specifications for alterations to existing buildings or new construction shall be submitted to the Department for approval and shall be accompanied by an application for plan review on forms furnished by the Department. The application shall: (1) Identify and describe the work to be covered by the plan review for which the application is made.

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	(2) Describe the land on which the proposed work is to be done, by lot, block, tract or house and street address or similar description that will readily identify and definitely locate the proposed building or work. (3) Show the present and proposed use or occupancy of all parts of the building or buildings. (4) State the number of square meters (feet) of floor area involved in new construction and in alterations. (5) Give such other information as may be required by the Department for unusual design circumstances. (6) Be signed by the person designing the work or the owner of the work. (b) The application for plan review shall also include a written statement that a description of the proposed work has been submitted to the Area Comprehensive Health Planning Agency approved by the State Advisory Health Council pursuant to Section 437.7 of the Health and Safety Code.
§ 70805	**Space Conversion.** Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the Department. **Survey procedures:** Assure that spaces approved for specific uses at the time of licensure are not converted to other uses without the written approval of the Department.
§ 70807	**Notice to Department.** The licensee shall notify the Department in writing not later than ten days after the date when construction of a new hospital is commenced or when construction involving an increase in bed capacity or change of services of an existing hospital is commenced. **Survey procedures:** Assure that the licensee notified the Department in writing not later than ten days after the date when construction of a new hospital is commenced or when construction involving an increase in bed capacity or change of services of an existing hospital is commenced.
§ 70809	**Patient Accommodations.** (a) No hospital shall have more patients or beds set up for overnight use by patients than the approved licensed bed capacity except in the case of justified emergency when temporary permission may be granted by the Director or his designee. Beds not used for overnight stay such as labor room beds, recovery beds, beds used for admission screening or beds used for diagnostic purposes in X-ray or laboratory departments are not included in the approved licensed bed capacity. (b) Five percent of a facility's total licensed bed capacity may be used for a classification other than that

	designated on the license. Upon application to the Director and a showing that seasonal fluctuations justify, the Director may grant the use of an additional five percent of the beds for other than the classified use. (c) Patients shall not be housed in areas which have not been approved by the Department for patient housing and which have not been granted a fire clearance by the State Fire Marshal, except as provided in paragraph (a) above. (d) The number of licensed beds shown on a license shall not exceed the number of beds for which the facility meets applicable construction and operational requirements. **Survey procedures:** Tour and verify the following: • No patients or beds set up for overnight use by patients than the approved licensed bed capacity except in the case of justified emergency when temporary permission may be granted by the Director or his designee. Beds not used for overnight stay such as labor room beds, recovery beds, beds used for admission screening or beds used for diagnostic purposes in X-ray or laboratory departments are not included in the approved licensed bed capacity. • No more than five percent of a facility's total licensed bed capacity may be used for a classification other than that designated on the license. • Patients are not housed in areas which have not been approved by the Department for patient housing and which have not been granted a fire clearance by the State Fire Marshal.
§ 70811	**Patient Rooms.** (a) Patients shall be accommodated only in rooms with the following minimum floor area: (1) Single rooms: 10.2 square meters (110 square feet) of floor area, except for private rooms in pediatric units which shall have at least 9.3 square meters (100 square feet). (2) Multi-patient rooms: 7.4 square meters (80 square feet) of floor area per bed with one meter (three feet) between beds, except in specialized units. (b) Each patient room shall be labeled with a number, letter or combination of the two for identification. (c) Patient rooms which are approved for ambulatory patients only shall not accommodate nonambulatory patients. Before patients are accommodated in ambulatory sections, they shall demonstrate that they are ambulatory, and this shall be noted in the patient's medical record. The hospital shall transfer patients from the ambulatory section when their condition becomes nonambulatory. The ambulatory status of patients shall be demonstrated upon request of the Department. (d) Patient rooms approved for use by ambulatory patients only shall be identified as follows: the words Reserved for Ambulatory Patients, in letters at least one and one-half centimeters (one-half inch) high shall be posted on the outside of the door or on the wall alongside the door where they are visible to

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	persons entering the room. (e) Except in rooms approved by the Department for detention and for psychiatric patients, patients' rooms shall not be kept locked when occupied. (f) Any exit door, corridor or perimeter fence may be locked for egress only upon the written approval of the Department. **Survey procedures:** Verify the following: • Patients are accommodated only in rooms with the following minimum floor area: ▪ Single rooms: 110 square feet of floor area, except for private rooms in pediatric units which shall have at least 9.3 square meters 100 square feet. ▪ Multi-patient rooms: 80 square feet of floor area per bed with three feet between beds, except in specialized units. • Each patient room will be labeled with a number, letter or combination of the two for identification.
§ 70813	**Patient Property Storage.** Patients shall be provided with closet or locker space for clothing, toilet articles and other personal belongings. Bedside tables or the equivalent shall be provided for each patient. **Survey procedures:** Tour and verify that patients: • Are provided with closet or locker space for clothing, toilet articles and other personal belongings. • Bedside tables or the equivalent shall be provided for each patient.
§ 70815	**Patient Room Furnishings.** A bed with a suitable mattress and a chair shall be provided for each patient. In hospitals all beds, except cribs and bassinets, shall be adjustable. **Survey procedures:** Tour and verify that the equipment e.g. bed (adjustable), chairs, mattress are operational.
§ 70817	**Provisions for Emptying Bedpans.** Bedpans shall be emptied and cleaned in utility rooms or in toilets adjoining patients' rooms when such toilets are equipped with flushing attachments and vacuum breakers. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:**

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	Tour and verify that the separate utility room is available for emptying and cleaning or in toilets in patient rooms. A vacuum breaker/or anti-siphone valve should be attached to the plumbing used.
§ 70819	**Provision for Privacy.** A method of assuring visual privacy for each patient shall be maintained in patient rooms and in tub, shower and toilet rooms. **Survey procedures:** Tour and verify that the mechanisms are in place to ensure privacy for patient rooms, toilets, shower, and tub rooms.
§ 70821	**Public Telephone.** Each floor accommodating patients shall have a telephone installed for patient use. Such telephones shall be readily accessible to patients who are limited to wheel chairs and stretchers. This may not be required in separate buildings having six (6) or fewer beds which are restricted to occupancy by ambulatory patients. **Survey procedures:** Tour and verify that a phone is available on each floor.
§ 70823	**Isolation Facilities.** A private room shall be available for any patient in need of physical separation as defined by the infection control committee. Private toilet facilities shall be immediately adjacent to this room. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** Tour and verify that there are private rooms available for the purpose of physical separation.
§ 70825	**Laundry Service.** (a) Laundry and linen. (1) An adequate supply of clean linen shall be provided for at least three complete bed changes for the hospital's licensed bed capacity. (2) There shall be written policies and procedures developed and implemented pertaining to the handling, storage, transportation and processing of linens. (3) If the hospital operates its own laundry, such laundry shall be: (A) Located in such relationship to other areas that steam, odors, lint and objectionable noises do not reach patient or personnel areas. (B) Well-lighted and ventilated and adequate in size for the needs of the hospital and for the

protection of employees.
(C) Maintained in a sanitary manner and kept in good repair.
(D) Not part of a storage area.

(4) Hospital linens shall be washed according to the following method:
All linens shall be washed using an effective soap or detergent and thoroughly rinsed to remove soap or detergent and soil. Linens shall be exposed to water at a minimum temperature of 71 degrees C (160 degrees F) for at least 24 minutes during the washing process.

(5) Separate rooms shall be maintained in the hospital for storage of clean linen and for storage of soiled linen. Linen storage rooms shall not be used for any other purpose. Storage shall not be permitted in attic spaces, corridors or plenums (air distribution chambers) of air conditioning or ventilating systems.

(6) Handwashing and toilet facilities for laundry personnel shall be provided at locations convenient to the laundry.

(7) Soiled and clean linen carts shall be so labeled and provided with covers made of washable materials which shall be laundered or suitably cleaned daily. Linen carts used for the storage or transportation of dirty linen shall be washed before being used for the storage and transportation of clean linen.

(8) If the hospital does not maintain a laundry service, the commercial laundry utilized shall meet the standards of this section.

(b) Soiled linen.

(1) Soiled linen shall be handled, stored and processed in a safe manner that will prevent the spread of infection and will assure the maintenance of clean linen.

(2) Policies and procedures shall be developed and implemented pertaining to linen soiled with chemotherapeutic agents or radioactive substances.

(3) Soiled linen shall be sorted in a separate enclosed room by a person instructed in methods of protection from contamination. This person shall not have responsibility for immediately handling clean linen until protective attire worn in the soiled linen area is removed and hands are washed.

(4) Soiled linen shall be bagged or covered for transport.

(5) If chutes are used for transporting soiled linen, the chutes shall be maintained in a clean, sanitary state.

(c) Clean linen.

(1) Persons processing clean linen shall be dressed in clean garments at all times while on duty shall not handle soiled linen.

(2) Clean linen from a commercial laundry shall be delivered to the hospital completely wrapped and delivered to a designated clean area.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276,

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	Health and Safety Code. **Survey procedures:** Verify the following: • Written policies and procedures developed and implemented pertaining to the handling, storage, transportation and processing of linens. • If the hospital operates its own laundry, such laundry shall be: ▪ Located in such relationship to other areas that steam, odors, lint and objectionable noises do not reach patient or personnel areas. ▪ Well-lighted and ventilated and adequate in size for the needs of the hospital and for the protection of employees. ▪ Maintained in a sanitary manner and kept in good repair. ▪ Not part of a storage area. • Hospital linens shall be washed according to the following method: ▪ All linens are washed using an effective soap or detergent and thoroughly rinsed to remove soap or detergent and soil. Linens shall be exposed to water at a minimum temperature of 71°C (160°F) for at least 24 minutes during the washing process. ▪ Separate rooms are maintained in the hospital for storage of clean linen and for storage of soiled linen. Linen storage rooms are not used for any other purpose. Storage is not permitted in attic spaces, corridors or plenums (air distribution chambers) of air conditioning or ventilating systems. ▪ Hand washing and toilet facilities for laundry are provided at locations convenient to the laundry. ▪ Soiled linen are handled, stored and processed in a safe manner that will prevent the spread of infection and assure the maintenance of clean linen. ▪ Soiled linen are bagged or covered for transport. • Tour the area/interview staff related to process. • Interview Infection Control Preventionist (ICP) about his/her role in laundry service • If laundry is contracted out, ask ICP if he/she has inspected the service and ask for report.
§ 70827	**Housekeeping.** (a) Each hospital shall make provision for the routine cleaning of articles and surfaces such as furniture, floors, walls, ceilings, supply and exhaust grills and lighting fixtures with a detergent/disinfectant. (b) There shall be written policies and procedures developed and implemented to include but not be limited to the following: (1) Cleaning of occupied patient areas, nurses' stations, work areas, halls, entrances, storage areas, rest rooms, laundry, pharmacy, offices, etc. (2) Cleaning of specialized areas such as nursery, operating and delivery rooms.

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	(3) Cleaning of isolation areas. (4) Cleaning of kitchen and associated areas. (5) Cleaning of walls and ceilings. (6) Terminal cleaning of patient unit upon discharge of patient. (c) Housekeeping cleaning supplies and equipment provided. (d) Housekeeping personnel shall maintain the interior of the hospital in a safe, clean, orderly, attractive manner free from offensive odors. One person shall be designated to be in charge of the housekeeping service. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** Verify the following: • The hospital makes provision for the routine cleaning of articles and surfaces such as furniture, floors, walls, ceilings, supply and exhaust grills and lighting fixtures with a detergent/disinfectant. • Written policies and procedures developed and implemented to include but not be limited to the following: ▪ Cleaning of occupied patient areas, nurses' stations, work areas, halls, entrances, storage areas, rest rooms, laundry, pharmacy, offices, etc. ▪ Cleaning of specialized areas such as nursery, operating and delivery rooms. ▪ Cleaning of isolation areas. ▪ Cleaning of kitchen and associated areas. ▪ Cleaning of walls and ceilings. ▪ Terminal cleaning of patient unit upon discharge of patient. ▪ Housekeeping cleaning supplies and equipment provided. • Housekeeping personnel maintains the interior of the hospital in a safe, clean, orderly, attractive manner free from offensive odors. • One person is designated to be in charge of the housekeeping service.
§ 70829	**Morgue.** (a) Hospitals with a licensed bed capacity of 50 or more shall maintain a well-ventilated morgue with autopsy facilities unless adequate morgue and autopsy facilities are available in the local community. (b) Hospitals with a licensed bed capacity of 100 or more shall maintain a well-ventilated morgue with autopsy facilities. (c) Refrigerated compartments shall be maintained if human remains are held unembalmed. The air temperature shall not be higher than 7 degrees C (45 degrees F).

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	Survey procedures: Verify the facility has a morgue and that the temperature is 45°F/7°C
§ 70831	**Central Sterile Supply.** (a) Each hospital shall provide, prepare, sterilize and store sufficient sterile supplies and medical and surgical equipment and shall dispense them to all services in the hospital. The operation of this service shall be carried out in an area designated, equipped and staffed for this purpose. (b) A person shall be designated to be in charge of the central sterile supply. (c) There shall be written procedures developed and maintained pertaining to the cleaning, preparation, disinfection and sterilization of utensils, instruments, solutions, dressings and other articles. (d) There shall be effective separation of soiled or contaminated supplies and equipment from the clean and sterilized supplies and equipment. (e) Sterile supplies and equipment shall be stored in clean cabinets, cupboards or other satisfactory spaces. An orderly system of rotation of supplies shall be used so that supplies stored first will be used first. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** Verify the following: • Are sterilized materials packaged, handled, labeled, and stored in a manner that ensures sterility e.g., in a moisture and dust controlled environment? Have policies and procedures for expiration dates have been developed and are followed in accordance with accepted standards of practice? • Tour the central sterile supply space and interview staff about the practices mentioned above. • Is there effective separation of soiled or contaminated supplies and equipment from the clean and sterilized supplies and equipment? • Are sterile supplies and equipment stored in clean cabinets, cupboards or other satisfactory spaces with an orderly system of rotation of supplies shall be used so that supplies stored first will be used first?
§ 70833	**Autoclaves and Sterilizers.** (a) Autoclaves and sterilizers shall be maintained in operating condition at all times. (b) Instructions for operating autoclaves and sterilizers shall be posted in the area where the autoclaves and sterilizers are located. (c) Written procedures shall be developed, maintained and available to personnel responsible for sterilization of supplies and equipment that include, but are not limited to the following: (1) Time, temperature and pressure for sterilizing the various bundles, packs, dressings, instruments,

	solutions, etc. (2) Cleaning, packaging, storing and issuance of supplies and equipment. (3) Dating and outdating of materials sterilized. (4) Loading of the sterilizer. (5) Daily checking of recording and indicating thermometers and filing for one year of recording thermometer charts. (6) Monthly bacteriological test, the bacterial organism used and filing for one year of the test results. (7) Length of aeration time for materials gas-sterilized. **Survey procedures:** Verify the following: • Autoclaves and sterilizers functioning? Review preventive maintenance records if indicated. • Written procedures for personnel responsible for sterilization of supplies and equipment will include, but are not limited to the following: ▪ Time, temperature and pressure for sterilizing the various bundles, packs, dressings, instruments, solutions, etc. ▪ Cleaning, packaging, storing and issuance of supplies and equipment. ▪ Dating and outdating of materials sterilized. ▪ Loading of the sterilizer. ▪ Daily checking of recording and indicating thermometers and filing for one year of recording thermometer charts. Monthly bacteriological test, the bacterial organism used and filing for one year of the test results. ▪ Length of aeration time for materials gas-sterilized.
§ 70835	**Disinfecting.** Note: Authority cited: Sections 208 (a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.
§ 70837	**General Safety and Maintenance.** (a) The hospital shall be clean, sanitary and in good repair at all times. Maintenance shall include provision and surveillance of services and procedures for the safety and well-being of patients, personnel and visitors. (b) Hospital buildings and grounds shall be maintained free of such environmental pollutants and such nuisances as may adversely affect the health or welfare of patients to the extent that such conditions are within the reasonable control of the hospital. (c) All hospitals shall maintain in operating condition all buildings, fixtures and spaces in the numbers and types as specified in construction requirements under which the hospital or unit was first licensed.

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	(d) A written manual on maintenance of heating, air conditioning and ventilation systems shall be adopted by each hospital and a maintenance log shall be maintained. (e) Equipment provided must meet any and all applicable California Occupational Safety and Health Act requirements in effect as of the time of purchase. All portable electrical equipment using 110-120 volt 60 hertz current shall be equipped with a three-wire grounded power cord with an Underwriters Laboratories approved hospital grade three-prong plug. The cord grip shall be an integral part of the plug. (f) All gauging and measuring equipment shall be regularly calibrated as specified by the manufacturer and records of such testing kept for at least two years. **Survey procedures:** Verify the following: • The hospital is clean, sanitary and in good repair at all times. Maintenance includes provision and surveillance of services and procedures for the safety and well-being of patients, personnel and visitors. • All survey team members can participate with general observations of the physical plant and environment. • Many aspects of everyday equipment are tagged with an identifier used by bio medical repair. • Select high use/high turnover items, record the item # and ask for the preventive maintenance inspection report.
§ 70839	**Air Filters.** (a) The licensee shall be responsible for regular inspection, cleaning or replacement of all filters installed in heating, air conditioning and ventilating systems, as necessary to maintain the systems in normal operating condition. The efficiency of the replacement filters shall be equal to the efficiency rating of the replaced filters. (b) A written record of inspection, cleaning or replacement including static pressure drop shall be regularly maintained and available for inspection. The record shall include a description of the filters originally installed, the American Society of Heating, Refrigeration and Air Conditioning Engineers (ASHRAE) atmospheric dust spot test efficiency rating and the criteria established by the manufacturer or supplier to determine when replacement or cleaning is necessary. (c) Following filter replacement or cleaning, the installation shall be visually inspected for torn media and bypass in filter frames by means of a flashlight or equivalent, both with fans in operation and stopped. Tears in filter media and bypass in filter frames shall be eliminated in accordance with the manufacturer's directions and as required by the Department. (d) Where filter maintenance is performed by an equipment service company, a certification shall be

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	provided to the licensee that the requirements listed in Section 70839 (a) and (b) have been accommodated. (e) If filter maintenance as required in Section 70839 (a) and (b) is performed by employees of the hospital, a written record shall be maintained by the licensee. **Survey procedures:** Verify the preventive maintenance inspection report for air handlers/heating, ventilation, air conditioning (HVAC).
§ 70841.(a)	**Emergency Lighting and Power System.** (a) Auxiliary lighting and power facilities shall be readily available at all times. (1) The emergency lighting and power system shall be maintained in operating condition to provide automatic restoration of power for emergency circuits within ten seconds after normal power failure. (2) Emergency generators shall be tested as follows: (A) Non-diesel generators installed in hospitals shall be tested under load conditions for at least 30 minutes at intervals of not more than 7 days. (B) Diesel backup generators installed in hospitals shall be tested as required by Health and Safety Code, section 41514.1. (b) The licensee shall provide and maintain an emergency electrical system in compliance with Section E702-7 and E702-20, Part 3, Title 24, California Administrative Code. The system shall serve all lighting, signals, alarms and equipment required to permit continued operation of all necessary functions of the hospital for a minimum of 24 hours. (c) The Department may require the licensee to submit a report of evaluation of the emergency electrical system by a registered electrical engineer to substantiate compliance with Subarticle E702-7, Part 3, Title 24, California Administrative Code. Essential engineering data, including load calculations, assumptions and tests and, where necessary, plans and specifications acceptable to the Department shall be included in the report. (d) Where alteration of the emergency electrical system is determined to be necessary, the work shall comply with Sections E702-20 and E702-24, Part 3, Title 24, California Administrative Code. (e) A written record of inspection, performance, exercising period and repairs shall be maintained and available. Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Section 1276, 131050, 131051 and 131052, Health and Safety Code. **Survey procedures:** • Verify the systems for emergency power and lighting have been maintained and tested.

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	• Ask for reports of generator tests and/or preventive maintenance done on these systems.
§ 70843	**Storage and Disposal of Solid Wastes.** (a) Solid wastes shall be stored and eliminated in a manner to preclude the transmission of communicable disease. These wastes shall not be a nuisance or a breeding place for insects or rodents nor be a food source for either. (b) Solid waste containers shall be stored and located in a manner that will protect against odors. (c) Syringes and needles shall be disposed of safely as biohazardous waste in puncture proof containers. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** • Verify solid waste containers are secure and prevent transmission of pathogens. • Are needles exposed in containers? • Solid waste containers are cleaned after each use? Unless protective barriers are used e.g. plastic liners/bags.
§ 70845	**Solid Waste Containers.** (a) All containers, except movable bins used for storage of solid wastes, shall have tight-fitting covers in good repair, external handles and be leakproof and rodent proof. (b) Movable bins, when used for storing or transporting solid wastes from the premises, shall have approval of the local health department and meet the following requirements: (1) Have tight-fitting covers. (2) Be in good repair. (3) Be leakproof. (4) Be rodent proof unless stored in a room or screened enclosure. (c) All containers receiving putrescible wastes shall be emptied at least every four days or more often if necessary. (d) Solid waste containers, including movable bins, shall be thoroughly washed and cleaned each time they are emptied unless soil contact surfaces have been completely protected from contamination by disposable liners, bags or other devices removed with the waste. Each movable bin should provide for suitable access and a drainage device to allow complete cleaning at the storage area. Note: Authority cited: Sections 208(a) and 1254, Health and Safety Code. Reference: Sections 1250, 1275 and 25157.3, Health and Safety Code. **Survey procedures:** • Verify solid waste containers are secure and prevent transmission of pathogens.

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	• Are needles exposed in containers? • Solid waste containers are cleaned after each use? Unless protective barriers are used e.g. plastic liners/bags.
§ 70847	**Infectious Waste.** Infectious waste, as defined in Health and Safety Code Section 25117.5, shall be handled and disposed of in accordance with the Hazardous Waste Control Law, Chapter 6.5, Division 20, Health and Safety Code (beginning with Section 25100) and the regulations adopted thereunder (beginning with Section 66100 of this Title). Note: Authority cited: Sections 208, 1254, 25150 and 25157.3, Health and Safety Code. Reference: Sections 1250, 25117 and 25117.5, Health and Safety Code. **Survey procedures:** Ask provider how the infectious waste is disposed of?
§ 70849	**Gases for Medical Use.** (a) Provision shall be made for safe handling and storage of medical gas cylinders. (b) Transfer of gas by hospital personnel from one cylinder to another is prohibited except when approved by the Department. (c) Gases for medical use include carbon dioxide, cyclopropane, ethylene, helium, nitrous oxide, oxygen, helium-oxygen mixtures and carbon dioxide-oxygen mixtures. (d) All anesthesia machines and related equipment shall be so constructed that connections for different gases are not interchangeable. This requirement shall be accomplished by installing permanent fittings as indicated below: (1) Yoke connections of anesthesia machines and flush outlet valves for small compressed gas cylinders (Style E and smaller) shall conform with the pin index safety system contained in pamphlet B57.1 Compressed Gas Cylinder Valve Outlet and Inlet Connections, 1965 Edition, by the American National Standards Institute, Inc., 1430 Broadway, New York, NY 10018. (2) Valve outlet connections for large cylinders (Style F and larger) for oxygen and nitrous oxide shall conform with the standards contained in pamphlet B57.1, Compressed Gas Cylinder Valve Outlet and Inlet Connections, 1965 Edition, by the American National Standards Institute, Inc., 1430 Broadway, New York, NY 10018. Standard connection No. 540 shall be used with oxygen cylinders and standard connection No. 1320 shall be used with nitrous oxide cylinders. Cylinders for medical gases, other than oxygen and nitrous oxide, used with anesthesia machines shall be limited to Style E and smaller. (3) Removable exposed threaded connections, where employed in medical gas piping systems and equipment used in conjunction with resuscitators and oxygen therapy apparatus, shall be provided with noninterchangeable connections which conform with pamphlet V-5, Diameter-Index Safety System, May 1970 printing, by the Compressed Gas Association, Inc., 500 Fifth Avenue, New York, NY 10036. (4) Station outlets from piped oxygen and nitrous oxide systems shall conform with the standards

	contained in bulletin NFPA No. 56 degrees F, Nonflammable Medical Gas Systems, 1973, by the National Fire Protection Association, 470 Atlantic Avenue, Boston, MA 02210. (5) Removable connection hoses from station outlets or cylinders to yokes of anesthesia machines shall be fitted with permanently connected fittings to match the standards listed above in paragraphs (1), (2), (3) and (4). (e) The piped oxygen or nitrous oxide system(s) shall be tested in accordance with the National Fire Protection Association Bulletin NFPA No. 56F, referred to above, and a written report shall be maintained in each of the following instances: (1) Upon completion of initial installation. (2) Whenever changes are made to a system. (3) Whenever the integrity of a system has been breached. (4) At least annually. (f) Oxygen Equipment. (1) Vaporizer bottles shall be sterilized after each use. (2) Only sterile fluids shall be used in vaporizer bottles. (3) Vaporizer bottles shall be changed at least every 24 hours. **Survey procedures:** • Examine medical gas connections to ensure they consist of failsafe connectors. Can 02 gases be connected to compressed air? Pay special attention to labeling, easy mating of keyed parts, color coding, and other features of equipment that help prevent improper connections. • Hospital policies should reflect the safe handling of medical gases, vacuum/suction, and compressed air.
§ 70851	**Lighting.** (a) All rooms, attics, basements, passageways and other spaces shall be illuminated. (b) Adequate illumination shall be maintained for the comfort of patients and personnel. (c) All patient rooms shall have a minimum of 30 foot candles of light delivered to reading or working surfaces and not less than 10 foot candles of light in the remainder of the room. (d) All corridors, storerooms, stairways, ramps, exits and entrances shall have a minimum of five foot candles of light measured in the darkest corner. (e) Except in closets, storage spaces, attic spaces, equipment rooms and similar areas, lighting fixtures shall have suitable enclosures to control fixture brightness and to prevent accidental breakage. Where exposed lamp fixtures are permitted, suitable guards shall be maintained in locations where breakage could be hazardous to personnel. (f) Emergency lighting facilities shall be maintained for use during electrical power failure. In addition,

	flashlights shall be available at all times. Open flame lights shall not be used. **Survey procedures:** Verify the following: • There is adequate lighting in all rooms, attics, basements, passageways and other spaces shall be illuminated. • Verify the emergency lighting facilities is maintained for use during electrical power failure. In addition, flashlights shall be available at all times.
§ 70853	**Electrically Sensitive Areas.** (a) Electrically sensitive patient areas are those areas of the hospital where patients with invasive instrumentation (that can provide electrically conductive pathways directly to the heart) are usually located. These patients are particularly vulnerable to accidental electrocution from contact with equipment or other conducting surfaces bearing electrical potentials that would not normally be considered hazardous. These patient care areas must be provided with additional electrical safeguards. Such areas include but are not limited to: (1) Coronary care units. (2) Intensive care units. (3) Cardiac catheterization laboratories. (4) Operating rooms. (5) Portions of emergency rooms. (6) Postoperative recovery rooms. (b) All circuits serving electrically sensitive patient care areas shall have equipotential bonding. (c) Each patient bed shall be served by receptacles from two separate circuits and, as a minimum, one of the circuits shall be from a separate emergency power source. A portion of the receptacles should be located other than at the head of the bed. (d) All circuits from the same source shall be in the same phase. (e) To protect instrumented patients who are vulnerable to electric shock hazards, all conducting surfaces, that are or could be located within six feet of a patient shall be tested regularly and shown to meet the requirements set forth below. The measurements shall be made using a standard test load to simulate the conducting pathway provided by the patient. The standard test load and test conditions shall meet the requirements in Safe Current Limits: AAMI Safety Standard for Electromedical Apparatus, published April 1974 by the Association for the Advancement of Medical Instrumentation, 1500 Wilson Boulevard, Suite 417, Arlington, VA 22209. (1) Electromedical equipment with patient leads or other connections intended to be attached directly to the heart or to an invasive conductive pathway to the heart or great vessels shall be provided with special

electrically isolated leads or connections by optical coupling or some other technical provision. The current limits for such an isolated patient connection shall not exceed 20 microamperes at the patient end of the lead and shall not exceed 10 microamperes at the junction between the patient lead and the equipment.
(2) The current limit for electromedical equipment with an electrical or conductive patient contact, other than defined in (1) above, shall not exceed 50 microamperes.
(3) The limit for currents arising from metal parts associated with electromedical equipment, other than the cases defined in (1) and (2) above, shall not exceed 100 microamperes.
(f) All electrical service outlets and grounding circuits shall be inspected at least quarterly.
(1) Records of this inspection shall include at least the following information:
(A) Confirmation that the contact tension of each blade of each wall receptacle is not less than 225 grams (8 oz.) per blade.
(B) Confirmation of the presence and correct polarity of the hot and neutral connections in each wall receptacle.
(C) Verification of the continuity of the grounding circuit in each wall receptacle.
(D) Physical condition of each receptacle.
(E) Physical condition of any male plugs and line cords of equipment in use in the areas at the time of each inspection.
(F) Verification that the resistance between all exposed metal surfaces and each patient reference grounding point, or a selected wall receptacle ground, is less than 0.15 ohms.
(g) All portable (minor movable) electromedical equipment that is used in electrically sensitive patient areas shall be included in an appropriate preventive maintenance program.
(1) Records of the maintenance shall include at least the following information. These measurements and inspections shall be made at least once every three months.
(A) Determination of the leakage current levels for all electrically powered diagnostic, monitoring or therapeutic equipment, including electrically powered beds.
(B) Verification of the integrity of the power cords, including continuity of the conductors and adequacy of the strain relief device.

Guidance for the above regulations:

Be aware the standards for this area were written in by the AAMI Safety Standard for Electromedical Apparatus, published April 1974 by the Association for the Advancement of Medical Instrumentation and may not be applicable in all cases.

CDPH policy and procedure manual #301.110 allows for an alternate means of compliance on sections

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	70837 and 70853 without a written program flexibility. See 70129 for additional information. **Survey procedures:** • All survey team members can participate with general observations of the equipment of the physical plant and environment. • Observe for the use critical care equipment and high use items such as IV pumps, ventilators, imaging devices and other medical devices that connect to patients; observe all equipment for wear and tear. • Usually there will be a biomedical equipment tag with a number that associates the equipment to a specific preventative maintenance inspection (PMI) schedule. Copy the tag number down for further follow up with biomedical department. • Interview the person responsible for the environment of care in the biomedical department to gain access to the PMI records. Ask to be shown PMI policies related to the medical equipment. These policies should reflect an assessment of medical equipment related to risk and manufacturer's recommendations and specific PMI schedules.
§ 70855	**Mechanical Systems.** Heating, air conditioning and ventilating systems shall be maintained in operating condition to provide a comfortable temperature and to meet the new construction requirements in effect at the time plans were approved for the facility. **Survey procedures:** Review the preventive maintenance inspection report(s) for air handlers/heating, ventilation, air conditioning (HVAC).
§ 70857	**Screens.** To protect against insects, screens of 6 mesh per centimeter (16 mesh per inch) shall be provided on doors and openable windows. Screen doors shall be of a type approved by the State Fire Marshal. **Survey procedures:** If screens are used, verify the integrity.
§ 70859	**Signal Systems.** (a) A call system shall be maintained in operating order in all nursing units. Call systems shall be maintained to provide visible and audible signal communication between nursing personnel and patients. The minimum requirements are: (1) A call station or stations providing extension cords to each patient bed. These extension cords shall be

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	readily accessible to patients. (2) A visible signal in the corridor above the door of each patient room. (3) An audible signal and light indicating the room from which the call originates shall be located at the nurses' stations. Alternate systems must be approved in writing by the Department. (b) The call system shall be provided in each patient's toilet room, bathroom and shower room in locations easily accessible to the patients. Electric shock hazard shall be eliminated by grounding or by an equally effective method. (c) The call systems shall be designed to require resetting at the calling station unless a two-way voice communication component is included in the system. **Survey procedures:** • Interview staff regarding the operation of call/signal systems. • Verify the system is operational. • Verify that the audible sound can be heard in the units.
§ 70861	**Storage.** (a) All hospitals shall maintain general storage space of at least 1.9 square meters (20 square feet) per bed in addition to specialized storage space. (b) Storage is not permitted in plenums (air distribution chambers) of air conditioning or ventilation systems. **Survey procedures:** • All hospital have maintain general storage space of at least 1.9 square meters (20 square feet) per bed in addition to specialized storage space. • Storage is not permitted in plenums (air distribution chambers) of air conditioning or ventilation systems.
§ 70863	**Water Supply and Plumbing.** (a) Water for human consumption from an independent source shall be subjected to bacteriological analysis by the local health department, State Department of Health or a licensed commercial laboratory at least every three (3) months. A copy of the most recent laboratory report shall be available for inspection. (b) Plumbing and drainage facilities shall be maintained in compliance with Part 5, Title 24, California Administrative Code, Basic Plumbing Requirements. Drinking water supplies shall comply with Group 4, Subchapter 1, Chapter 5, Division T17, Part 6, of Title 24, California Administrative Code. (c) Backflow preventers (vacuum breakers) shall be maintained in operating condition where required by Section T17-210(c), Division T17, Part 6, Title 24, California Administrative Code.

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	(d) For hot water used by patients, there shall be temperature controls to automatically regulate the temperature between 40.5 degrees C (105 degrees F) and 48.9 degrees C (120 degrees F). (e) Hot water at a minimum temperature of 82.2 degrees C (180 degrees F) shall be maintained at the final rinse section of dishwashing facilities unless alternate methods are approved by the Department. (f) Taps delivering water at 51.6 degrees C (125 degrees F) or higher shall be identified prominently by warning signs with letters 5 cm (2 inches) high. (g) Grab bars shall be maintained for each toilet, bathtub and shower used by patients, where required in Section T17-212(b), Division T17, Part 6, of Title 24, California Administrative Code. (h) As a minimum, toilet, handwashing and bathing facilities shall be maintained in operating condition in the number and types specified in construction requirements in effect at the time the building or unit was constructed. **Survey procedures:** Verify a report has been completed by an independent source regarding an analysis of the water source.
§ 70865	**Ice.** Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner. Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code. **Survey procedures:** • Verify Ice used in connection with food or drink are from a sanitary source and handled and dispensed in a sanitary manner. • Interview staff related to who is responsible for maintenance and cleaning of ice producing equipment.

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§ 70901	**Applicability of Article 9.** Regulations found in Article 9 are applicable to all small and rural hospitals as defined in Health and Safety Code Section 442.2(c). Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.
§ 70903	**Enforcement of Article 9.** Each regulation in Article 9 provides an alternative for a specific regulation or regulations found

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	elsewhere in Chapter 1. Preceding or included in each section in Article 9 is the number of the section it will modify or replace. Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.
§ 70905	**Surgical Service General Requirements.** Section 70223 shall apply as written with the following exception: Hospitals with a licensed bed capacity of 25 or more but less than 50 shall only be required to maintain one operating room. Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.
§ 70907	**Dietetic Service Staff.** Section 70275 shall be replaced by the following: (a) A registered dietitian shall be employed on a full-time, part-time or consulting basis for approval of all menus and participation in development or revision of dietetic policies and procedures and in planning and conducting in-service education programs. (b) Sufficient dietetic service personnel shall be employed, oriented, trained and their working hours scheduled to provide for the nutritional needs of the patients and to maintain the dietetic service areas. If dietetic service employees are assigned duties in other service areas, those duties shall not interfere with the sanitation, safety or time required for dietetic work assignments. (c) A record shall be maintained of the number of persons by job title employed full or part-time in dietetic services and the number of hours each works weekly. (d) Hygiene of Dietetic Service Staff. (1) Dietetic service personnel shall be trained in basic food sanitation techniques, shall be clean, wear clean clothing, including a cap and/or a hair net and shall be excluded from duty when affected by skin infection or communicable diseases. Beards and mustaches which are not closely cropped and neatly trimmed shall be covered. (2) Employee's street clothing stored in the kitchen area shall be in a closed area. (3) Kitchen sinks shall not be used for handwashing. Separate handwashing facilities with soap, running water and individual towels shall be provided. (4) Persons other than dietetic personnel shall not be allowed in the kitchen area unless required to do so in the performance of their duties. Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.
§ 70909	**Intensive Care Service Space.** Section 70499 shall apply as written with the following exceptions: an intensive care unit may consist of less than four (4) but shall not consist of less than two (2) patient beds; an isolation room is not required.

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	ARTICLE 9 **REGULATIONS SPECIFIC TO SMALL AND RURAL HOSPITALS**
	Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.
§ 70911	**Perinatal Unit Staff.** Section 70549 shall be replaced by the following: (a) A physician shall have overall responsibility of the unit. This physician shall be certified or eligible for certification by the American Board of Obstetrics and Gynecologists or the American Board of Pediatrics. If a physician with one of the above qualifications is not available, a physician with training and experience in obstetrics and gynecology or pediatrics may administer the service. In this circumstance, a physician with the above qualifications shall provide consultation at a frequency which will assure high quality service. The physician responsible for the unit shall be responsible for: (1) Providing continuous obstetric, pediatric, anesthesia, laboratory and radiologic coverage. (2) Maintaining working relationships with intensive care newborn nursery. (3) Providing for joint staff conferences and continuing education of respective medical specialties.
§ 70911	**Perinatal Unit Staff.** (a) A physician shall have overall responsibility of the unit. This physician shall be certified or eligible for certification by the American Board of Obstetrics and Gynecologists or the American Board of Pediatrics. If a physician with one of the above qualifications is not available, a physician with training and experience in obstetrics and gynecology or pediatrics may administer the service. In this circumstance, a physician with the above qualifications shall provide consultation at a frequency which will assure high quality service. (b) A physician who has training and experience in newborn care shall be responsible for the nursery. (c) There shall be one registered nurse trained in infant resuscitation on duty on each shift assigned to the labor and delivery suite. In addition, there shall be sufficient trained personnel to assist the family, provide family education, monitor and evaluate labor, assist with the delivery and assist the patient during the post-partum period. (d) If the hospital has a nursery, a registered nurse who has had training and experience in neonatal nursing shall be responsible for the nursing care in the nursery. (1) A registered nurse trained in infant resuscitation shall be on duty on each shift. (2) A ratio of one licensed nurse to eight or fewer infants shall be maintained for normal infants. (e) There shall be evidence of continuing education and training programs for the nursing staff in perinatal nursing and infection control. Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.
§ 70913	**Perinatal Unit Space.**

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	Section 70553 shall apply as written with the following exception: The operating room may serve as the delivery room in hospitals having a licensed bed capacity of 50 or less. Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.
§ 70915	**Physical Therapy Service General Requirements.** Section 70557 shall apply as written with the following exception: Procedures for outpatient treatment, home visits and referrals to appropriate community agencies need only be established if such resources are available. Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.
§ 70917	**Physical Therapy Service Equipment and Supplies.** Section 70561 shall apply as written with the following exception: Adjustable tables shall not be required if a suitable alternative is available. Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.
§ 70919	**Physical Therapy Service Space.** Section 70563 shall not apply. Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.
§ 70921	**Standby Emergency Medical Services, Physician on Call, Space.** Section 70657 shall apply as written with the following exceptions: The reception area may be a multi-purpose area and the observation room need not be dedicated solely for that purpose. Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.
§ 70923	**Conference Room.** Section 70765 shall be modified as follows: A hospital shall either provide suitable space for conferences within the facility or shall otherwise provide access to suitable space for conferences. Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.

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	ARTICLE 10 **Hospital Administrative Penalties**
§ 70951	**Applicability.** (a) This article only applies to the assessment of administrative penalties pursuant to Health and Safety Code Section 1280.3. This article does not apply to: (1) Minor violations as defined in Section 70952. (2) Settlement of any enforcement action, or (3) Penalties assessed by the department under laws other than Health and Safety Code Section 1280.3, including but not limited to Health and Safety Code Sections 1278.5, 1280.15, 1280.4, 1317.3, 1317.4, and 1317.6 (a). (b) This article applies only to incidents occurring on or after April 1, 2014. As to such incidents, the hospital's compliance history prior to April 1, 2014, including deficiencies constituting immediate jeopardy, shall be considered in assessing administrative penalties as provided in this article and under Health and Safety Code Section 1280.3 (a) and (b). (c) Incidents occurring prior to April 1, 2014, shall be subject to administrative penalties as described in Health and Safety Code Section 1280.1(d). Note: Authority cited: Sections 1280.3, 100275(a), 131050, 131051, 131052 and 131200, Health and Safety Code. Reference: Sections 1280.1 and 1280.3, Health and Safety Code. HISTORY 1. New article 10 (sections 70951-70960) and section filed 12-5-2013; operative 4-1-2014 (Register 2013, No. 49).
§ 70952	**Definitions.** (a) As used in Health and Safety Code Section 1280.3 and this article: (1) “Actual financial harm” means concrete financial loss for medical costs incurred by a patient, where the loss was not covered or reimbursed by health insurance. (2) “Deficiency” means a licensee's failure to comply with any law relating to the operation or maintenance of a hospital as a requirement of licensure under the Health and Safety Code or this division. (3) “Hospital licensing requirements,” “hospital licensing standards,” and “licensure requirements” refer to the requirements in Health and Safety Code, Division 2, Chapter 2, and Division 107, Part 2, Chapter 2.5, Article 1 applicable to hospitals, and the regulations adopted thereunder. (4) “Minor violation” means any violation of law relating to the operation or maintenance of a hospital that the department determines has only a minimal relationship to the health or safety of hospital patients. This definition shall not apply to violations of Health and Safety Code, Division 107, Part 2, Chapter 2.5, Article 1 (Hospital Fair Pricing Policies).

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	(5) "Repeat deficiencies" means violations of hospital licensing requirements or federal certification standards in the same or substantially similar regulatory grouping of requirements, which are found during an inspection, subsequently corrected, and found again at a subsequent inspection. (6) "Substantial compliance" means a level of compliance with state hospital licensing standards and with federal laws that set forth the conditions of participation for hospitals in the Medicare program, such that any identified deficiencies pose no greater risk to patient health and safety than the potential for causing minimal harm. (7) "Willfulness," "willfully," or "willful" mean that the person doing an act or omitting to do an act intends the act or omission, and knows the relevant circumstances connected with the act or omission. (8) "Willful violation" means that the licensee, through its employees or contractors, willfully commits an act or makes an omission with knowledge of the facts, which bring the act or omission within the deficiency that is the basis for an administrative penalty. Note: Authority cited: Sections 1280.3, 100275(a), 131050, 131051, 131052 and 131200, Health and Safety Code. Reference: Section 1280.3, Health and Safety Code.
§ 70953	**Penalty Calculation.** Administrative penalties assessed pursuant to Health and Safety Code Section 1280.3 shall be assessed following the procedures set forth in this article, except that penalties for a violation of Health and Safety Code, division 107, part 2, chapter 2.5, article 1 (§ 127400 et seq.) shall be calculated under Section 70959. The penalty assessed for any violation in accordance with this article shall not exceed the maximum penalty specified in Health and Safety Code section 1280.3. Note: Authority cited: Sections 1280.3, 100275(a), 131050, 131051, 131052 and 131200, Health and Safety Code. Reference: Section 1280.3, Health and Safety Code.
§ 70954	**Determining the Initial Penalty for Each Violation.** (a) An initial penalty shall be determined for each deficiency, considering the nature, scope and severity of the deficiency by using the matrix set forth in subdivision (d). (b) Severity of the deficiency. (1) Severity of actual and potential harm to patients shall be considered when using the matrix. The categories for degree of severity based on actual or potential patient harm are defined as follows: Level 1-No actual patient harm but with potential for no more than minimal harm. Level 2-No actual patient harm but with potential for more than minimal patient harm, but no immediate jeopardy. Level 3-Actual patient harm that is not immediate jeopardy. Level 4-Immediate jeopardy to patient health or safety that is likely to cause serious injury or death.

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	Level 5-Immediate jeopardy to patient health or safety that caused serious injury to a patient. Level 6-Immediate jeopardy to patient health or safety that caused the death of a patient. (2) In determining the level of severity using the matrix in subdivision (d), the following factors shall be considered: (A) The patient's physical and mental condition. (B) The probability and severity of the risk that the violation presents to patients. (c) Scope of the noncompliance. (1) The scope of the noncompliance with hospital licensure requirements shall be considered using the matrix set forth in subsection (d). (2) The scope of the noncompliance shall be assessed as follows: (A) Isolated: (i) One or a very limited number of patients affected, or (ii) One or a very limited number of staff involved, or (iii) The situation occurred only occasionally, or (iv) The situation occurred in a very limited number of locations. (B) Pattern: (i) More than a very limited number of patients affected, or (ii) More than a very limited number of staff involved, or (iii) The situation occurred in several locations, or (iv) The same patient(s) had been affected by repeat occurrences. (C) Widespread: (i) Situation was pervasive throughout the hospital or (ii) The situation represented a systemic failure that affected or had the potential to affect a large portion or all of the hospital's patients. (d) The matrix set forth in this subdivision shall be used to determine the initial penalty for a deficiency by selecting a penalty percentage from the range provided in the matrix cell that corresponds to the appropriate scope of noncompliance and the severity of harm categories. The percentages in each cell of the following matrix shall be applied to the maximum administrative penalties as set forth in Health and Safety Code section 1280.3: (1) $25,000 for any deficiency that does not constitute an immediate jeopardy, (2) $75,000 for the first deficiency constituting an immediate jeopardy, (3) $100,000 for the second deficiency constituting an immediate jeopardy, and (4) $125,000 for the third deficiency and every subsequent deficiency constituting an immediate jeopardy. An immediate jeopardy penalty shall be considered a first administrative penalty if the date

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	the violation occurred is over three years from the date of violation of the last issued immediate jeopardy penalty, the hospital has not received additional immediate jeopardy violations, and the department finds that the hospital has been in substantial compliance for over three years prior to the date of the violation that is the subject of the penalty calculation. Note: Authority cited: Sections 1280.3, 100275(a), 131050, 131051, 131052 and 131200, Health and Safety Code. Reference: Section 1280.3, Health and Safety Code. **GRID TO DETERMINE SEVERITY/SCOPE on Page 816 CCR/T 22**
§ 70955	**Initial Penalty Adjustment Factors.** (a) The initial penalty shall be adjusted to calculate the base penalty using the following guidelines: (1) Patient's physical and mental condition. (A) The initial penalty shall be adjusted upward by 10 percent, if the violation caused actual harm to the patient at severity level 3 or 5 resulting in a physical or mental impairment that substantially limits one or more of the major life activities of a patient, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from the hospital, or the loss of a body part, or (B) The initial penalty shall be adjusted upward by 5 percent, if the violation caused actual harm to the patient at severity level 3 or 5 resulting in a physical or mental impairment that substantially limits one or more of the major life activities of a patient, or the loss of bodily function, if the impairment or loss lasts more than three days. (2) The initial penalty shall be adjusted upward by 1 percent, if the violation caused actual financial harm to the patient, based on information acquired by the department during the normal course of the investigation. (3) For factors beyond the hospital's control that restrict the hospital's ability to comply with licensure requirements, the initial penalty shall be adjusted downward by 5 percent, if the hospital developed and maintained disaster and emergency programs as required by state and federal law that were appropriately implemented during a disaster. (4) The initial penalty shall be adjusted upward by 10 percent if the deficiency was the result of a willful violation. (b) Adjustment of the initial penalty in accordance with the factors provided in subdivision (a) may result in an adjusted initial penalty percentage that is higher or lower than the percentage shown in the originally selected matrix cell. Note: Authority cited: Sections 1280.3, 100275(a), 131050, 131051, 131052 and 131200, Health and Safety Code. Reference: Section 1280.3, Health and Safety Code.

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§ 70956	**Base Penalty** The base penalty for a deficiency is the cumulative adjusted initial penalty as determined under Sections 70954 and 70955. For the purpose of penalty calculation, the base penalty may exceed the statutory maximum, so long as the final penalty does not exceed the statutory maximum. Note: Authority cited: Sections 1280.3, 100275(a), 131050, 131051, 131052 and 131200, Health and Safety Code. Reference: Section 1280.3, Health and Safety Code.
§ 70957	**Adjustments to the Base Penalty.** (a) The base penalty shall be adjusted considering each of the following adjustment factors: (1) Immediate correction of the violation. When the department determines that a hospital subject to an administrative penalty promptly corrects the noncompliance for which the administrative penalty was imposed, the base penalty shall be adjusted downward by 20 percent, provided that all of the following apply: (A) The hospital identified and immediately corrected the noncompliance. The correction of the noncompliance must have occurred before the noncompliance was identified by the department. Within ten calendar days of the date that the hospital identified the noncompliance, the hospital shall complete corrective action and take appropriate steps necessary to prevent the violation from recurring, with prompt and detailed documentation of these actions; (B) The noncompliance that was corrected did not constitute immediate jeopardy, or result in the death of a patient; (C) Met mandatory reporting requirements before it was identified by the department; and, (D) A penalty was not imposed for a repeat deficiency that received a penalty reduction under this article within the twelve-month period prior to the date of violation. (2) Compliance history with related State and federal laws. A hospital's compliance history refers to its record of compliance with licensure requirements under the Health and Safety Code, and the regulations adopted thereunder, and with federal laws that set forth the conditions of participation for hospitals in the Medicare program, for a period of three years prior to the date the administrative penalty is issued. (A) The base penalty shall be adjusted downward by five percent if hospital inspections within the last three years noted no state or federal deficiencies that resulted in patient harm or immediate jeopardy (severity levels 3 through 6, inclusive). (B) The base penalty shall be increased five percent if the hospital has three or more repeat deficiencies that pose a risk of more than minimal harm to patient health or safety (severity levels 2 through 6, inclusive) within the three year period immediately prior to the date of violation. Note: Authority cited: Sections 1280.3, 100275(a), 131050, 131051, 131052 and 131200, Health and

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	Safety Code. Reference: Section 1280.3, Health and Safety Code.
§ 70958	**Final Penalty** The final penalty for a deficiency is the cumulative adjusted base penalty as determined under section 70957, or the maximum penalty specified in Health and Safety Code section 1280.3, whichever is lower. Note: Authority: Sections 1280.3, 100275(a), 131050, 131051, 131052 and 131200, Health and Safety Code. Reference: Section 1280.3, Health and Safety Code.
§ 70958.1	**Penalties imposed by Department of Managed Health Care.** A penalty assessment under Health and Safety Code section 1280.3 may be adjusted under Health and Safety Code section 1280.6 after the department reviews the investigation report and penalty issued by the Department of Managed Health Care to determine whether the criteria in Health and Safety Code section 1280.6 are satisfied. Note: Authority cited: Sections 1280.3, 100275(a), 131050, 131051, 131052 and 131200, Health and Safety Code. Reference: Sections 1280.3 and 1280.6, Health and Safety Code.
§ 70959	**Penalties for Violations of Hospital Fair Pricing Policies Requirements.** (a) Administrative penalties assessed for a violation of Health and Safety Code, division 107, part 2, chapter 2.5, article 1 (§ 127400 et seq.) shall be calculated under this section. (b) The initial penalty for each deficiency shall be determined, considering the extent of noncompliance with the requirement violated by the hospital. The categories for extent of noncompliance from requirements and corresponding initial penalties are defined as follows: (1) Major - The action or inaction deviates from the requirement to such an extent that the requirement is completely ignored and none of its provisions are complied with, or the function of the requirement is rendered ineffective because some of its provisions are not complied with. The initial penalty for this category is $25,000. (2) Moderate - The action or inaction deviates from the requirement, but it complies to some extent, although not all of its important provisions are complied with. The initial penalty for this category is $12,500. (3) Minimal - The action or inaction deviates somewhat from the requirement. The requirement functions nearly as intended, but not as well as if all provisions had been met. A violation in this category is a minor violation and no administrative penalty is assessed. (c) The initial penalty shall be adjusted to calculate the base penalty using the following guidelines: (1) The initial penalty shall be adjusted upward by 5 percent, if the violation caused actual financial harm to the patient, based on information acquired by the department during the normal course of the investigation. (2) The initial penalty shall be adjusted upward by 10 percent if the deficiency was the result of a

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	willful violation. (d) The base penalty for a deficiency is the cumulative adjusted initial penalty as determined under subdivisions (b) and (c). For the purpose of penalty calculation, the base penalty may exceed the statutory maximum, so long as the final penalty does not exceed the statutory maximum. (e) The base penalty shall be adjusted considering each of the following adjustment factors: (1) Immediate correction of the violation. When the department determines that a hospital subject to an administrative penalty promptly corrects the noncompliance for which the administrative penalty was imposed, the base penalty shall be adjusted downward by 20 percent, provided that all of the following apply (A) The hospital identified and immediately corrected the noncompliance before it was identified by the department; (B) Within 10 calendar days of the date that the hospital identified the noncompliance, the hospital shall complete corrective action and steps necessary to prevent the violation from recurring, with prompt and detailed documentation of these actions; and (C) A penalty was not imposed for a repeat deficiency that received a penalty reduction under this article within the twelve-month period prior to the date of violation. (2) Compliance History. The base penalty shall be increased ten percent if the hospital has had one or more other violations of Health and Safety Code, division 107, part 2, chapter 2.5, article 1 (§ 127400 et seq.) within the three year period immediately prior to the date of violation. (f) The final penalty for a deficiency is the cumulative adjusted base penalty as determined under subdivision (e), or the maximum penalty specified in Health and Safety Code section 1280.3, whichever is lower. Note: Authority cited: Sections 1280.3, 100275(a), 131050, 131051, 131052 and 131200, Health and Safety Code. Reference: Section 1280.3, Health and Safety Code.
§ 70960	**Small and Rural Hospitals.** (a) A small and rural hospital that has been assessed an administrative penalty under H&SC Section 1280.3 may request: (1) Payment of the penalty extended over a period of time if immediate, full payment would cause financial hardship, or (2) Reduction of the penalty, if extending the penalty payment over a period of time would cause financial hardship, or (3) Both a penalty payment plan and reduction of the penalty. (b) The small and rural hospital shall submit its written request for penalty modification as described in subsection (a) to the department within ten days after the issuance of the administrative penalty. The

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	request shall describe the special circumstances showing financial hardship to the hospital and the potential severe adverse effects on access to quality care in the hospital. (c) Upon timely request from a small and rural hospital under subsection (b), the department may approve a penalty payment plan, reduce the final penalty, or both, if in the judgment of the department, immediate, full payment of the penalty would cause financial hardship to the hospital and thereby severely reduce access to quality care in the hospital. The department's decision shall be based on information provided by the small and rural hospital in support of its request and on hospital financial information from the Office of Statewide Health Planning and Development or other governmental agency. Note: Authority cited: Sections 1280.3, 100275(a), 131050, 131051, 131052 and 131200, Health and Safety Code. Reference: Section 1280.3, Health and Safety Code.

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H & S Code 442.5 End of Life Care	**End of Life Care** When a health care provider makes a diagnosis that a patient has a terminal illness, the health care provider shall, upon the patient's request, provide the patient with comprehensive information and counseling regarding legal end-of-life care options pursuant to this section. When a terminally ill patient is in a health facility, as defined in Section 1250, the health care provider, or medical director of the health facility if the patient's health care provider is not available, may refer the patient to a hospice provider or private or public agencies and community-based organizations that specialize in end-of-life care case management and consultation to receive comprehensive information and counseling regarding legal end-of-life care options. (a) If the patient indicates a desire to receive the information and counseling, the comprehensive information shall include, but not be limited to, the following: (1) Hospice care at home or in a health care setting. (2) A prognosis with and without the continuation of disease-targeted treatment. (3) The patient's right to refusal of or withdrawal from life-sustaining treatment. (4) The patient's right to continue to pursue disease-targeted treatment, with or without concurrent palliative care. (5) The patient's right to comprehensive pain and symptom management at the end of life, including, but not limited to, adequate pain medication, treatment of nausea, palliative chemotherapy, relief of shortness of breath and fatigue, and other clinical treatments useful when a patient is actively dying. (6) The patient's right to give individual health care instruction pursuant to Section 4670 of the Probate Code, which provides the means by which a patient may provide written health care instruction, such as an advance health care directive, and the patient's right to appoint a legally recognized health care decision maker. (b) The information described in subdivision (a) may, but is not required to, be in writing. Health care providers may utilize information from organizations specializing in end-of-life care that provide information on factsheets and Internet Web sites to convey the information described in subdivision (a). (c) Counseling may include, but is not limited to, discussions about the outcomes for the patient and his or her family, based on the interest of the patient. Information and counseling, as described in subdivision (a), may occur over a series of meetings with the health care provider or others who may be providing the information and counseling based on the patient's needs. (d) The information and counseling sessions may include a discussion of treatment options in a manner that the patient and his or her family can easily understand. If the patient requests information on the costs of treatment options, including the availability of insurance and eligibility of the patient for coverage, the patient shall be referred to the appropriate entity for that information.

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	Survey procedures: Interview at least 1 of the following: Administrative Staff; Medical Director, Clinical Manager, Clinical Staff, Social Services, Case Management: • What comprehensive information & counseling regarding end-of-life options is provided when the patient or the person authorized to make health care decisions for the patient requests it? Find out if this includes: • Hospice care at home or in a health care setting; • A prognosis with and without the continuation of disease-targeted treatment; • The patient's right to refusal of or withdrawal from life-sustaining treatment (advanced care directive); • The patient's right to continue to pursue disease-targeted treatment, with or without concurrent palliative care; • The patient's right to comprehensive pain and symptom management at the end of life; • The patient's right to give individual health care instruction, patients/patient representatives. • The information can be provided orally or in writing • How does the hospital ensure that requested counseling is based on the interest & needs of the patient? • How does the hospital ensure that requested counseling is provided in a manner that the patient & his/her family can easily understand? • What does the hospital do if the patient and/or his/her family requests information on the costs of treatment options, including the availability of insurance and eligibility for coverage? They should be referring to the appropriate entity for insurance coverage information. **Document Review:** Review information and counseling provided to the patient or the person authorized to make health care decisions for the patient. Review documentation of available resources that healthcare providers use for patient referral to appropriate community-based organizations.
H & S Code 442.7 End of Life Care	**End of Life Care** If a health care provider does not wish to comply with his or her patient's request or, when applicable, the request of another person authorized to make health care decisions, as defined in Section 4617 of the Probate Code, for the patient for information on end-of-life options, the health care provider shall do both of the following: (a) Refer or transfer a patient to another health care provider that shall provide the requested information.

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	(b) Provide the patient or other person authorized to make health care decisions for the patient with information on procedures to transfer to another health care provider that shall provide the requested information. **Survey procedures:** Interview at least 1 of the following: Administrative Staff; Medical Director, Clinical Manager, Clinical Staff, Social Services, Case Management: • If the patient's health care provider does not wish to comply with his/her patient's request for information on end-of-life options, what is the hospital's procedure for the healthcare provider to refer/transfer the patient to another health care provider that shall provide the requested information. • Provide the patient or other person authorized to make health care decisions f with information on procedures to transfer to another health care provider that will provide the requested information.
H & S Code 1254.4 Brain Death Policies and Procedures	**Brain Death Policy and Procedures** (a) A general acute care hospital shall adopt a policy for providing family or next of kin with a reasonably brief period of accommodation, as described in subdivision (b), from the time that a patient is declared dead by reason of irreversible cessation of all functions of the entire brain, including the brain stem, in accordance with Section 7180, through discontinuation of cardiopulmonary support for the patient. During this reasonably brief period of accommodation, a hospital is required to continue only previously ordered cardiopulmonary support. No other medical intervention is required. (b) For purposes of this section, a "reasonably brief period" means an amount of time afforded to gather family or next of kin at the patient's bedside. (c)(1) A hospital subject to this section shall provide the patient's legally recognized health care decision maker if any, or the patient's family or next of kin, if available, with a written statement of the policy described in subdivision (a), upon request, but no later than shortly after the treating physician has determined that the potential for brain death is imminent. (2) If the patient's legally recognized health care decision maker, family, or next of kin voices any special religious or cultural practices and concerns of the patient or the patient's family surrounding the issue of death by reason of irreversible cessation of all functions of the entire brain of the patient, the hospital shall make reasonable efforts to accommodate those religious and cultural practices and concerns. **Survey procedures:** Interview at least 1 of the following: Administrative Staff, Social Services, Critical Care Director, and Emergency Unit Director. • What is the hospital's policy for providing a period of accommodation to the patient's family or the person authorized to make health care decisions for the patient.

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	Note: A "reasonably brief period" means an amount of time afforded to gather family or next of kin at the patient's bedside. The Hospital's P&P should ensure that, for the patient who is declared brain dead, the family/next of kin is provided with a reasonably brief period of accommodation prior to discontinuing cardiopulmonary support. • After a patient who is on life support measures is declared brain dead, how does the hospital accommodate special religious or cultural requests of the family or the person authorized to make health care decisions for the patient. • What written information is provided for the family or the person authorized to make health care decisions for the patient on the hospital's procedures? Is there a copy of the written information provided? Interview Clinical Staff: • What is your policy on continuing cardiopulmonary support if the family is on the way? **Policy and Procedure Review:** • The facility's policy and procedures on brain death. • Written information provided to the family or the person authorized to make health care decisions for the patient.
H & S Code 127405 **Fair Pricing** -	(a) (1) (A) Each hospital shall maintain an understandable written policy regarding discount payments for financially qualified patients as well as an understandable written charity care policy. Uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level, as defined in subdivision (b) of Section 127400, shall be eligible to apply for participation under a hospital's charity care policy or discount payment policy. Notwithstanding any other provision of this article, a hospital may choose to grant eligibility for its discount payment policy or charity care policies to patients with incomes over 350 percent of the federal poverty level. Both the charity care policy and the discount payment policy shall state the process used by the hospital to determine whether a patient is eligible for charity care or discounted payment. (B) The written policy regarding discount payments shall also include a statement that an emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital. (2) Rural hospitals, as defined in Section 124840, may establish eligibility levels for financial assistance and charity care at less than 350 percent of the federal poverty level as appropriate to maintain their

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	financial and operational integrity. (b) A hospital's discount payment policy shall clearly state eligibility criteria based upon income consistent with the application of the federal poverty level. The discount payment policy shall also include an extended payment plan to allow payment of the discounted price over time. The policy shall provide that the hospital and the patient shall negotiate the terms of the payment plan, and take into consideration the patient's family income and essential living expenses. If the hospital and the patient cannot agree on the payment plan, the hospital shall use the formula described in subdivision (i) of Section 127400 to create a reasonable payment plan. (c) The charity care policy shall state clearly the eligibility criteria for charity care. In determining eligibility under its charity care policy, a hospital may consider income and monetary assets of the patient. **Survey procedures:** **Policy & Procedure Review** • Review the policies on discount payments for financially qualified patients & charity care. • The written policies must be understandable and state the process used by the hospital to determine whether a patient is eligible for charity care or discounted payment. • The policy designates a hospital representative who the patient may contact in the event of a dispute. • The hospital's discount payment policy must clearly state the criteria used to seek eligibility based upon income consistent with the application of the federal poverty level. The discount payment policy must include an extended payment plan that allows payment of the discounted price over time along with an option for the patient and their family to negotiate the terms of the payment plan. • The charity care policy must state the eligibility criteria for charity care. GACHs may consider income and monetary assets of patient when determining eligibility. Monetary assets must not include retirement or deferred compensation plans. • The hospital must provide patients with written notice that contains eligibility and availability of the GACH's discount payment and charity care policies including eligibility and contact information of hospital employee or office from which to attain additional information. Understandable written notice shall also be given to patients who receive emergency or outpatient care that may be billed, but who were not admitted in a language spoken by the patient consistent with Section 12693.30 of the Insurance Code and applicable state and federal law.

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	• Review the written notice provided to patients of the availability of the hospital's discount payment and charity care policies, including information about eligibility, and contact information for a hospital employee or office from which the patient may obtain further information about these polices. • Review the hospital's policy regarding patient debt collection indicating source of debt collection as being the hospital, affiliate or subsidiary of the hospital, or an external collection agency. ***Note**: The GACH must have a written policy defining hospital practices and standards for collection of debt and a written agreement from any collecting agency to adopt hospital standards and scope of practices.* **Patient Record Review/Document Review:** Review the business records of the uninsured patient sample to see if the record shows documentation of the written discount payment or charity care notice provided to the patient. The facility must be able to provide evidence of such documentation. **Observation**: • Observe postings in the GACH of the notice of the hospital's policy for financially qualified and self-pay patients. The policy for financially qualified/self pay patients must be clearly and conspicuously posted in locations visible to public not limited to: Emergency Department, Billing Office, Admissions Office, other outpatient settings. **Interview** at least 1 of the following: Chief Financial Officer, Business Manager • How are patients, including patients who receive emergency or outpatient care who may be billed for that care, but who are not admitted, provided with written notice containing information of the availability of the hospital's discount payment and charity care policies? • Does this include information about eligibility, and contact information for a hospital employee or office from which the patient may obtain further information about these polices? • How are patients who have not provided proof of coverage by a third party provided clear and conspicuous notice of the following: 1) Statement of charges for hospital rendered services rendered by the hospital. 2) A request that the patient inform the hospital if the patient has health insurance coverage (Medicare, Healthy Families, Medi-Cal, or other coverage) 3) A statement that, if the patient does not have health insurance coverage, the patient may be eligible for Medicare, Healthy Families, Medi-Cal, California Children's Services Programs or charity care if no

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124730(a) **124730(b)** **124730(c)** **127440**	insurance coverage 4) A statement indicating how the patient may obtain applications for Med-Cal, Healthy Families Programs and that the GACH will provide these applications. If patient does not indicate third party insurance coverage or requests a discounted price of charity care, hospital will provide an application for Med-Cal program or other governmental program prior to discharge or when receiving emergency or outpatient care. 5) Information regarding financially qualified patient and charity care application including the following: a. A statement that informs patients that may lack or have inadequate insurance and meets certain low to moderate income requirements, the patient may qualify for discounted payment or charity care. b. The name and telephone number of a hospital employee/office to contact regarding information/application for discount payment/charity care policies/assistance. How are patients whose hospital bills require debt collection action provided with written notification by the hospital? What is the hospital's process for reimbursing patients for excess amounts paid on their bills, including interest, owed by the hospital? **Policy & Procedure Review** • Policy about when and under whose authority patient debt is advanced for collection, whether the collection activity is conducted by the hospital, an affiliate or subsidiary of the hospital, or by an external collection agency. • Policy defining standards and practices for the collection of debt. Note: The hospital must have a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices. Prior to commencing collection activities against a patient the patient shall receive a clear notice that includes: • Plain language summary of the patient's rights pursuant to this section HSC §12730, the Rosenthal Fair Debt Collection Practices Act (Title 1.6C (commencing with Section 1788) of Part 4 of Division 3 of the Civil Code), and the federal Fair Debt Collection Practices Act (Subchapter V (commencing with section 1692) of Chapter 41 of Title 15 of the United States Code). The summary shall include a statement that the Federal Trade Commission enforces the federal act. • A statement that nonprofit credit counseling services may be available in the area.

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

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	the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor, unless the department accepts the recommendation of the Healthcare Associated Infection Advisory Committee, or its successor, that are determined to be preventable. 1279.7 (e) A health facility that is required to develop a patient safety plan pursuant to Section 1279.6 shall include in the patient safety plan measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines.
Guidance to Surveyors	**Nursing and Medication: Observe the preparation of drugs and their administration to patients [medication pass] in order to verify that procedures are being followed. Collaborate with the CDPH pharmacist consultant related to this task.** **Basic safe practices for medication administration:** • The hospital's policies and procedures must reflect accepted standards of practice that require the following be confirmed prior to each administration of medication. • The patient's identity— acceptable patient identifiers include, but are not limited to: the patient's full name; an identification number assigned by the hospital; or date of birth. Identifiers must be confirmed by patient wrist band, patient identification card, patient statement (when possible) or other means outlined in the hospital's policy. The patient's identification must be confirmed to be in agreement with the medication administration record and medication labeling prior to medication administration to ensure that the medication is being given to the correct patient. The correct medication, to ensure that the medication being given to the patient matches that prescribed for the patient • The correct dose, to ensure that the dosage of the medication matches the prescribed dose, and that the prescription itself does not reflect an unsafe dosage level (i.e., a dose that is too high or too low) • The correct route, to ensure that the method of administration – orally, intramuscular, intravenous, etc., is the appropriate one for that particular medication and patient; and • The appropriate time, to ensure adherence to the prescribed frequency and time of administration. • Verify that the hospital's policy describes requirements for the administration of identified time-

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	critical medications. Is it clear whether time-critical medications or medication types are identified as such for the entire hospital or are unit-, patient diagnosis-, or clinical situation- specific? • Verify the hospital has established total windows of time that do not exceed the following: 1 hour for time-critical scheduled medications 2 hours for medications prescribed more frequently than daily, but no more frequently than every 4 hours; and 4 hours for medications prescribed for daily or longer administration intervals.

Example of Tracer Methodology for Surgery

1. Report to the pre surgical area. In this location patients are being assessed/evaluated by physicians and nurses for impending surgery. The patients may be either inpatient or outpatient.
2. Observe the process and interview staff related to any questions or concerns. Do not interrupt the working flow of the unit.
3. Select a patient for interview and request the patient's permission to observe aspects of the surgical process. Inform the patient this would require you accompany them into the surgical suite.
4. Obtain permission from the physician/surgeon to be present in the surgical suite. Emphasize the patient has consented to your presence.

5. Review the medical record at the appropriate time. Look for informed consent (SEE Informed Consent in section 70223 for more information), a history and physical, anesthesia evaluation.
6. Enter the surgical suite wearing the appropriate attire and observe. This is not the time for any in depth interviews or conversation from the surveyor.
7. You may want to limit your observations in the surgical suite to ensure the patient/procedure/laterality is verified prior to scalpel touching the skin. Usually referred to as TIME OUT.
8. Ensure all members of the surgical team are actively engaged in the TIME OUT.
9. There is no need to observe the entire surgical procedure. Leave the suite to observe the cleaning and turn-around of other surgical suites.
10. Interview staff related to the products they are using to include dwell time on surfaces, mixing of the various cleaning agents.
11. When the patient clears the surgical suite other opportunities are presented for the observation regarding continuation of care in post anesthesia care (PACU) and eventually to an inpatient room.

STATE OF CALIFORNIA - DEPARTMENT OF PUBLIC HEALTH

*** CONFIDENTIAL NAMES *** *** CONFIDENTIAL NAMES ***

Statutes and Regulations require that the names of patients jeopardized by a violation not be specified on a public documents but a separate list of names be prepared. The following is a list of persons involved in the report identified below. Reminder- Residents/patients referenced in both the federal recertification survey and the state licensing surveys are assigned the same identifier number. Additional residents added during the state licensing survey are assigned an identifier that does not duplicate the resident identifier in the federal recertification process. The additional residents selected for the state licensing process are ONLY added to the separate state confidential names list.

FACILITY: VISIT TYPE:

LAST DATE OF SURVEY: PROVIDER NUMBER:

REFERENCE NUMBER	NAME OF PERSON	DATE OF BIRTH	LOCATION / LOCATION OF EVIDENCE

Reference number corresponds to number used on the citation or public report.

GACH STATE LICENSING SURVEY - SURVEYOR TIME DATA COLLECTION

PROVIDER / SUPPLIER NAME:

SURVEYOR NAME: _____

Date								
Time Spent in Licensing Survey Activity								
Total Time for Day								

* As you complete a licensing activity during the survey, document the time spent in one of the “time” boxes under that date. At the end of the day, add up the column to total the amount of time spent that day on Licensing Activities. You do not need to indicate what the activity was, just the amount of time spent.

STATE LICENSING SURVEY - SURVEYOR TIME DATA COLLECTION

PROVIDER / SUPPLIER NAME:

SURVEYOR NAME: _____

Date								
Time Spent in Licensing Survey Activity								
Total Time for Day								

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CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
LICENSING & CERTIFICATION

STATE LICENSING SURVEY - SURVEYOR TIME DATA COLLECTION

PROVIDER / SUPPLIER NAME:

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STATE LICENSING SURVEY WORKLOAD REPORT

PROVIDER/SUPPLIER NUMBER	PROVIDER/SUPPLIER NAME

STATE LICENSING SURVEY TEAM AND WORKLOAD DATA
Please enter the workload information for each surveyor. Use the surveyor's State identification number.

	State Surveyor ID Number	Date Licensing Survey Began	Date Licensing Survey Ended	Pre-Survey Preparation Hours for Licensing Survey	Number of Hours to complete Title 22 Licensing Part of Survey	Travel Hours	Hours to Prepare Licensing Report
1.	Team Leader						
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Number of Hours for Supervisory Review……	
Number of Hours for Clerical/Support Staff Entry……	