

ARTICLE 5. ADMINISTRATION

s 72501. Licensee -General Duties.

(a) The licensee shall be responsible for compliance with licensing requirements and for the organization, management, operation and control of the licensed facility. The delegation of any authority by a licensee shall not diminish the responsibilities of such licensee.

(b) The licensee, if an administrator, may act as the administrator or shall appoint an administrator, to carry out the policies of the licensee. A responsible adult who is knowledgeable in the policies and procedures of the licensee shall be appointed, in writing, to carry out the policies of the licensee in the absence of the administrator. If the administrator is to be absent for more than 30 consecutive days, the licensee shall appoint an acting administrator to carry out the day-to-day functions of the facility.

(c) The licensee shall delegate to the designated administrator, in writing, authority to organize and carry out the day-to-day functions of the facility.

(d) Except where provided for in approved continuing care agreements, or except when approved by the Department, no facility owner, administrator, employee or representative thereof shall act as guardian or conservator of a patient therein or of that patient's estate, unless that patient is a relative within the second degree of consanguinity.

(e) The licensee shall employ an adequate number of qualified personnel to carry out all the functions of the facility and shall provide for initial orientation of all new employees, a continuing in-service training program and competent supervision.

(f) If language or communication barriers exist between skilled nursing facility staff and patients, arrangements shall be made for interpreters or for the use of other mechanisms to ensure adequate communication between patients and personnel.

(g) The Department may require the licensee to provide additional professional, administrative or supportive personnel whenever the Department determines through a written evaluation that additional personnel is needed to provide for the health and safety of patients.

(h) The licensee shall ensure that all employees serving patients or the public shall wear name and title badges unless contraindicated.

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

s 72503. Consumer Information to Be Posted.

(a) The following consumer information shall be conspicuously posted in a prominent location accessible to the public.

- (1) Name, license number and date of employment of the current administrator of the facility.
- (2) A listing of all services and special programs provided in the facility and those provided through written contracts.
- (3) The current and following week's menus for regular and therapeutic diets.
- (4) A notice that the facility's written admission and discharge policies are available upon request.
- (5) Most recent licensing visit report supported by the related follow-up plan of correction visit reports.
- (6) The names and addresses of all previous owners of the facility.
- (7) A listing of all other skilled nursing and intermediate care facilities owned by the same person, firm, partnership, association, corporation or parent or subsidiary corporation, or a subsidiary of the parent corporation.
- (8) A statement that an action to revoke the facility's license is pending, if such an action has been initiated by the filing of an accusation, pursuant to Section 11503 of the Government Code, and the accusation has been served on the licensee.
- (9) A notice of the name, address and telephone number of the District Office of the Licensing and Certification Division, Department of Health Services, having jurisdiction over the facility.

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

s 72505. Fire Safety.

The licensee shall conform to the regulations adopted by the State Fire Marshal establishing minimum standards for the prevention of fire and for the protection of life and property against fire and panic. A copy of the State Fire Marshal's current fire clearance shall be available in the facility.

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

s 72507. Smoking.

- (a) Patients shall not be permitted to smoke in or on the bed except when a facility staff member or responsible adult is present in the room to ensure safety against fire hazards.
- (b) The facility shall provide designated areas for smoking. Patients shall be permitted to smoke only in designated areas. The designated area shall be under the periodic

observation of facility personnel or responsible adults. This does not preclude the designation of the patient rooms as smoking areas.

(c) The facility shall provide a designated area for nonsmoking patients. Such a designated area shall be identified by prominently posted "No Smoking" signs.

(d) Smoking or open flames shall not be permitted in any rooms or spaces where oxygen cylinders are stored or where oxygen is in use. Such rooms or spaces shall be identified by prominently posted "No Smoking" or "No Open Flame" signs.

(e) The facility shall make every reasonable effort to assign patients to rooms according to the patient's individual nonsmoking or smoking preferences.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1286 and 25942, Health and Safety Code.

s 72509. Advertising.

(a) No skilled nursing facility shall make or disseminate false or misleading statements or advertise by any other manner or means any false or misleading claims regarding facilities or services provided.

(b) No skilled nursing facility shall use the words "Approved by the California Department of Health Services" or any other words conveying the same idea in any advertising material.

(c) The term "rehabilitation" shall not be used unless the facility has rehabilitation services which are approved by the Department.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1256 and 1276, Health and Safety Code.

s 72511. Use of Outside Resources.

(a) If a facility does not employ qualified personnel to render a specific service to be provided by the facility, there shall be arrangements through a written agreement with outside resources which shall meet the standards and requirements of these regulations.

(b) Copies of affiliation agreements, contracts or written arrangements for advice, consultation, services, training or transportation, with other facilities, organizations or individuals, public or private agencies, shall be on file in the facility's administrative office. These shall be readily available for inspection and review by the Department.

(c) The affiliation agreement, contracts and written arrangements shall include, but not be limited to:

(1) Description of the services to be provided.

(2) Financial arrangements.

(3) Methods by which the services are to be provided.

(4) Conditions upon which the agreement, contract or written arrangement can be terminated.

(5) Time frame of the affiliation agreement, contract or written arrangement.

(6) Effective date of affiliation agreement, contract or written arrangement.

(7) Date affiliation agreement, contract or written arrangement was signed.

(8) Signatures of all parties to the written agreement.

(d) The outside resource, when acting as a consultant, shall apprise the administrator in writing of recommendations, plans for implementation and continuing assessment through dated and signed reports which shall document the length of the visit and shall be retained by the administrator for follow-up action and evaluation of performance. The administrator shall provide evidence of review of the recommendations.

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

s 72513. Administrator.

(a) Each skilled nursing facility shall employ or otherwise provide an administrator to carry out the policies of the licensee. The administrator shall be responsible for the administration and management of only one skilled nursing facility unless all of the following conditions are met:

(1) If other skilled nursing facilities for which the administrator is responsible are in the same geographic area, and within one hour surface travel time of each other, and are operated by the same governing body.

(2) The administrator shall not be responsible for more than three facilities or a total of no more than 200 beds.

(3) The administrator shall designate a responsible adult who is knowledgeable in the policies and procedures of the licensee in each facility to be responsible for carrying out the policies of the licensee in the administrator's absence.

(b) The administrator shall have sufficient freedom from other responsibilities and shall be on the premises of the skilled nursing facility a sufficient number of hours to permit adequate attention to the management and administration of the facility. The Department may require that the administrator spend additional hours in the facility whenever the

Department determines through a written evaluation that such additional hours are needed to provide adequate administrative management.

(c) A copy of the current skilled nursing facility regulations contained in this chapter shall be maintained by the administrator and shall be available to all personnel.

(d) The administrator shall be responsible for informing appropriate staff of the applicable additions, deletions and changes to skilled nursing facility regulations.

(e) The administrator shall be responsible for informing the Department, via telephone within 24 hours of any unusual occurrences as specified in Section 72541. If the unusual occurrence involves the discontinuance or disruption of services occurring during other than regular business hours of the Department or its designee, a telephone report shall be made immediately upon the resumption of business hours of the Department.

(f) The administrator or designee shall be responsible for screening patients for admission to the facility to ensure that the facility admits only those patients for whom it can provide adequate care. The administrator, or designee, shall conduct preadmission personal interviews as appropriate with the patient's physician, the patient, the patient's next of kin or sponsor or the representative of the facility from which the patient is being transferred. A telephone interview may be substituted when a personal interview is not feasible.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276 and 1276.1, Health and Safety Code.

s 72515. Admission of Patients.

The licensee shall:

(a) Admit a patient only on physician's orders.

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

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

s 72516. Standard Admission Agreement.

(a) The licensee shall use the California Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities, form number HS 327 (02/05), which is incorporated by reference herein, as the sole contract of admission between residents and the licensee.

(b) Except to enter information specific to the facility or the resident in blank spaces provided in the Standard Admission Agreement form or its attachments, the licensee shall not alter the Standard Admission Agreement without the prior written authorization of the Department.

(c) No resident or his or her legal representative shall be required to sign any other document at the time of, or as a condition of, admission to the licensee's facility, or as a condition of continued stay in the facility.

(d) The licensee shall not present any arbitration agreement to a prospective resident as a part of the Standard Admission Agreement. Any arbitration agreement shall be separate from the Standard Admission Agreement and shall contain the following advisory in a prominent place at the top of the proposed arbitration agreement, in bold-face font of not less than 12 point type: "Residents shall not be required to sign this arbitration agreement as a condition of admission to this facility, and cannot waive the ability to sue for violation of the Resident Bill of Rights."

Note: Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1276, 1430, 1599.60, 1599.61, 1599.81 and 123222.1, Health and Safety Code.

HISTORY

New section filed 7-6-2005; operative 1-2-2006 (Register 2005, No. 27).

s 72517. Staff Development.

(a) Each facility shall have an ongoing educational program planned and conducted for the development and improvement of necessary skills and knowledge for all facility personnel. Each program shall include, but not be limited to:

- (1) Problems and needs of the aged, chronically ill, acutely ill and disabled patients.
- (2) Prevention and control of infections.
- (3) Interpersonal relationship and communication skills.
- (4) Fire prevention and safety.
- (5) Accident prevention and safety measures.
- (6) Confidentiality of patient information.
- (7) Preservation of patient dignity, including provision for privacy.
- (8) Patient rights and civil rights.
- (9) Signs and symptoms of cardiopulmonary distress.
- (10) Choking prevention and intervention.

(b) In addition to (a) above, all licensed nurses shall have training in cardiopulmonary resuscitation.

(c) Records of each staff development program shall be maintained. The records shall include name and title of presenter, date of presentation, title of subject presented, description of content and the signatures of those attending.

(d) Each facility shall have a written orientation program for all newly hired employees. Each employee shall receive orientation to the facility, the employee's job description and duties, the patient population, the pertinent policies and procedures and the facility staff.

(e) Consultants employed by the facility shall participate in the staff development program.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276 and 1276.1, Health and Safety Code.

s 72519. Patient Transfer.

(a) The licensee shall maintain written transfer agreements with other nearby health facilities to make the services of those facilities accessible and to facilitate the transfer of patients. Complete and accurate patient information, in sufficient detail to provide for continuity of care shall be transferred with the patient at time of transfer.

(b) When a patient is transferred to another facility, the following shall be entered in the patient health record:

(1) The date, time, condition of the patient and a written statement of the reason for the transfer.

(2) Informed written or telephone acknowledgement of the patient, patient's guardian or authorized representative except in an emergency or as provided in Section 72527(a)(5).

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

s 72520. Bed Hold.

(a) If a patient of a skilled nursing facility is transferred to a general acute care hospital as defined in Section 1250(a) of the Health and Safety Code, the skilled nursing facility shall afford the patient a bed hold of seven (7) days, which may be exercised by the patient or the patient's representative.

(1) Upon transfer to a general acute care hospital, the patient or the patient's representative shall notify the skilled nursing facility within twenty-four (24) hours after being informed of the right to have the bed held, if the patient desires the bed hold.

(2) Except as provided in Section 51535.1, Title 22, California Administrative Code, any patient who exercises the bedhold option shall be liable to pay reasonable charges, not to exceed the patient's daily rate for care in the facility, for bed hold days.

(3) If the patient's attending physician notifies the skilled nursing facility in writing that the patient's stay in the general acute care hospital is expected to exceed seven (7) days, the skilled nursing facility shall not be required to maintain the bed hold.

(b) Upon admission of the patient to the skilled nursing facility and upon transfer of the patient of a skilled nursing facility to a general acute care hospital, the skilled nursing facility shall inform the patient, or the patient's representative, in writing of the right to exercise this bed hold provision. No later than June 1, 1985, every skilled nursing facility shall inform each current patient or patient's representative in writing of the right to exercise the bed hold provision. Each notice shall include information that a non-Medical eligible patient will be liable for the cost of the bed hold days, and that insurance may or may not cover such costs.

(c) A licensee who fails to meet these requirements shall offer to the patient the next available bed appropriate for the patient's needs. This requirement shall be in addition to any other remedies provided by law.

The provisions of this section do not apply to patients covered only by Medicare, Title XVIII benefits pursuant to Code of Federal Regulations, Title 42, Subsection 489.22(d)(1).

Note: Authority cited: Sections 208(a), 1275 and 1276, Health and Safety Code.
Reference: Sections 1275 and 1276, Health and Safety Code; and 42 CFR 489.22 (d)(1).

HISTORY

1. New section filed 12-17-84 as an emergency; effective upon filing (Register 85, No. 1). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 4-16-85.

2. Certificate of Compliance including amendment of subsection (b) transmitted to OAL 4-11-85 and filed 5-15-85 (Register 85, No. 21).

3. Last sentence added to clarify that Section 72520 as originally adopted was not applicable to patients covered only by Medicare, Title XVIII benefits.

(See 42 CFR 489.22(d)(1).)

s 72521. Administrative Policies and Procedures.

(a) Written administrative, management and personnel policies shall be established and implemented to govern the administration and management of the facility.

(b) All policies and procedures required by these regulations shall be in writing and shall be carried out as written. They shall be made available upon request to patients or their agents and to employees and the public. Policies and procedures shall be reviewed at least annually, revised as needed and approved in writing by the governing body or licensee.

(c) Each facility shall establish at least the following:

(1) Personnel policies and procedures which shall include:

(A) Written job descriptions detailing qualifications, duties and limitations of each classification of employee available to all personnel.

(B) Employee orientation to facility, job, patient population, policies, procedures and staff.

(C) Staff Development.

(D) Employee benefits.

(E) Employee health and grooming.

(F) Verification of licensure, credentials and references.

(2) Policies and procedures for patient admission, leave of absence, transfer, pass and discharge, categories of patients accepted and retained, rate of charge for services included in the basic rate, type of services offered, charges for extra services, limitations of services, cause for termination of services and refund policies applying to termination of services.

(3) Policies and procedures for admission or discharge of a patient which state that a patient shall not be admitted or discharged on the basis of race, color, religion, ancestry or national origin except:

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 subsection may establish admission policies limiting or giving preference to its own members or adherents and such policies shall not be construed as a violation of (c)(3) above. Any admission of nonmembers or nonadherents shall be subject to (c)(3) above.

(4) Written policies and procedures governing patient health records which shall be developed with the assistance of a person skilled in record maintenance and preservation.

(A) Policies and procedures governing access to, duplication of and dissemination of, information from the patient's health record.

(B) Policies and procedures shall be established to ensure the confidentiality of patient health information, in accordance with applicable laws and regulations.

(5) Policies and procedures to assure that the facility accepts and retains only those patients for whom it can provide care.

(6) Procedures for reporting of unusual occurrences.

(d) The facility shall have a written organizational chart showing the major programs of the facility, the person in charge of each program, the lines of authority, responsibility and communication and the staff assignments.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276 and 1285, Health and Safety Code.

s 72523. Patient Care Policies and Procedures.

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

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

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

(1) Physician services policies and procedures which include:

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

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

(2) Nursing services policies and procedures which include:

(A) A current nursing procedure manual.

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

(C) Screening of all patients for tuberculosis upon admission. These procedures shall be determined by the patient care policy committee. A tuberculosis screening procedure may not be required if there is satisfactory written evidence available that a tuberculosis

screening procedure has been completed within 90 days of the date of admission to the facility. Subsequent tuberculosis screening procedures shall be determined by the attending physician.

(D) Notification of physician regarding sudden or marked adverse change in a patient's condition.

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

(3) Infection control policies and procedures.

(4) Dietary services policies and procedures which include:

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

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

(5) Pharmaceutical services policies and procedures.

(6) Activity program policies and procedures.

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

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

s 72525. Required Committees.

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

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

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

(1) Patient care policy committee.

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

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

(C) The committee shall meet at least annually.

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

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

(F) The Patient Care Policy Committee shall implement the provisions of the Health and Safety Code, Sections 1315 and 1316.5, by means of written policies and procedures.

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

2. Only physicians shall assume overall care of patients, including performing admitting history and physical examinations and issuing orders for medical care.

(G) The Patient Care Policy Committee shall implement the provisions of the Health and Safety Code, Section 1316, by means of written policies and procedures.

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

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

(2) Infection control committee.

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

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

(C) The committee shall meet at least quarterly.

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

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

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

(3) Pharmaceutical service committee.

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

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

(C) The committee shall meet at least quarterly.

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

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

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

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

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

HISTORY

Amendment filed 2-8-83; designated effective 3-2-83 (Register 83, No. 7).

s 72527. Patients' Rights.

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

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

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

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

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

(5) To receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure. The disclosure of material information for administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function shall include the disclosure of information listed in Section 72528(b).

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

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

(8) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

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

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

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

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

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

- (14) To meet with others and participate in activities of social, religious and community groups.
- (15) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients.
- (16) If married, to be assured privacy for visits by the patient's spouse and if both are patients in the facility, to be permitted to share a room.
- (17) To have daily visiting hours established.
- (18) To have visits from members of the clergy at any time at the request of the patient or the patient's representative.
- (19) To have visits from persons of the patient's choosing at any time if the patient is critically ill, unless medically contraindicated.
- (20) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.
- (21) To have reasonable access to telephones and to make and receive confidential calls.
- (22) To be free from any requirement to purchase drugs or rent or purchase medical supplies or equipment from any particular source in accordance with the provisions of Section 1320 of the Health and Safety Code.
- (23) To be free from psychotherapeutic drugs and physical restraints used for the purpose of patient discipline or staff convenience and to be free from psychotherapeutic drugs used as a chemical restraint as defined in Section 72018, except in an emergency which threatens to bring immediate injury to the patient or others. If a chemical restraint is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient and used only for a specified and limited period of time.
- (24) Other rights as specified in Health and Safety Code, Section 1599.1.
- (25) Other rights as specified in Welfare and Institutions Code, Sections 5325 and 5325.1, for persons admitted for psychiatric evaluations or treatment.
- (26) Other rights as specified in Welfare and Institutions Code Sections 4502, 4503 and 4505 for patients who are developmentally disabled as defined in Section 4512 of the Welfare and Institutions Code.
- (b) A patient's rights, as set forth above, may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented in the patient's health record.

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

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

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

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

(2) How the facility, in consultation with the patient's physician, will identify consistent with current statutory case law, who may serve as a patient's representative when an incapacitated patient has no conservator or attorney in fact under a valid Durable Power of Attorney for Health Care.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1320, 1599, 1599.1, 1599.2 and 1599.3, Health and Safety Code; and Cobbs v. Grant (1972) 8 Cal.3d 229.

HISTORY

Amendment of subsections (a) and (b), repealer of subsection (c), and new subsections (c), (d), and (e) filed 5-27-92; operative 5-27-92 (Register 92, No. 22).

s 72528. Informed Consent Requirements.

(a) It is the responsibility of the attending physician to determine what information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. Information that is commonly appreciated need not be disclosed. The disclosure of the material information

and obtaining informed consent shall be the responsibility of the physician.

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

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

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

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

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

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

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

(c) Before initiating the administration of psychotherapeutic drugs, or physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function, facility staff shall verify that the patient's health record contains documentation that the patient has given informed consent to the proposed treatment or procedure. The facility shall also ensure that all decisions concerning the withdrawal or withholding of life sustaining treatment are documented in the patient's health record.

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

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

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

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

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

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

(h) If a patient or his or her representative cannot communicate with the physician because of language or communication barriers, the facility shall arrange for an interpreter.

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

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

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276 and 1599.72, Health and Safety Code; and Cobbs v. Grant (1972) 8 Cal.3d 229.

HISTORY

New section filed 5-27-92; operative 5-27-92 (Register 92, No. 22).

s 72529. Safeguards for Patients' Monies and Valuables.

(a) Each facility to whom a patient's money or valuables have been entrusted shall comply with the following:

(1) No licensee shall mingle patients' monies or valuables with that of the licensee or the facility. Patients' monies and valuables shall be maintained separate, intact and free from any liability that the licensee incurs in the use of the licensee's or the facility's funds. The provisions of this section shall not be interpreted to preclude prosecution for the fraudulent appropriation of patients' monies or valuables as theft, as defined by Section 484 of the Penal Code.

(2) Each licensee shall maintain safeguards and accurate records of patients' monies and valuables entrusted to the licensee's care including the maintenance of a detailed inventory and at least a quarterly accounting of financial transactions made on the patient's behalf.

(A) Records of patients' monies which are maintained as a drawing account shall include a control account for all receipts and expenditures, supporting vouchers and receipts for all expenditures of monies and valuables entrusted to the licensee, 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. All of these records shall be maintained at the facility for a minimum of three years from the date of transaction. At no time may the balance in a patient's drawing account be less than zero.

(B) 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 patient's authorized representative. Each item of patient property entrusted to the licensee shall be clearly identified as belonging to that patient.

(3) Patients' monies not kept in the facility 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, or in a federally insured bank or savings and loan association under a plan approved by the Department. If a facility is operated by a county, such funds may be deposited with the county treasurer. If a facility is operated by the State, such funds may be deposited with the State Treasurer. All banking records related to these funds, including but not limited to deposit slips, checks, cancelled checks, statements and check registers, shall be maintained in the facility for a minimum of three years from the date of transaction. Identification as a patient trust fund account shall be clearly printed on each patient's trust account checks and bank statements.

(4) A separate list shall be maintained for all checks from patient funds which are, or have been outstanding for 45 days or more as reflected on the most recent bank statement. Bank statements shall be reconciled monthly with copies of the reconciliation maintained by the facility. Any checks on such accounts written off or uncashed shall result in an addition to the appropriate patient's account.

(5) Expenditures, for a particular patient, from the patient fund account as specified in (3) above may not exceed the drawing right that the patient has in the account. Expenditures from the patient fund account shall only be for the immediate benefit of that particular

patient. No more than one month's advance payment for care may be received from a patient's account.

(6) A person, firm partnership, association or corporation which is licensed to operate more than one health facility shall maintain a separate demand trust account as specified in (3) above for each such facility. Records relating to these accounts shall be maintained at each facility as specified in (2) above. Patient funds from one facility shall not be mingled with funds from another facility.

(7) When the amount of patients' money entrusted to a licensee exceeds \$500, all money in excess of \$500 shall be deposited in a demand trust account as specified in (3) and (5) above unless the licensee provides a fireproof safe and the licensee desires the protection accorded by Section 1860 of the Civil Code.

(8) Upon discharge of a patient, all money and valuables of that patient which have been entrusted to the licensee and kept within the facility shall be surrendered to the patient or authorized representative in exchange for a signed receipt. Monies in a demand trust account or with the county treasurer shall be made available within three normal banking days. Upon discharge, the patient or authorized representative shall be given a detailed list of personal property and a current copy of the debits and credits of the patient's monies.

(9) Within 30 days following the death of a patient, except in a coroner or medical examiner 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 or to the executor or the administrator of the estate in exchange for a signed receipt. Whenever a patient without known heirs dies, written notice within five working days, shall be given by the facility to the public administrator of the county as specified by Section 1145 of the California Probate Code and a copy of said notice shall be available in the facility for review by the Department.

(10) Upon change of ownership of a facility, there shall be a written verification by a public accountant of all patients' monies which are being transferred to the custody of the new owner(s). A signed receipt for the amount of funds in the patients' trust account shall be given by the new owner to the previous owner.

(11) Upon closure of a facility a written verification by a public accountant of all patients' monies shall be available for review by the Department. Each patients' monies shall be transferred with the patient.

(b) If property is purchased for use of more than one patient, from patient trust funds, the facility shall secure a written agreement between all patients whose funds are used, or their authorized representatives. The agreement shall expressly acknowledge consent of all parties and shall provide for disposition of the property in the event of disagreements, discharge, transfer or death.

(c) No licensee, owner, administrator, employee or their immediate relative or representatives of the aforementioned may act as an authorized representative of patients' monies or valuables, unless the patient is a relative within the second degree of consanguinity.

(d) The facility shall make reasonable efforts to safeguard patients' property and valuables that are in possession of the patient.

(e) For purposes of this section, patients' funds maintained in a financial institution shall be deemed to be entrusted to a facility if the licensee, or any agent or employee thereof, is an authorized signatory to said account. Records maintained and provided by the financial institution in accordance with a plan which has obtained the written approval of the Department, may fulfill the obligation of the facility with regard to the maintenance of records for such funds.

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

s 72531. Liability for Rent and Return of Rental Advance.

(a) This section shall apply to all rental agreements executed on or after January 1, 1982.

(b) Whenever accommodations in a skilled nursing facility are rented by or for a patient on a month to month basis, the renter or his heir, legatee or personal representative shall not be liable for any rent due under the rental agreement for accommodations beyond the date on which the patient died.

(c) Any advance of rent by the renter shall be returned to the heir, legatee or personal representative of the patient no later than two weeks after discharge or death of the patient.

(d) The rights described in (b) and (c) above shall not be modified or waived in the rental agreement.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1934.5, Civil Code; and Section 1276, Health and Safety Code.

s 72533. Employee Personnel Records.

(a) Each facility shall maintain current complete and accurate personnel records for all employees.

(1) The record shall include:

(A) Full name.

(B) Social Security number.

(C) Professional license or registration number, if applicable.

(D) Employment classification.

(E) Information as to past employment and qualifications.

(F) Date of beginning employment.

(G) Date of termination of employment.

(H) Documented evidence of orientation to the facility.

(I) Performance evaluations.

(2) Such records shall be retained for at least three years following termination of employment. Employee personnel records shall be maintained in a confidential manner, and shall be made available to authorized representatives of the Department upon request.

(b) Records of hours and dates worked by all employees during at least the most recent 12-month period shall be kept on file at the place of employment or at a central location within the State of California. Upon request such records shall be made available, at a time and location specified by the Department.

(c) A permanent log of the temporary health services personnel employed in the facility shall be kept for three years, and shall include the following:

(1) Employee's full name.

(2) Name of temporary health services personnel agency.

(3) Professional license and registration number and date of expiration.

(4) Verification of health status.

(5) Record of hours and dates worked.

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

s 72535. Employees' Health Examination and Health Records.

(a) All employees working in the facility, including the licensee, shall have a health examination within 90 days prior to employment or within seven days after employment and at least annually thereafter by a person lawfully authorized to perform such a procedure. Each such examination shall include a medical history and physical evaluation. The report signed by the examiner shall indicate that the person is sufficiently

free of disease to perform assigned duties and does not have any health condition that would create a hazard for himself, fellow employees, or patients or visitors.

(b) The initial health examination and subsequent annual examination shall include a purified protein derivative intermediate strength intradermal skin test for tuberculosis. A chest X-ray is indicated if the employee has previously had a positive reaction to a tuberculosis skin test or is currently being treated for tuberculosis. Positive reaction to the skin test shall be followed by a 35.56 cm x 43.18 cm (14 " x 17 ") chest X-ray. Evidence of tuberculosis screening within 90 days prior to employment shall be considered as meeting the intent of this Section.

(c) The facility shall maintain a health record of the administrator and for each employee which includes reports of all employment-related health examinations. Such records shall be kept for a minimum of three years following termination of employment.

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

s 72537. Reporting of Communicable Diseases.

All cases of reportable communicable 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.

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

s 72539. Reporting of Outbreaks.

Any outbreak or undue prevalence of infectious or parasitic disease or infestation shall be reported to the local health officer in accordance with Section 2502, Article 1, Subchapter 4, Chapter 4, Title 17, California Administrative Code.

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

s 72541. Unusual Occurrences.

Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors shall be reported by the facility within 24 hours either by telephone (and confirmed in writing) or by telegraph to the local health officer and the Department. An incident report shall be retained on file by the facility for one year. The facility shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the

local fire authority or in areas not having an organized fire service, to the State Fire Marshal.

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

s 72543. Patients' Health Records.

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

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

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

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

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

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

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

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

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

available for review by the Department. All entries in the health record shall be authenticated with the date, name, and title of the persons making the entry.

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

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

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

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

s 72545. Admission Records.

(a) For each patient a facility shall complete an admission record which shall include the following:

(1) Name and Social Security number.

(2) Current address.

(3) Age and date of birth.

(4) Sex.

(5) Date of admission.

(6) Date of discharge.

(7) Name, address and telephone number of guardian, authorized representative, person or agency responsible for patient and next of kin.

(8) Name, address and telephone number of attending physician and the name, address and telephone number of the podiatrist, dentist or clinical psychologist if such practitioner is primarily responsible for the treatment of the patient.

(9) Name, address and telephone number of the designated alternate physician.

(10) Admission diagnoses, known allergies and final diagnoses.

(11) Medicare and Medi-Cal numbers when appropriate.

(12) An inventory including but not limited to:

(A) Items of jewelry.

(B) Items of furniture.

(C) Radios, television and other appliances.

(D) Prosthetic and orthopedic devices.

(E) Other valuable items, so identified by the patient, family or authorized representative.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

HISTORY

1. Amendment filed 2-8-83; designated effective 3-2-83 (Register 83, No. 7).

2. Editorial correction filed 8-31-83; effective thirtieth day thereafter (Register 83, No. 36).

s 72547. Content of Health Records.

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

(1) Admission record.

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

(3) Current diagnoses.

(4) Physician orders, including drugs, treatment and diet orders, progress notes, signed and dated on each visit. Physician's orders shall be correctly recapitulated.

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

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

1. Care and treatment of the patient.

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

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

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

(C) Name, dosage and time of administration of drugs, the route of administration or site of injection, if other than oral. If the scheduled time is indicated on the record, the initial of the person administering the dose shall be recorded, provided that the drug is given within one hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both initials and the time of administration. Medication and treatment records shall contain the name and professional title of staff signing by initials.

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

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

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

(G) Documentation of oxygen administration.

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

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

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

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

(10) Discharge planning notes when applicable.

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

(12) Records of each treatment given by the therapist, weekly progress notes and a record of reports to the physician after the first 2 weeks of therapy and at least every 30 days thereafter. Progress notes written by the social service worker if the patient is receiving social services.

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

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

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

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

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

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

s 72549. Patient Death Reports.

(a) All patients' deaths shall be reported by the licensee when requested by the Department or its designee. The report shall be made accurately at a time and in such a manner as may be requested by the Department or its designee.

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

s 72551. External Disaster and Mass Casualty Program.

(a) A written external disaster and mass casualty program plan shall be adopted and followed. The plan shall be developed with the advice and assistance of county or regional and local planning offices and shall not conflict with county and community disaster plans. A copy of the plan shall be available on the premises for review by the Department.

(b) The plan shall provide procedures in event of community and widespread disasters. The written plan shall include at least the following:

(1) Sources of emergency utilities and supplies, including gas, water, food and essential medical supportive materials.

(2) Procedures for assigning personnel and recalling off-duty personnel.

(3) Unified medical command. A chart of lines of authority in the facility.

(4) Procedures for the conversion of all usable space into areas for patient observation and immediate care of emergency admissions.

(5) Prompt transfer of casualties when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering

definitive care. Procedures for moving patients from damaged areas of the facility to undamaged areas.

(6) Arrangements for provision of transportation of patients including emergency housing where indicated. Procedures for emergency transfers of patients who can be moved to other health facilities, including arrangements for safe and efficient transportation and transfer information.

(7) Procedures for emergency discharge of patients who can be discharged without jeopardy into the community, including prior arrangements for their care, arrangements for safe and efficient transportation and at least one follow-up inquiry within 24 hours to ascertain that patients are receiving required care.

(8) Procedures for maintaining a record of patient relocation.

(9) An evacuation plan, including evacuation routes, emergency phone numbers of physicians, health facilities, the fire department and local emergency medical services agencies and arrangements for the safe transfer of patients after evacuation.

(10) A tag containing all pertinent personal and medical information which shall accompany each patient who is moved, transferred, discharged or evacuated.

(11) Procedures for maintaining security in order to keep relatives, visitors and curious persons out of the facility during a disaster.

(12) Procedures for providing emergency care to incoming patients from other health facilities.

(13) Assignment of public relations liaison duties to a responsible individual employed by the facility to release information to the public during a disaster.

(c) The plan shall be reviewed at least annually and revised as necessary to ensure that the plan is current. All personnel shall be instructed in the requirements of the plan. There shall be evidence in the personnel files, or the orientation checklist, indicating that all new employees have been oriented to the plan and procedures at the beginning of their employment.

(d) The facility shall participate in all local and state disaster drills and test exercises when asked to do so by the local or state disaster or emergency medical services agencies.

(e) A disaster drill shall be held by the facility at six-month intervals. There shall be a written report of the facility's participation in each drill or test exercise. Staff from all shifts shall participate in drills or test exercises.

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

s 72553. Fire and Internal Disasters.

(a) A written fire and internal disaster plan incorporating evacuation procedures shall be developed with the assistance of qualified fire, safety and other appropriate experts. A copy of the plan shall be available on the premises for review by the staff and the Department.

(b) The written plan shall include at least the following:

(1) Procedures for the assignment of personnel to specific tasks and responsibilities.

(2) Procedures for the use of alarm systems and signals.

(3) Procedures for fire containment.

(4) Priority for notification of staff including names and telephone numbers.

(5) Location of fire-fighting equipment.

(6) Procedures for evacuation and specification of evacuation routes.

(7) Procedures for moving patients from damaged areas of the facility to undamaged areas.

(8) Procedures for emergency transfer of patients who can be moved to other health facilities, including arrangements for safe and efficient transportation.

(9) Procedures for emergency discharge of patients who can be discharged without jeopardy into the community, including prior arrangements for their care, arrangements for safe and efficient transportation and at least one follow-up inquiry within 24 hours to ascertain that patients are receiving their required care.

(10) A disaster tag containing all pertinent personal and medical information to accompany each patient who is moved, transferred, discharged or evacuated.

(11) Procedures for maintaining a record of patient relocation.

(12) Procedures for handling incoming or relocated patients.

(13) Other provisions as dictated by circumstances.

(c) Fire and internal disaster drills shall be held at least quarterly, under varied conditions for each individual shift of the facility personnel. 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.
- (4) Emergency telephone number of the local fire department.

(e) A dated, written report and evaluation of each drill and rehearsal shall be maintained and shall include signatures of all employees who participated.

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

s 72555. Patient Identification.

Each patient shall be provided with a wristband identification tag or other means of identification which shall be worn at all times unless the attending physician notes in the health record that the patient's condition would not permit such identification. Minimum information shall include the name of the patient and the name of the facility.

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

s 72557. Equipment and Supplies.

(a) Equipment and supplies in each facility shall be of the quality and in the quantity necessary for care of patients as ordered or indicated. At least the following items shall be provided and properly maintained at all times:

- (1) Airways.
- (2) Bedpans.
- (3) Catheter equipment.
- (4) Clerical supplies and equipment.
- (5) Denture cups.
- (6) Drug service trays and/or carts.
- (7) Ear syringes.

- (8) Emergency oxygen supply and equipment for administration.
- (9) Emesis basins.
- (10) Examination light.
- (11) First aid supplies, as determined by the patient care policy committee.
- (12) Flashlights.
- (13) Gloves (sterile and unsterile).
- (14) Ice caps.
- (15) Intravenous therapy supplies if facility provides such services.
- (16) Medicine droppers.
- (17) Medicine glasses, cups or other small containers which are accurately calibrated.
- (18) Mortar and pestle.
- (19) Rectal speculum.
- (20) Refrigerator with accurate thermometer.
- (21) Rubber tubing.
- (22) Scales for weighing all patients.
- (23) Shower and commode chairs, wheelchairs and walkers.
- (24) Soap for bathing.
- (25) Soap dishes or soap containers.
- (26) Sphygmomanometers.
- (27) Sterile dressings.
- (28) Stethoscopes.
- (29) Suction apparatus.
- (30) Suture tray.

(31) Suture removal equipment.

(32) Syringes and needles.

(33) Test supplies necessary to perform urine sugar and acetone testing.

(34) Thermometers, oral and rectal.

(35) Tongue depressors.

(36) Urinals.

(37) Vaginal speculum.

(38) Washbasins.

(39) Water pitchers and drinking vessels.

(b) The facility shall provide current authoritative, pertinent, basic books, periodicals and reference materials related to all services provided. At least the following shall be provided:

(1) Dictionaries, medical and standard.

(2) Directories of available community resources.

(3) Current publications relating to gerontological nursing.

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