Chapter 21
Health Care Facility Licensing and Inspection Act

Part 1
General Provisions

26-21-1 Title.
This chapter is known as the "Health Care Facility Licensing and Inspection Act."

Amended by Chapter 209, 1997 General Session

26-21-2 Definitions.
As used in this chapter:
(1) "Abortion clinic" means a type I abortion clinic or a type II abortion clinic.
(2) "Activities of daily living" means essential activities including:
   (a) dressing;
   (b) eating;
   (c) grooming;
   (d) bathing;
   (e) toileting;
   (f) ambulation;
   (g) transferring; and
   (h) self-administration of medication.
(3) "Ambulatory surgical facility" means a freestanding facility, which provides surgical services to patients not requiring hospitalization.
(4) "Assistance with activities of daily living" means providing of or arranging for the provision of assistance with activities of daily living.
(5)
   (a) "Assisted living facility" means:
      (i) a type I assisted living facility, which is a residential facility that provides assistance with activities of daily living and social care to two or more residents who:
         (A) require protected living arrangements; and
         (B) are capable of achieving mobility sufficient to exit the facility without the assistance of another person; and
      (ii) a type II assisted living facility, which is a residential facility with a home-like setting that provides an array of coordinated supportive personal and health care services available 24 hours per day to residents who have been assessed under department rule to need any of these services.
   (b) Each resident in a type I or type II assisted living facility shall have a service plan based on the assessment, which may include:
      (i) specified services of intermittent nursing care;
      (ii) administration of medication; and
      (iii) support services promoting residents' independence and self sufficiency.
(6) "Birthing center" means a freestanding facility, receiving maternal clients and providing care during pregnancy, delivery, and immediately after delivery.
(7) "Committee" means the Health Facility Committee created in Section 26-1-7.
(8) "Consumer" means any person not primarily engaged in the provision of health care to individuals or in the administration of facilities or institutions in which such care is provided and who does not hold a fiduciary position, or have a fiduciary interest in any entity involved in the provision of health care, and does not receive, either directly or through his spouse, more than 1/10 of his gross income from any entity or activity relating to health care.

(9) "End stage renal disease facility" means a facility which furnishes staff-assisted kidney dialysis services, self-dialysis services, or home-dialysis services on an outpatient basis.

(10) "Freestanding" means existing independently or physically separated from another health care facility by fire walls and doors and administrated by separate staff with separate records.

(11) "General acute hospital" means a facility which provides diagnostic, therapeutic, and rehabilitative services to both inpatients and outpatients by or under the supervision of physicians.

(12) "Governmental unit" means the state, or any county, municipality, or other political subdivision or any department, division, board, or agency of the state, a county, municipality, or other political subdivision.

(13)
(a) "Health care facility" means general acute hospitals, specialty hospitals, home health agencies, hospices, nursing care facilities, residential-assisted living facilities, birthing centers, ambulatory surgical facilities, small health care facilities, abortion clinics, facilities owned or operated by health maintenance organizations, end stage renal disease facilities, and any other health care facility which the committee designates by rule.

(b) "Health care facility" does not include the offices of private physicians or dentists, whether for individual or group practice, except that it does include an abortion clinic.

(14) "Health maintenance organization" means an organization, organized under the laws of any state which:
(a) is a qualified health maintenance organization under 42 U.S.C. Sec. 300e-9; or
(b)
(i) provides or otherwise makes available to enrolled participants at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency, and preventive services and out-of-area coverage;
(ii) is compensated, except for copayments, for the provision of the basic health services listed in Subsection (14)(b)(i) to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health services are provided and which is fixed without regard to the frequency, extent, or kind of health services actually provided; and
(iii) provides physicians' services primarily directly through physicians who are either employees or partners of such organizations, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(15)
(a) "Home health agency" means an agency, organization, or facility or a subdivision of an agency, organization, or facility which employs two or more direct care staff persons who provide licensed nursing services, therapeutic services of physical therapy, speech therapy, occupational therapy, medical social services, or home health aide services on a visiting basis.

(b) "Home health agency" does not mean an individual who provides services under the authority of a private license.
(16) "Hospice" means a program of care for the terminally ill and their families which occurs in a home or in a health care facility and which provides medical, palliative, psychological, spiritual, and supportive care and treatment.

(17) "Nursing care facility" means a health care facility, other than a general acute or specialty hospital, constructed, licensed, and operated to provide patient living accommodations, 24-hour staff availability, and at least two of the following patient services:
(a) a selection of patient care services, under the direction and supervision of a registered nurse, ranging from continuous medical, skilled nursing, psychological, or other professional therapies to intermittent health-related or paraprofessional personal care services;
(b) a structured, supportive social living environment based on a professionally designed and supervised treatment plan, oriented to the individual's habilitation or rehabilitation needs; or
(c) a supervised living environment that provides support, training, or assistance with individual activities of daily living.

(18) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof.

(19) "Resident" means a person 21 years of age or older who:
(a) as a result of physical or mental limitations or age requires or requests services provided in an assisted living facility; and
(b) does not require intensive medical or nursing services as provided in a hospital or nursing care facility.

(20) "Small health care facility" means a four to 16 bed facility that provides licensed health care programs and services to residents.

(21) "Specialty hospital" means a facility which provides specialized diagnostic, therapeutic, or rehabilitative services in the recognized specialty or specialties for which the hospital is licensed.

(22) "Substantial compliance" means in a department survey of a licensee, the department determines there is an absence of deficiencies which would harm the physical health, mental health, safety, or welfare of patients or residents of a licensee.

(23) "Type I abortion clinic" means a facility, including a physician's office, but not including a general acute or specialty hospital, that:
(a) performs abortions, as defined in Section 76-7-301, during the first trimester of pregnancy; and
(b) does not perform abortions, as defined in Section 76-7-301, after the first trimester of pregnancy.

(24) "Type II abortion clinic" means a facility, including a physician's office, but not including a general acute or specialty hospital, that:
(a) performs abortions, as defined in Section 76-7-301, after the first trimester of pregnancy; or
(b) performs abortions, as defined in Section 76-7-301, during the first trimester of pregnancy and after the first trimester of pregnancy.

Amended by Chapter 161, 2011 General Session

26-21-2.1 Services.
(1) General acute hospitals and specialty hospitals shall remain open and be continuously ready to receive patients 24 hours of every day in a year and have an attending medical staff consisting of one or more physicians licensed to practice medicine and surgery under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.
(2) A specialty hospital shall provide on-site all basic services required of a general acute hospital that are needed for the diagnosis, therapy, or rehabilitation offered to or required by patients admitted to or cared for in the facility.

(3)
(a) A home health agency shall provide at least licensed nursing services or therapeutic services directly through the agency employees.
(b) A home health agency may provide additional services itself or under arrangements with another agency, organization, facility, or individual.

Amended by Chapter 209, 1997 General Session

26-21-3 Health Facility Committee -- Members -- Terms -- Organization -- Meetings.
(1) The Health Facility Committee created by Section 26-1-7 consists of 15 members appointed by the governor with the consent of the Senate. The appointed members shall be knowledgeable about health care facilities and issues. The membership of the committee is:
(a) one physician, licensed to practice medicine and surgery under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, who is a graduate of a regularly chartered medical school;
(b) one hospital administrator;
(c) one hospital trustee;
(d) one representative of a freestanding ambulatory surgical facility;
(e) one representative of an ambulatory surgical facility that is affiliated with a hospital;
(f) two representatives of the nursing care facility industry;
(g) one registered nurse, licensed to practice under Title 58, Chapter 31b, Nurse Practice Act;
(h) one professional in the field of intellectual disabilities not affiliated with a nursing care facility;
(i) one licensed architect or engineer with expertise in health care facilities;
(j) two representatives of assisted living facilities licensed under this chapter;
(k) two consumers, one of whom has an interest in or expertise in geriatric care; and
(l) one representative from either a home health care provider or a hospice provider.

(2)
(a) Except as required by Subsection (2)(b), members shall be appointed for a term of four years.
(b) Notwithstanding the requirements of Subsection (2)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of committee members are staggered so that approximately half of the committee is appointed every two years.
(c) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term by the governor, giving consideration to recommendations made by the committee, with the consent of the Senate.
(d) A member may not serve more than two consecutive full terms or 10 consecutive years, whichever is less. However, a member may continue to serve as a member until he is replaced.
(e) The committee shall annually elect from its membership a chair and vice chair.
(f) The committee shall meet at least quarterly, or more frequently as determined by the chair or five members of the committee.
(g) Eight members constitute a quorum. A vote of the majority of the members present constitutes action of the committee.

Amended by Chapter 366, 2011 General Session
26-21-4 Per diem and travel expenses of committee members.
A member may not receive compensation or benefits for the member’s service, but may receive
per diem and travel expenses in accordance with:
(1) Section 63A-3-106;
(2) Section 63A-3-107; and
(3) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

Amended by Chapter 286, 2010 General Session

26-21-5 Duties of committee.
The committee shall:
(1) with the concurrence of the department, make rules in accordance with Title 63G, Chapter 3,
Utah Administrative Rulemaking Act:
(a) for the licensing of health-care facilities; and
(b) requiring the submission of architectural plans and specifications for any proposed new
health-care facility or renovation to the department for review;
(2) approve the information for applications for licensure pursuant to Section 26-21-9;
(3) advise the department as requested concerning the interpretation and enforcement of the rules
established under this chapter; and
(4) advise, consult, cooperate with, and provide technical assistance to other agencies of the state
and federal government, and other states and affected groups or persons in carrying out the
purposes of this chapter.

Amended by Chapter 74, 2016 General Session

26-21-6 Duties of department.
(1) The department shall:
(a) enforce rules established pursuant to this chapter;
(b) authorize an agent of the department to conduct inspections of health care facilities pursuant
to this chapter;
(c) collect information authorized by the committee that may be necessary to ensure that
adequate health care facilities are available to the public;
(d) collect and credit fees for licenses as free revenue;
(e) collect and credit fees for conducting plan reviews as dedicated credits;
(f)
   (i) collect and credit fees for conducting clearance under Chapter 21, Part 2, Clearance for
Direct Patient Access; and
   (ii) beginning July 1, 2012:
      (A) up to $105,000 of the fees collected under Subsection (1)(f)(i) are dedicated credits; and
      (B) the fees collected for background checks under Subsection 26-21-204(6) and Section
26-21-205 shall be transferred to the Department of Public Safety to reimburse the
Department of Public Safety for its costs in conducting the federal background checks;
(g) designate an executive secretary from within the department to assist the committee in
carrying out its powers and responsibilities;
(h) establish reasonable standards for criminal background checks by public and private entities;
(i) recognize those public and private entities that meet the standards established pursuant to
Subsection (1)(h); and
(j) provide necessary administrative and staff support to the committee.
(2) The department may:
(a) exercise all incidental powers necessary to carry out the purposes of this chapter;
(b) review architectural plans and specifications of proposed health care facilities or renovations
of health care facilities to ensure that the plans and specifications conform to rules
established by the committee; and
(c) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, make rules as
necessary to implement the provisions of this chapter.

Amended by Chapter 74, 2016 General Session

26-21-6.5 Licensing of an abortion clinic -- Rulemaking authority -- Fee.
(1) A type I abortion clinic may not operate in the state without a license issued by the department
to operate a type I abortion clinic.
(2) A type II abortion clinic may not operate in the state without a license issued by the department
to operate a type II abortion clinic.
(3) The department shall make rules establishing minimum health, safety, sanitary, and
recordkeeping requirements for:
(a) a type I abortion clinic; and
(b) a type II abortion clinic.
(4) To receive and maintain a license described in this section, an abortion clinic shall:
(a) apply for a license on a form prescribed by the department;
(b) satisfy and maintain the minimum health, safety, sanitary, and recordkeeping requirements
established under Subsection (3) that relate to the type of abortion clinic licensed;
(c) comply with the recordkeeping and reporting requirements of Section 76-7-313;
(d) comply with the requirements of Title 76, Chapter 7, Part 3, Abortion;
(e) pay the annual licensing fee; and
(f) cooperate with inspections conducted by the department.
(5) The department shall, at least twice per year, inspect each abortion clinic in the state to ensure
that the abortion clinic is complying with all statutory and licensing requirements relating to the
abortion clinic. At least one of the inspections shall be made without providing notice to the
abortion clinic.
(6) The department shall charge an annual license fee, set by the department in accordance with
the procedures described in Section 63J-1-504, to an abortion clinic in an amount that will pay
for the cost of the licensing requirements described in this section and the cost of inspecting
abortion clinics.
(7) The department shall deposit the licensing fees described in this section in the General Fund as
a dedicated credit to be used solely to pay for the cost of the licensing requirements described
in this section and the cost of inspecting abortion clinics.

Amended by Chapter 282, 2018 General Session

26-21-7 Exempt facilities.
This chapter does not apply to:
(1) a dispensary or first aid facility maintained by any commercial or industrial plant, educational
institution, or convent;
(2) a health care facility owned or operated by an agency of the United States;
(3) the office of a physician, physician assistant, or dentist whether it is an individual or group practice, except that it does apply to an abortion clinic;

(4) a health care facility established or operated by any recognized church or denomination for the practice of religious tenets administered by mental or spiritual means without the use of drugs, whether gratuitously or for compensation, if it complies with statutes and rules on environmental protection and life safety;

(5) any health care facility owned or operated by the Department of Corrections, created in Section 64-13-2; and

(6) a residential facility providing 24-hour care:
   (a) that does not employ direct care staff;
   (b) in which the residents of the facility contract with a licensed hospice agency to receive end-of-life medical care; and
   (c) that meets other requirements for an exemption as designated by administrative rule.

Amended by Chapter 349, 2019 General Session

26-21-8 License required -- Not assignable or transferable -- Posting -- Expiration and renewal -- Time for compliance by operating facilities.

(1) A person or governmental unit acting severally or jointly with any other person or governmental unit, may not establish, conduct, or maintain a health care facility in this state without receiving a license from the department as provided by this chapter and the rules adopted pursuant to this chapter.

(b) This Subsection (1) does not apply to facilities that are exempt under Section 26-21-7.

(2) A license issued under this chapter is not assignable or transferable.

(3) The current license shall at all times be posted in each health care facility in a place readily visible and accessible to the public.

(4) The department may issue a license for a period of time not to exceed 12 months from the date of issuance for an abortion clinic and not to exceed 24 months from the date of issuance for other health care facilities that meet the provisions of this chapter and department rules adopted pursuant to this chapter.

(b) Each license expires at midnight on the day designated on the license as the expiration date, unless previously revoked by the department.

(c) The license shall be renewed upon completion of the application requirements, unless the department finds the health care facility has not complied with the provisions of this chapter or the rules adopted pursuant to this chapter.

(5) A license may be issued under this section only for the operation of a specific facility at a specific site by a specific person.

(6) Any health care facility in operation at the time of adoption of any applicable rules as provided under this chapter shall be given a reasonable time for compliance as determined by the committee.

Amended by Chapter 74, 2016 General Session

26-21-9 Application for license -- Information required -- Public records.

(1) An application for license shall be made to the department in a form prescribed by the department. The application and other documentation requested by the department as part of
the application process shall require such information as the committee determines necessary
to ensure compliance with established rules.

(2) Information received by the department in reports and inspections shall be public records,
except the information may not be disclosed if it directly or indirectly identifies any individual
other than the owner or operator of a health facility (unless disclosure is required by law) or if its
disclosure would otherwise constitute an unwarranted invasion of personal privacy.

(3) Information received by the department from a health care facility, pertaining to that facility's
accreditation by a voluntary accrediting organization, shall be private data except for a
summary prepared by the department related to licensure standards.

Amended by Chapter 297, 2011 General Session

26-21-11 Violations -- Denial or revocation of license -- Restricting or prohibiting new
admissions -- Monitor.
    If the department finds a violation of this chapter or any rules adopted pursuant to this chapter
the department may take one or more of the following actions:
    (1) serve a written statement of violation requiring corrective action, which shall include time
        frames for correction of all violations;
    (2) deny or revoke a license if it finds:
        (a) there has been a failure to comply with the rules established pursuant to this chapter;
        (b) evidence of aiding, abetting, or permitting the commission of any illegal act; or
        (c) conduct adverse to the public health, morals, welfare, and safety of the people of the state;
    (3) restrict or prohibit new admissions to a health care facility or revoke the license of a health care
        facility for:
        (a) violation of any rule adopted under this chapter; or
        (b) permitting, aiding, or abetting the commission of any illegal act in the health care facility;
    (4) place a department representative as a monitor in the facility until corrective action is
        completed;
    (5) assess to the facility the cost incurred by the department in placing a monitor;
    (6) assess an administrative penalty as allowed by Subsection 26-23-6(1)(a); or
    (7) issue a cease and desist order to the facility.

Amended by Chapter 209, 1997 General Session

26-21-11.1 Failure to follow certain health care claims practices -- Penalties.
    (1) The department may assess a fine of up to $500 per violation against a health care facility that
violates Section 31A-26-313.
    (2) The department shall waive the fine described in Subsection (1) if:
        (a) the health care facility demonstrates to the department that the health care facility mitigated
            and reversed any damage to the insured caused by the health care facility or third party's
            violation; or
        (b) the insured does not pay the full amount due on the bill that is the subject of the violation,
            including any interest, fees, costs, and expenses, within 120 days after the day on which
            the health care facility or third party makes a report to a credit bureau or takes an action in
            violation of Section 31A-26-313.

Amended by Chapter 203, 2018 General Session
26-21-12 Issuance of new license after revocation -- Restoration.

(1) If a license is revoked, the department may issue a new license only after it determines by inspection that the facility has corrected the conditions that were the basis of revocation and that the facility complies with all provisions of this chapter and applicable rules.

(2) If the department does not renew a license because of noncompliance with the provisions of this chapter or the rules adopted under this chapter, the department may issue a new license only after the facility complies with all renewal requirements and the department determines that the interests of the public will not be jeopardized.

Amended by Chapter 209, 1997 General Session

26-21-13 License issued to facility in compliance or substantial compliance with chapter and rules.

(1) The department shall issue a standard license for a health care facility which is found to be in compliance with the provisions of this chapter and with all applicable rules adopted by the committee.

(2) The department may issue a provisional or conditional license for a health care facility which is in substantial compliance if the interests of the public will not be jeopardized.

Amended by Chapter 114, 1990 General Session

26-21-13.5 Intermediate care facilities for people with an intellectual disability -- Licensing.

(1) It is the Legislature's intent that a person with a developmental disability be provided with an environment and surrounding that, as closely as possible, resembles small community-based, homelike settings, to allow those persons to have the opportunity, to the maximum extent feasible, to exercise their full rights and responsibilities as citizens.

(b) It is the Legislature's purpose, in enacting this section, to provide assistance and opportunities to enable a person with a developmental disability to achieve the person's maximum potential through increased independence, productivity, and integration into the community.

(2) After July 1, 1990, the department may only license intermediate care beds for people with an intellectual disability in small health care facilities.

(3) The department may define by rule "small health care facility" for purposes of licensure under this section and adopt rules necessary to carry out the requirements and purposes of this section.

(4) This section does not apply to the renewal of a license or the licensure to a new owner of any facility that was licensed on or before July 1, 1990, and that licensure has been maintained without interruption.

Amended by Chapter 366, 2011 General Session

26-21-13.6 Rural hospital -- Optional service designation.

(1) The Legislature finds that:

(a) the rural citizens of this state need access to hospitals and primary care clinics;

(b) financial stability of remote-rural hospitals and their integration into remote-rural delivery networks is critical to ensure the continued viability of remote-rural health care; and

(c) administrative simplicity is essential for providing large benefits to small-scale remote-rural providers who have limited time and resources.
(2) After July 1, 1995, the department may grant variances to remote-rural acute care hospitals for specific services currently required for licensure under general hospital standards established by department rule.

(3) For purposes of this section, "remote-rural hospitals" are hospitals that are in a county with less than 20 people per square mile.

Enacted by Chapter 321, 1995 General Session

26-21-14 Closing facility -- Appeal.
(1) If the department finds a condition in any licensed health care facility that is a clear hazard to the public health, the department may immediately order that facility closed and may prevent the entrance of any resident or patient onto the premises of that facility until the condition is eliminated.

(2) Parties aggrieved by the actions of the department under this section may obtain an adjudicative proceeding and judicial review.

Amended by Chapter 114, 1990 General Session

26-21-15 Action by department for injunction.
Notwithstanding the existence of any other remedy, the department may, in the manner provided by law, upon the advice of the attorney general, who shall represent the department in the proceedings, maintain an action in the name of the state for injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, management, or operation of a health care facility which is in violation of this chapter or rules adopted by the committee.

Amended by Chapter 114, 1990 General Session

26-21-16 Operating facility in violation of chapter a misdemeanor.
In addition to the penalties in Section 26-23-6, any person owning, establishing, conducting, maintaining, managing, or operating a health care facility in violation of this chapter is guilty of a class A misdemeanor.

Amended by Chapter 347, 2009 General Session

26-21-17 Department agency of state to contract for certification of facilities under Social Security Act.
The department is the sole agency of the state authorized to enter into a contract with the United States government for the certification of health care facilities under Title XVIII and Title XIX of the Social Security Act, and any amendments thereto.

Amended by Chapter 114, 1990 General Session

26-21-19 Life and Health Insurance Guaranty Association Act not amended.
The provisions of this chapter do not amend, affect, or alter the provisions of Title 31A, Chapter 28, Guaranty Associations.

Amended by Chapter 242, 1985 General Session
26-21-20 Requirement for hospitals to provide statements of itemized charges to patients.
(1) For purposes of this section, "hospital" includes:
   (a) an ambulatory surgical facility;
   (b) a general acute hospital; and
   (c) a specialty hospital.
(2) A hospital shall provide a statement of itemized charges to any patient receiving medical care
or other services from that hospital.
(3)
   (a) The statement shall be provided to the patient or the patient's personal representative or
       agent at the hospital's expense, personally, by mail, or by verifiable electronic delivery after
       the hospital receives an explanation of benefits from a third party payer which indicates the
       patient's remaining responsibility for the hospital charges.
   (b) If the statement is not provided to a third party, it shall be provided to the patient as soon as
       possible and practicable.
(4) The statement required by this section:
   (a) shall itemize each of the charges actually provided by the hospital to the patient;
   (b)  
       (i) shall include the words in bold "THIS IS THE BALANCE DUE AFTER PAYMENT FROM
           YOUR HEALTH INSURER"; or
       (ii) shall include other appropriate language if the statement is sent to the patient under
           Subsection (3)(b); and
   (c) may not include charges of physicians who bill separately.
(5) The requirements of this section do not apply to patients who receive services from a hospital
under Title XIX of the Social Security Act.
(6) Nothing in this section prohibits a hospital from sending an itemized billing statement to a
patient before the hospital has received an explanation of benefits from an insurer. If a hospital
provides a statement of itemized charges to a patient prior to receiving the explanation of
benefits from an insurer, the itemized statement shall be marked in bold: "DUPLICATE: DO
NOT PAY" or other appropriate language.

Amended by Chapter 11, 2009 General Session

26-21-21 Authentication of medical records.
Any entry in a medical record compiled or maintained by a health care facility may be
authenticated by identifying the author of the entry by:
(1) a signature including first initial, last name, and discipline; or
(2) the use of a computer identification process unique to the author that definitively identifies the
author.

Enacted by Chapter 31, 1992 General Session

26-21-22 Reporting of disciplinary information -- Immunity from liability.
A health care facility licensed under this chapter which reports disciplinary information on a
licensed nurse to the Division of Occupational and Professional Licensing within the Department of
Commerce as required by Section 58-31b-702 is entitled to the immunity from liability provided by
that section.
26-21-23 Licensing of a new nursing care facility -- Approval for a licensed bed in an existing nursing care facility -- Fine for excess Medicare inpatient revenue.

(1) Notwithstanding Section 26-21-2, as used in this section:
(a) "Medicaid" means the Medicaid program, as that term is defined in Section 26-18-2.
(b) "Medicaid certification" means the same as that term is defined in Section 26-18-501.
(c) "Nursing care facility" and "small health care facility":
   (i) mean the following facilities licensed by the department under this chapter:
      (A) a skilled nursing facility;
      (B) an intermediate care facility; or
      (C) a small health care facility with four to 16 beds functioning as a skilled nursing facility; and
   (ii) do not mean:
      (A) an intermediate care facility for the intellectually disabled;
      (B) a critical access hospital that meets the criteria of 42 U.S.C. 1395i-4(c)(2) (1998);
      (C) a small health care facility that is hospital based; or
      (D) a small health care facility other than a skilled nursing care facility with no more than 16 beds.
   (d) "Rural county" means the same as that term is defined in Section 26-18-501.

(2) Except as provided in Subsection (6) and Section 26-21-28, a new nursing care facility shall be approved for a health facility license only if:
(a) under the provisions of Section 26-18-503 the facility's nursing care facility program has received Medicaid certification or will receive Medicaid certification for each bed in the facility;
(b) the facility's nursing care facility program has received or will receive approval for Medicaid certification under Subsection 26-18-503(5), if the facility is located in a rural county; or
(c) (i) the applicant submits to the department the information described in Subsection (3); and
(ii) based on that information, and in accordance with Subsection (4), the department determines that approval of the license best meets the needs of the current and future patients of nursing care facilities within the area impacted by the new facility.

(3) A new nursing care facility seeking licensure under Subsection (2) shall submit to the department the following information:
(a) proof of the following as reasonable evidence that bed capacity provided by nursing care facilities within the county or group of counties that would be impacted by the facility is insufficient:
   (i) nursing care facility occupancy within the county or group of counties:
      (A) has been at least 75% during each of the past two years for all existing facilities combined; and
      (B) is projected to be at least 75% for all nursing care facilities combined that have been approved for licensure but are not yet operational;
   (ii) there is no other nursing care facility within a 35-mile radius of the new nursing care facility seeking licensure under Subsection (2); and
(b) a feasibility study that:
   (i) shows the facility's annual Medicare inpatient revenue, including Medicare Advantage revenue, will not exceed 49% of the facility's annual total revenue during each of the first three years of operation;
   (ii) shows the facility will be financially viable if the annual occupancy rate is at least 88%;
(iii) shows the facility will be able to achieve financial viability;
(iv) shows the facility will not:
   (A) have an adverse impact on existing or proposed nursing care facilities within the county or group of counties that would be impacted by the facility; or
   (B) be within a three-mile radius of an existing nursing care facility or a new nursing care facility that has been approved for licensure but is not yet operational;
(v) is based on reasonable and verifiable demographic and economic assumptions;
(vi) is based on data consistent with department or other publicly available data; and
(vii) is based on existing sources of revenue.
(4) When determining under Subsection (2)(c) whether approval of a license for a new nursing care facility best meets the needs of the current and future patients of nursing care facilities within the area impacted by the new facility, the department shall consider:
   (a) whether the county or group of counties that would be impacted by the facility is underserved by specialized or unique services that would be provided by the facility; and
   (b) how additional bed capacity should be added to the long-term care delivery system to best meet the needs of current and future nursing care facility patients within the impacted area.
(5) The department may approve the addition of a licensed bed in an existing nursing care facility only if:
   (a) each time the facility seeks approval for the addition of a licensed bed, the facility satisfies each requirement for licensure of a new nursing care facility in Subsections (2)(c), (3), and (4); or
   (b) the bed has been approved for Medicaid certification under Section 26-18-503 or 26-18-505.
(6) Subsection (2) does not apply to a nursing care facility that:
   (a) has, by the effective date of this act, submitted to the department schematic drawings, and paid applicable fees, for a particular site or a site within a three-mile radius of that site;
   (b) before July 1, 2016:
      (i) filed an application with the department for licensure under this section and paid all related fees due to the department; and
      (ii) submitted to the department architectural plans and specifications, as defined by the department by administrative rule, for the facility;
   (c) applies for a license within three years of closing for renovation;
   (d) replaces a nursing care facility that:
      (i) closed within the past three years; or
      (ii) is located within five miles of the facility;
   (e) is undergoing a change of ownership, even if a government entity designates the facility as a new nursing care facility; or
   (f) is a state-owned veterans home, regardless of who operates the home.
(7)
   (a) For each year the annual Medicare inpatient revenue, including Medicare Advantage revenue, of a nursing care facility approved for a health facility license under Subsection (2) exceeds 49% of the facility's total revenue for the year, the facility shall be subject to a fine of $50,000, payable to the department.
   (b) A nursing care facility approved for a health facility license under Subsection (2)(c) shall submit to the department the information necessary for the department to annually determine whether the facility is subject to the fine in Subsection (7)(a).
   (c) The department:
(i) shall make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specifying the information a nursing care facility shall submit to the department under Subsection (7)(b);  
(ii) shall annually determine whether a facility is subject to the fine in Subsection (7)(a);  
(iii) may take one or more of the actions in Section 26-21-11 or 26-23-6 against a facility for nonpayment of a fine due under Subsection (7)(a); and  
(iv) shall deposit fines paid to the department under Subsection (7)(a) into the Nursing Care Facilities Provider Assessment Fund, created by Section 26-35a-106.

Amended by Chapter 443, 2017 General Session

26-21-24 Prohibition against bed banking by nursing care facilities for Medicaid reimbursement.

(1) For purposes of this section:  
(a) "bed banking" means the designation of a nursing care facility bed as not part of the facility's operational bed capacity; and  
(b) "nursing care facility" is as defined in Subsection 26-21-23(1).

(2) Beginning July 1, 2008, the department shall, for purposes of Medicaid reimbursement under Chapter 18, Part 1, Medical Assistance Programs, prohibit the banking of nursing care facility beds.

Enacted by Chapter 347, 2008 General Session

26-21-25 Patient identity protection.

(1) As used in this section:  
(a) "EMTALA" means the federal Emergency Medical Treatment and Active Labor Act.  
(b) "Health professional office" means:  
(i) a physician's office; or  
(ii) a dental office.  
(c) "Medical facility" means:  
(i) a general acute hospital;  
(ii) a specialty hospital;  
(iii) a home health agency;  
(iv) a hospice;  
(v) a nursing care facility;  
(vi) a residential-assisted living facility;  
(vii) a birthing center;  
(viii) an ambulatory surgical facility;  
(ix) a small health care facility;  
(x) an abortion clinic;  
(xi) a facility owned or operated by a health maintenance organization;  
(xii) an end stage renal disease facility;  
(xiii) a health care clinic; or  
(xiv) any other health care facility that the committee designates by rule.

(2)  
(a) In order to discourage identity theft and health insurance fraud, and to reduce the risk of medical errors caused by incorrect medical records, a medical facility or a health professional
office shall request identification from an individual prior to providing in-patient or out-patient services to the individual.

(b) If the individual who will receive services from the medical facility or a health professional office lacks the legal capacity to consent to treatment, the medical facility or a health professional office shall request identification:

(i) for the individual who lacks the legal capacity to consent to treatment; and

(ii) from the individual who consents to treatment on behalf of the individual described in Subsection (2)(b)(i).

(3) A medical facility or a health professional office:

(a) that is subject to EMTALA:

(i) may not refuse services to an individual on the basis that the individual did not provide identification when requested; and

(ii) shall post notice in its emergency department that informs a patient of the patient's right to treatment for an emergency medical condition under EMTALA;

(b) may not be penalized for failing to ask for identification;

(c) is not subject to a private right of action for failing to ask for identification; and

(d) may document or confirm patient identity by:

(i) photograph;

(ii) fingerprinting;

(iii) palm scan; or

(iv) other reasonable means.

(4) The identification described in this section:

(a) is intended to be used for medical records purposes only; and

(b) shall be kept in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996.

Amended by Chapter 218, 2010 General Session

26-21-26 General acute hospital to report prescribed controlled substance poisoning or overdose.

(1) If a person who is 12 years of age or older is admitted to a general acute hospital for poisoning or overdose involving a prescribed controlled substance, the general acute hospital shall, within three business days after the day on which the person is admitted, send a written report to the Division of Occupational and Professional Licensing, created in Section 58-1-103, that includes:

(a) the patient's name and date of birth;

(b) each drug or other substance found in the person's system that may have contributed to the poisoning or overdose, if known;

(c) the name of each person who the general acute hospital has reason to believe may have prescribed a controlled substance described in Subsection (1)(b) to the person, if known; and

(d) the name of the hospital and the date of admission.

(2) Nothing in this section may be construed as creating a new cause of action.

Amended by Chapter 99, 2016 General Session

26-21-27 Consumer access to health care facility charges.

Beginning January 1, 2011, a health care facility licensed under this chapter shall, when requested by a consumer:
(1) make a list of prices charged by the facility available for the consumer that includes the facility's:
   (a) in-patient procedures;
   (b) out-patient procedures;
   (c) the 50 most commonly prescribed drugs in the facility;
   (d) imaging services; and
   (e) implants; and
(2) provide the consumer with information regarding any discounts the facility provides for:
   (a) charges for services not covered by insurance; or
   (b) prompt payment of billed charges.

Enacted by Chapter 68, 2010 General Session

26-21-28 Pilot program for managed care model with a small health care facility operating as a skilled nursing facility.
(1) Notwithstanding the requirement for Medicaid certification under Chapter 18, Part 5, Long Term Care Facility - Medicaid Certification, and Section 26-21-23, a small health care facility with four to 16 beds, functioning as a skilled nursing facility, may be approved for licensing by the department as a pilot program in accordance with this section, and without obtaining Medicaid certification for the beds in the facility.
(2)
   (a) The department shall establish one pilot program with a facility that meets the qualifications under Subsection (3). The purpose of the pilot program is to study the impact of an integrated managed care model on cost and quality of care involving pre- and post-surgical services offered by a small health care facility operating as a skilled nursing facility.
   (b) The small health care facility that is operating as a skilled nursing facility and is participating in the pilot program, shall, on or before November 30, 2020, issue a report to the Legislative Health and Human Services Interim Committee on patient outcomes and cost of care associated with the pilot program.
(3) A small health care facility with four to 16 beds that functions as a skilled nursing facility may apply for a license under the pilot program if the facility will:
   (a) be located in:
      (i) a county of the second class that has at least 1,800 square miles within the county; and
      (ii) a city of the fifth class; and
   (b) limit a patient's stay in the facility to no more than 10 days.

Enacted by Chapter 357, 2016 General Session

26-21-29 Birthing centers -- Regulatory restrictions.
(1) For purposes of this section:
   (a) "Certified nurse midwife" means an individual who is licensed under Title 58, Chapter 44a, Nurse Midwife Practice Act.
   (b) "Direct-entry midwife" means an individual who is licensed under Title 58, Chapter 77, Direct-Entry Midwife Act.
   (c) "Licensed maternity care practitioner" includes:
      (i) a physician;
      (ii) a certified nurse midwife;
      (iii) a direct entry midwife;
(iv) a naturopathic physician; and
(v) other individuals who are licensed under Title 58, Occupations and Professions and whose scope of practice includes midwifery or obstetric care.
(d) "Naturopathic physician" means an individual who is licensed under Title 58, Chapter 71, Naturopathic Physician Practice Act.
(e) "Physician" means an individual who is licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

(2) The Health Facility Committee and the department may not require a birthing center or a licensed maternity care practitioner who practices at a birthing center to:
(a) maintain admitting privileges at a general acute hospital;
(b) maintain a written transfer agreement with one or more general acute hospitals;
(c) maintain a collaborative practice agreement with a physician; or
(d) have a physician or certified nurse midwife present at each birth when another licensed maternity care practitioner is present at the birth and remains until the maternal patient and newborn are stable postpartum.

(3) The Health Facility Committee and the department shall:
(a) permit all types of licensed maternity care practitioners to practice in a birthing center; and
(b) except as provided in Subsection (2)(b), require a birthing center to have a written plan for the transfer of a patient to a hospital in accordance with Subsection (4).

(4) A transfer plan under Subsection (3)(b) shall:
(a) be signed by the patient; and
(b) indicate that the plan is not an agreement with a hospital.

(5) If a birthing center transfers a patient to a licensed maternity care practitioner or facility, the responsibility of the licensed maternity care practitioner or facility, for the patient:
(a) does not begin until the patient is physically within the care of the licensed maternity care practitioner or facility;
(b) is limited to the examination and care provided after the patient is transferred to the licensed maternity care practitioner or facility; and
(c) does not include responsibility or accountability for the patient’s decision to pursue an out-of-hospital birth and the services of a birthing center.

(6)
(a) Except as provided in Subsection (6)(c), a licensed maternity care practitioner who is not practicing at a birthing center may, upon receiving a briefing from a member of a birthing center’s clinical staff, issue a medical order for the birthing center’s patient without assuming liability for the care of the patient for whom the order was issued.
(b) Regardless of the advice given or order issued under Subsection (6)(a), the responsibility and liability for caring for the patient is that of the birthing center and the birthing center’s clinical staff.
(c) The licensed maternity care practitioner giving the order under Subsection (6)(a) is responsible and liable only for the appropriateness of the order, based on the briefing received under Subsection (6)(a).

(7) The department shall hold a public hearing under Subsection 63G-3-302(2)(a) for a proposed administrative rule, and amendment to a rule, or repeal of a rule, that relates to birthing centers.

Enacted by Chapter 73, 2016 General Session

26-21-30 Disposal of controlled substances at nursing care facilities.
(1) As used in this section:
(a) "Controlled substance" means the same as that term is defined in Section 58-37-2.

(b) (i) "Irretrievable" means a state in which the physical or chemical condition of a controlled substance is permanently altered through irreversible means so that the controlled substance is unavailable and unusable for all practical purposes.

   (ii) A controlled substance is irretrievable if the controlled substance is non-retrievable as that term is defined in 21 C.F.R. Sec. 1300.05.

(2) A nursing care facility that is in lawful possession of a controlled substance in the nursing care facility’s inventory that desires to dispose of the controlled substance shall dispose of the controlled substance in a manner that:

   (a) renders the controlled substance irretrievable; and

   (b) complies with all applicable federal and state requirements for the disposal of a controlled substance.

(3) A nursing care facility shall:

   (a) develop a written plan for the disposal of a controlled substance in accordance with this section; and

   (b) make the plan described in Subsection (3)(a) available to the department and the committee for inspection.

Enacted by Chapter 157, 2018 General Session

26-21-31 Prohibition on certain age-based physician testing.

A health care facility may not require for purposes of employment, privileges, or reimbursement, that a physician, as defined in Section 58-67-102, take a cognitive test when the physician reaches a specified age, unless the test reflects the standards described in Subsections 58-67-302(5)(b)(i) through (x).

Amended by Chapter 445, 2019 General Session

26-21-32 Notification of air ambulance policies and charges.

(1) For any patient who is in need of air medical transport provider services, a health care facility shall:

   (a) provide the patient or the patient's representative with the information described in Subsection 26-8a-107(7)(a) before contacting an air medical transport provider; and

   (b) if multiple air medical transport providers are capable of providing the patient with services, provide the patient or the patient's representative with an opportunity to choose the air medical transport provider.

(2) Subsection (1) does not apply if the patient:

   (a) is unconscious and the patient's representative is not physically present with the patient; or

   (b) is unable, due to a medical condition, to make an informed decision about the choice of an air medical transport provider, and the patient's representative is not physically present with the patient.

Enacted by Chapter 262, 2019 General Session

26-21-100 Reserved.

Reserved
Part 2
Clearance for Direct Patient Access

26-21-201 Definitions.

As used in this part:
(1) "Clearance" means approval by the department under Section 26-21-203 for an individual to have direct patient access.
(2) "Covered body" means a covered provider, covered contractor, or covered employer.
(3) "Covered contractor" means a person that supplies covered individuals, by contract, to a covered employer or covered provider.
(4) "Covered employer" means an individual who:
   (a) engages a covered individual to provide services in a private residence to:
      (i) an aged individual, as defined by department rule; or
      (ii) a disabled individual, as defined by department rule;
   (b) is not a covered provider; and
   (c) is not a licensed health care facility within the state.
(5) "Covered individual":
   (a) means an individual:
      (i) whom a covered body engages; and
      (ii) who may have direct patient access;
   (b) includes:
      (i) a nursing assistant, as defined by department rule;
      (ii) a personal care aide, as defined by department rule;
      (iii) an individual licensed to engage in the practice of nursing under Title 58, Chapter 31b, Nurse Practice Act;
      (iv) a provider of medical, therapeutic, or social services, including a provider of laboratory and radiology services;
      (v) an executive;
      (vi) administrative staff, including a manager or other administrator;
      (vii) dietary and food service staff;
      (viii) housekeeping and maintenance staff; and
      (ix) any other individual, as defined by department rule, who has direct patient access; and
   (c) does not include a student, as defined by department rule, directly supervised by a member of the staff of the covered body or the student’s instructor.
(6) "Covered provider" means:
   (a) an end stage renal disease facility;
   (b) a long-term care hospital;
   (c) a nursing care facility;
   (d) a small health care facility;
   (e) an assisted living facility;
   (f) a hospice;
   (g) a home health agency; or
   (h) a personal care agency.
(7) "Direct patient access" means for an individual to be in a position where the individual could, in relation to a patient or resident of the covered body who engages the individual:
   (a) cause physical or mental harm;
   (b) commit theft; or
   (c) view medical or financial records.

(8) "Engage" means to obtain one's services:
   (a) by employment;
   (b) by contract;
   (c) as a volunteer; or
   (d) by other arrangement.

(9) "Long-term care hospital":
   (a) means a hospital that is certified to provide long-term care services under the provisions of 42 U.S.C. Sec. 1395tt; and
   (b) does not include a critical access hospital, designated under 42 U.S.C. Sec. 1395i-4(c)(2).

(10) "Patient" means an individual who receives health care services from one of the following covered providers:
   (a) an end stage renal disease facility;
   (b) a long-term care hospital;
   (c) a hospice;
   (d) a home health agency; or
   (e) a personal care agency.

(11) "Personal care agency" means a health care facility defined by department rule.

(12) "Resident" means an individual who receives health care services from one of the following covered providers:
   (a) a nursing care facility;
   (b) a small health care facility;
   (c) an assisted living facility; or
   (d) a hospice that provides living quarters as part of its services.

(13) "Residential setting" means a place provided by a covered provider:
   (a) for residents to live as part of the services provided by the covered provider; and
   (b) where an individual who is not a resident also lives.

(14) "Volunteer" means an individual, as defined by department rule, who provides services without pay or other compensation.

Enacted by Chapter 328, 2012 General Session

26-21-202 Clearance required.
(1) A covered provider may engage a covered individual only if the individual has clearance.
(2) A covered contractor may supply a covered individual to a covered employer or covered provider only if the individual has clearance.
(3) A covered employer may engage a covered individual who does not have clearance.
(4)
   (a) Notwithstanding Subsections (1) and (2), if a covered individual does not have clearance, a covered provider may engage the individual or a covered contractor may supply the individual to a covered provider or covered employer:
      (i) under circumstances specified by department rule; and
      (ii) only while an application for clearance for the individual is pending.
(b) For purposes of Subsection (4)(a), an application is pending if the following have been submitted to the department for the individual:
   (i) an application for clearance;
   (ii) the personal identification information specified by the department under Subsection 26-21-204(4)(b); and
   (iii) any fees established by the department under Subsection 26-21-204(9).

Enacted by Chapter 328, 2012 General Session

26-21-203 Department authorized to grant, deny, or revoke clearance -- Department may limit direct patient access.
(1) As provided in Section 26-21-204, the department may grant, deny, or revoke clearance for an individual, including a covered individual.
(2) The department may limit the circumstances under which a covered individual granted clearance may have direct patient access, based on the relationship the factors under Subsection 26-21-204(4)(a) and other mitigating factors may have to patient and resident protection.

Enacted by Chapter 328, 2012 General Session

26-21-204 Clearance.
(1) The department shall determine whether to grant clearance for each applicant for whom it receives:
   (a) the personal identification information specified by the department under Subsection 26-21-204(4)(b); and
   (b) any fees established by the department under Subsection 26-21-204(9).
(2) The department shall establish a procedure for obtaining and evaluating relevant information concerning covered individuals, including fingerprinting the applicant and submitting the prints to the Criminal Investigations and Technical Services Division of the Department of Public Safety for checking against applicable state, regional, and national criminal records files.
(3) The department may review the following sources to determine whether an individual should be granted or retain clearance, which may include:
   (a) Department of Public Safety arrest, conviction, and disposition records described in Title 53, Chapter 10, Criminal Investigations and Technical Services Act, including information in state, regional, and national records files;
   (b) juvenile court arrest, adjudication, and disposition records, as allowed under Section 78A-6-209;
   (c) federal criminal background databases available to the state;
   (d) the Department of Human Services' Division of Child and Family Services Licensing Information System described in Section 62A-4a-1006;
   (e) child abuse or neglect findings described in Section 78A-6-323;
   (f) the Department of Human Services' Division of Aging and Adult Services vulnerable adult abuse, neglect, or exploitation database described in Section 62A-3-311.1;
   (g) registries of nurse aids described in 42 C.F.R. Sec. 483.156;
   (h) licensing and certification records of individuals licensed or certified by the Division of Occupational and Professional Licensing under Title 58, Occupations and Professions; and
   (i) the List of Excluded Individuals and Entities database maintained by the United States Department of Health and Human Services’ Office of Inspector General.
(4) The department shall adopt rules that:
(a) specify the criteria the department will use to determine whether an individual is granted or
retains clearance:
(i) based on an initial evaluation and ongoing review of information under Subsection (3); and
(ii) including consideration of the relationship the following may have to patient and resident
protection:
(A) warrants for arrest;
(B) arrests;
(C) convictions, including pleas in abeyance;
(D) pending diversion agreements;
(E) adjudications by a juvenile court of committing an act that if committed by an adult
would be a felony or misdemeanor, if the individual is over 28 years of age and has
been convicted, has pleaded no contest, or is subject to a plea in abeyance or diversion
agreement for a felony or misdemeanor, or the individual is under 28 years of age; and
(F) any other findings under Subsection (3); and
(b) specify the personal identification information that must be submitted by an individual or
covered body with an application for clearance, including:
(i) the applicant's Social Security number; and
(ii) fingerprints.
(5) For purposes of Subsection (4)(a), the department shall classify a crime committed in another
state according to the closest matching crime under Utah law, regardless of how the crime is
classified in the state where the crime was committed.
(6) The Department of Public Safety, the Administrative Office of the Courts, the Department of
Human Services, the Division of Occupational and Professional Licensing, and any other state
agency or political subdivision of the state:
(a) shall allow the department to review the information the department may review under
Subsection (3); and
(b) except for the Department of Public Safety, may not charge the department for access to the
information.
(7) The department shall adopt measures to protect the security of the information it reviews under
Subsection (3) and strictly limit access to the information to department employees responsible
for processing an application for clearance.
(8) The department may disclose personal identification information specified under Subsection
(4)(b) to the Department of Human Services to verify that the subject of the information is not
identified as a perpetrator or offender in the information sources described in Subsections (3)(d)
through (f).
(9) The department may establish fees, in accordance with Section 63J-1-504, for an application
for clearance, which may include:
(a) the cost of obtaining and reviewing information under Subsection (3);
(b) a portion of the cost of creating and maintaining the Direct Access Clearance System
database under Section 26-21-209; and
(c) other department costs related to the processing of the application and the ongoing review of
information pursuant to Subsection (4)(a) to determine whether clearance should be retained.

Amended by Chapter 47, 2018 General Session

26-21-205 Department of Public Safety -- Retention of information -- Notification of
Department of Health.
The Criminal Investigations and Technical Services Division within the Department of Public Safety shall:
(1) retain, separate from other division records, personal information, including any fingerprints, sent to it by the Department of Health pursuant to Subsection 26-21-204(3)(a); and
(2) notify the Department of Health upon receiving notice that an individual for whom personal information has been retained is the subject of:
(a) a warrant for arrest;
(b) an arrest;
(c) a conviction, including a plea in abeyance; or
(d) a pending diversion agreement.

Enacted by Chapter 328, 2012 General Session

26-21-206 Covered providers and covered contractors required to apply for clearance of certain individuals.
(1) As provided in Subsection (2), each covered provider and covered contractor operating in this state shall:
(a) collect from each covered individual it engages, and each individual it intends to engage as a covered individual, the personal identification information specified by the department under Subsection 26-21-204(4)(b); and
(b) submit to the department an application for clearance for the individual, including:
   (i) the personal identification information; and
   (ii) any fees established by the department under Subsection 26-21-204(9).
(2) Clearance granted for an individual pursuant to an application submitted by a covered provider or a covered contractor is valid until the later of:
(a) two years after the individual is no longer engaged as a covered individual; or
(b) the covered provider's or covered contractor's next license renewal date.

Enacted by Chapter 328, 2012 General Session

26-21-207 Covered providers required to apply for clearance for certain individuals other than residents residing in residential settings -- Certain individuals other than residents prohibited from residing in residential settings without clearance.
(1) A covered provider that provides services in a residential setting shall:
   (a) collect the personal identification information specified by the department under Subsection 26-21-204(4)(b) for each individual 12 years of age or older, other than a resident, who resides in the residential setting; and
   (b) submit to the department an application for clearance for the individual, including:
      (i) the personal identification information; and
      (ii) any fees established by the department under Subsection 26-21-204(9).
(2) A covered provider that provides services in a residential setting may allow an individual 12 years of age or older, other than a resident, to reside in the residential setting only if the individual has clearance.

Enacted by Chapter 328, 2012 General Session

26-21-208 Application for clearance by individuals.
(1) An individual may apply for clearance by submitting to the department an application, including:
(a) the personal identification information specified by the department under Subsection 26-21-204(4)(b); and
(b) any fees established by the department under Subsection 26-21-204(9).

(2) Clearance granted to an individual who makes application under Subsection (1) is valid for two years unless the department determines otherwise based on its ongoing review under Subsection 26-21-204(4)(a).

Enacted by Chapter 328, 2012 General Session

26-21-209 Direct Access Clearance System database -- Contents -- Use.

(1) The department shall create and maintain a Direct Access Clearance System database, which:
(a) includes the names of individuals for whom the department has received:
   (i) an application for clearance under this part; or
   (ii) an application for background clearance under Section 26-8a-310; and
(b) indicates whether an application is pending and whether clearance has been granted and retained for:
   (i) an applicant under this part; and
   (ii) an applicant for background clearance under Section 26-8a-310.

(2)
(a) The department shall allow covered providers and covered contractors to access the database electronically.
(b) Data accessible to a covered provider or covered contractor is limited to the information under Subsections (1)(a)(i) and (1)(b)(i) for:
   (i) covered individuals engaged by the covered provider or covered contractor; and
   (ii) individuals:
      (A) whom the covered provider or covered contractor could engage as covered individuals; and
      (B) who have provided the covered provider or covered contractor with sufficient personal identification information to uniquely identify the individual in the database.

(c)
(i) The department may establish fees, in accordance with Section 63J-1-504, for use of the database by a covered contractor.
(ii) The fees may include, in addition to any fees established by the department under Subsection 26-21-204(9), an initial set-up fee, an ongoing access fee, and a per-use fee.

Amended by Chapter 307, 2015 General Session

26-21-210 No civil liability.

A covered body is not civilly liable for submitting to the department information required under this part or refusing to employ an individual who does not have clearance to have direct patient access under Section 26-21-203.

Enacted by Chapter 328, 2012 General Session

Part 3
Assisted Living Facilities
26-21-301 Title.
This part is known as "Assisted Living Facilities."

Amended by Chapter 220, 2018 General Session

26-21-302 Definitions.
As used in this part:
(1) "Facility" means an assisted living facility.
(2) "Legal representative" means an individual who is legally authorized to make health care decisions on behalf of another individual.
(3) (a) "Monitoring device" means:
(i) a video surveillance camera; or
(ii) a microphone or other device that captures audio.
(b) "Monitoring device" does not include:
(i) a device that is specifically intended to intercept wire, electronic, or oral communication without notice to or the consent of a party to the communication; or
(ii) a device that is connected to the Internet or that is set up to transmit data via an electronic communication.
(4) "Ombudsman" means the same as that term is defined in Section 62A-3-202.
(5) "Resident" means an individual who receives health care from a facility.
(6) "Responsible person" means an individual who:
(a) is designated in writing by a resident to receive communication on behalf of the resident; or
(b) a legal representative.
(7) "Room" means a resident's private or shared primary living space.
(8) "Roommate" means an individual sharing a room with a resident.

Amended by Chapter 220, 2018 General Session

26-21-303 Monitoring device -- Installation, notice, and consent -- Liability.
(1) A resident or the resident's legal representative may operate or install a monitoring device in the resident's room if the resident and the resident's legal representative, if any, unless the resident is incapable of informed consent:
(a) notifies the resident's facility in writing that the resident or the resident's legal representative, if any:
(i) intends to operate or install a monitoring device in the resident's room; and
(ii) consents to a waiver agreement, if required by a facility;
(b) obtains written consent from each of the resident's roommates, and their legal representative, if any, that specifically states the hours when each roommate consents to the resident or the resident's legal representative operating the monitoring device; and
(c) assumes all responsibility for any cost related to installing or operating the monitoring device.
(2) A facility shall not be civilly or criminally liable to:
(a) a resident or resident's roommate for the operation of a monitoring device consistent with this part; and
(b) any person other than the resident or resident's roommate for any claims related to the use or operation of a monitoring device consistent with this part, unless the claim is caused by the acts or omissions of an employee or agent of the facility.
(3) Notwithstanding any other provision of this part, an individual may not, under this part, operate
a monitoring device in a facility without a court order:
(a) in secret; or
(b) with an intent to intercept a wire, electronic, or oral communication without notice to or the
consent of a party to the communication.

Enacted by Chapter 141, 2016 General Session

26-21-304 Monitoring device -- Facility admission, patient discharge, and posted notice.
(1) A facility may not deny an individual admission to the facility for the sole reason that the
individual or the individual's legal representative requests to install or operate a monitoring
device in the individual's room.
(2) A facility may not discharge a resident for the sole reason that the resident or the resident's
legal representative requests to install or operate a monitoring device in the individual's room.
(3) A facility may require the resident or the resident's legal representative to place a sign near the
entrance of the resident's room that states that the room contains a monitoring device.

Enacted by Chapter 141, 2016 General Session

26-21-305 Transfer or discharge.
When a facility initiates the transfer or discharge of a resident, the facility shall:
(1) notify the resident and the resident's responsible person, if any, in writing and in a language
and a manner that is most likely to be understood by the resident and the resident's responsible
person, of:
(a) the reasons for the transfer or discharge;
(b) the effective date of the transfer or discharge;
(c) the location to which the resident will be transferred or discharged, if known; and
(d) the name, address, email, and telephone number of the ombudsman;
(2) send a copy, in English, of the notice described in Subsection (1)(a) to the ombudsman on the
same day on which the facility delivers the notice described in Subsection (1)(a) to the resident
and the resident's responsible person;
(3) provide the notice described in Subsection (1)(a) at least 30 days before the day on which the
resident is transferred or discharged, unless:
(a) notice for a shorter period of time is necessary to protect:
   (i) the safety of individuals in the facility from endangerment due to the medical or behavioral
       status of the resident; or
   (ii) the health of individuals in the facility from endangerment due to the resident's continued
       residency;
(b) an immediate transfer or discharge is required by the resident's urgent medical needs; or
(c) the resident has not resided in the facility for at least 30 days;
(4) update the transfer or discharge notice as soon as practicable before the transfer or discharge
   if information in the notice changes before the transfer or discharge;
(5) orally explain to the resident:
   (a) the services available through the ombudsman; and
   (b) the contact information for the ombudsman;
(6) provide and document the provision of preparation and orientation, in a language and manner
the resident is most likely to understand, for a resident to ensure a safe and orderly transfer or
discharge from the facility; and
(7) in the event of a facility closure, provide written notification of the closure to the ombudsman, each resident of the facility, and each resident's responsible person.

Enacted by Chapter 220, 2018 General Session