

Effective 5/3/2023

Part 2
Health Care Facility Licensing and Inspection

26B-2-201 Definitions.

As used in this part:

- (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 facility that:
 - (a) receives maternal clients and provides care during pregnancy, delivery, and immediately after delivery; and
 - (b)
 - (i) is freestanding; or
 - (ii) is not freestanding, but meets the requirements for an alongside midwifery unit described in Subsection 26B-2-228(7).
- (7) "Committee" means the Health Facility Committee created in Section 26B-1-204.
- (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 old 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.

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 - (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:
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 - (a) receives maternal clients and provides care during pregnancy, delivery, and immediately after delivery; and
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- (7) "Committee" means the Health Facility Committee created in Section 26B-1-204.
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- (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.
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- (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.
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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;
 - (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; and
 - (iv) provides physician assistant services.
- (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.
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- (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 old 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.
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 - (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 113, 2024 General Session

Amended by Chapter 240, 2024 General Session

26B-2-202 Duties of department.

- (1) The department shall:
 - (a) enforce rules established pursuant to this part;
 - (b) authorize an agent of the department to conduct inspections of health care facilities pursuant to this part;
 - (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 certification for direct patient access under Sections 26B-2-239 and 26B-2-240; 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 26B-2-240(6) and Subsection 26B-2-241(4) 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 part;
 - (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 part.

Amended by Chapter 240, 2024 General Session

26B-2-203 Services required -- General acute hospitals -- Specialty Hospitals.

- (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.
- (4) Beginning January 1, 2023, a hospice program shall provide at least one qualified medical provider, as that term is defined in Section 26B-4-201, for the treatment of hospice patients.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-204 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, and Title 76, Chapter 7a, Abortion Prohibition;
 - (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.

26B-2-204 Licensing of an abortion clinic -- Rulemaking authority -- Fee -- Licensing of a clinic meeting the definition of hospital.

- (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, and Title 76, Chapter 7a, Abortion Prohibition;
 - (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 240, 2024 General Session

26B-2-205 Exempt facilities.

This part 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.

26B-2-206 License required -- Not assignable or transferable -- Posting -- Expiration and renewal -- Time for compliance by operating facilities.

- (1)
 - (a) 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 part and the rules adopted pursuant to this part .
 - (b) This Subsection (1) does not apply to facilities that are exempt under Section 26B-2-205.
- (2) A license issued under this part 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)
 - (a) 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 part and department rules adopted pursuant to this part.
 - (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 part or the rules adopted pursuant to this part.
- (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 part shall be given a reasonable time for compliance as determined by the committee.

26B-2-207 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.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-212 Intermediate care facilities for people with an intellectual disability -- Licensing.

- (1)
 - (a) 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.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-213 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.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-217 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.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-218 Life and Health Insurance Guaranty Association Act not amended.

The provisions of this part do not amend, affect, or alter the provisions of Title 31A, Chapter 28, Guaranty Associations.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-219 Requirement for hospitals to provide statements of itemized charges to patients.

- (1) As used in 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.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-220 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.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-221 Reporting of disciplinary information -- Immunity from liability.

A health care facility licensed under this part which reports disciplinary information on a licensed nurse to the Division of 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.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-222 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 26B-2-201, as used in this section:

- (a) "Medicaid" means the Medicaid program, as that term is defined in Section 26B-3-101.
- (b) "Medicaid certification" means the same as that term is defined in Section 26B-3-301.
- (c) "Nursing care facility" and "small health care facility":

(i) mean the following facilities licensed by the department under this part:

- (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. Sec. 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 26B-3-301.

(2) Except as provided in Subsection (6) and Section 26B-2-227, a new nursing care facility shall be approved for a health facility license only if:

- (a) under the provisions of Section 26B-3-311 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 26B-3-311(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 26B-3-311 or 26B-3-313.
- (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)(c) 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 26B-2-202 or 26B-2-703 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 in Section 26B-3-405.

Amended by Chapter 267, 2024 General Session

26B-2-223 Prohibition against bed banking by nursing care facilities for Medicaid reimbursement.

- (1) As used in this section:
 - (a) "Bed banking" means the designation of a nursing care facility bed as not part of the facility's operational bed capacity.
 - (b) "Nursing care facility" means the same as that term is defined in Section 26B-2-222.
- (2) Beginning July 1, 2008, the department shall, for purposes of Medicaid reimbursement under Chapter 3, Part 1, Health Care Assistance, prohibit the banking of nursing care facility beds.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-224 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.

26B-2-225 General acute hospital to report prescribed controlled substance poisoning or overdose.

- (1) If a person who is 12 years old 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 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.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-226 Information regarding certain health care facility charges.

- A health care facility licensed under this part 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.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-227 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 Sections 26B-3-310 through 26B-3-313, and Section 26B-2-222, 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).
 - (b) The purpose of the pilot program described in Subsection (2)(a) 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.
- (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.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-228 Birthing centers -- Regulatory restrictions.

- (1) As used in this section:
 - (a) "Alongside midwifery unit" means a birthing center that meets the requirements described in Subsection (7).

- (b) "Certified nurse midwife" means an individual who is licensed under Title 58, Chapter 44a, Nurse Midwife Practice Act.
 - (c) "Direct-entry midwife" means an individual who is licensed under Title 58, Chapter 77, Direct-Entry Midwife Act.
 - (d) "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.
 - (e) "Naturopathic physician" means an individual who is licensed under Title 58, Chapter 71, Naturopathic Physician Practice Act.
 - (f) "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 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 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)
 - (a) A birthing center that is not freestanding may be licensed as an alongside midwifery unit if the birthing center:
 - (i) is accredited by the Commission on Accreditation of Birth Centers;
 - (ii) is connected to a hospital facility, either through a bridge, ramp, or adjacent to the labor and delivery unit within the hospital with care provided with the midwifery model of care, where maternal patients are received and care provided during labor, delivery, and immediately after delivery; and
 - (iii) is supervised by a clinical director who is licensed as a physician as defined in Section 58-67-102 or a certified nurse midwife under Title 58, Chapter 44a, Nurse Midwife Practice Act.
 - (b) An alongside midwifery unit shall have a transfer agreement in place with the adjoining hospital:
 - (i) to transfer a patient to the adjacent hospital's labor and delivery unit if a higher level of care is needed; and
 - (ii) for services that are provided by the adjacent hospital's staff in collaboration with the alongside midwifery unit staff.
 - (c) An alongside midwifery unit may:
 - (i) contract with staff from the adjoining hospital to assist with newborn care or resuscitation of a patient in an emergency; and
 - (ii) integrate the alongside midwifery unit's medical records with the medical record system utilized by the adjoining hospital.
 - (d) Notwithstanding Title 58, Chapter 77, Direct-Entry Midwife Act, licensure as a direct-entry midwife under Section 58-77-301 is not sufficient to practice as a licensed maternity care practitioner in an alongside midwifery unit.
- (8) 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.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-229 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.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-230 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).

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-231 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 following information before contacting an air medical transport provider:
 - (i) which health insurers in the state the air medical transport provider contracts with;
 - (ii) if sufficient data is available, the average charge for air medical transport services for a patient who is uninsured or out of network; and
 - (iii) whether the air medical transport provider balance bills a patient for any charge not paid by the patient's health insurer; 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.

Amended by Chapter 5, 2024 Special Session 3

26B-2-232 Treatment of aborted remains.

(1) As used in this section, "aborted fetus" means a product of human conception, regardless of gestational age, that has died from an abortion as that term is defined in Section 76-7-301.

(2)

- (a) A health care facility having possession of an aborted fetus shall provide for the final disposition of the aborted fetus through:
 - (i) cremation as that term is defined in Section 58-9-102; or
 - (ii) interment.
- (b) A health care facility may not conduct the final disposition of an aborted fetus less than 72 hours after an abortion is performed unless:

- (i) the pregnant woman authorizes the health care facility, in writing, to conduct the final disposition of the aborted fetus less than 72 hours after the abortion is performed; or
 - (ii) immediate disposition is required under state or federal law.
 - (c) A health care facility may serve as an authorizing agent as defined in Section 58-9-102 with respect to the final disposition of an aborted fetus if:
 - (i) the pregnant woman provides written authorization for the health care facility to act as the authorizing agent; or
 - (ii)
 - (A) more than 72 hours have passed since the abortion was performed; and
 - (B) the pregnant woman did not exercise her right to control the final disposition of the aborted fetus under Subsection (4)(a).
 - (d) Within 120 business days after the day on which an abortion is performed, a health care facility possessing an aborted fetus shall:
 - (i) conduct the final disposition of the aborted fetus in accordance with this section; or
 - (ii) ensure that the aborted fetus is preserved until final disposition.
 - (e) A health care facility shall conduct the final disposition under this section in accordance with applicable state and federal law.
- (3) Before performing an abortion, a health care facility shall:
- (a) provide the pregnant woman with the information described in Subsection 76-7-305.5(2)(w) through:
 - (i) a form approved by the department;
 - (ii) an in-person consultation with a physician; or
 - (iii) an in-person consultation with a mental health therapist as defined in Section 58-60-102; and
 - (b) if the pregnant woman makes a decision under Subsection (4)(b), document the pregnant woman's decision under Subsection (4)(b) in the pregnant woman's medical record.
- (4) A pregnant woman who has an abortion:
- (a) except as provided in Subsection (6), has the right to control the final disposition of the aborted fetus;
 - (b) if the pregnant woman has a preference for disposition of the aborted fetus, shall inform the health care facility of the pregnant woman's decision for final disposition of the aborted fetus;
 - (c) is responsible for the costs related to the final disposition of the aborted fetus at the chosen location if the pregnant woman chooses a method or location for the final disposition of the aborted fetus that is different from the method or location that is usual and customary for the health care facility; and
 - (d) for a medication-induced abortion, shall be permitted to return the aborted fetus to the health care facility in a sealed container for disposition by the health care facility in accordance with this section.
- (5) The form described in Subsection (3)(a)(i) shall include the following information:
- "You have the right to decide what you would like to do with the aborted fetus. You may decide for the provider to be responsible for disposition of the fetus. If you are having a medication-induced abortion, you also have the right to bring the aborted fetus back to this provider for disposition after the fetus is expelled. The provider may dispose of the aborted fetus by burial or cremation. You can ask the provider if you want to know the specific method for disposition."
- (6) If the pregnant woman is a minor, the health care facility shall obtain parental consent for the disposition of the aborted fetus unless the minor is granted a court order under Subsection 76-7-304.5(1)(b).

- (7)
 - (a) A health care facility may not include fetal remains with other biological, infectious, or pathological waste.
 - (b) Fetal tissue that is sent for permanently fixed pathology or used for genetic study is not subject to the requirements of this section.
 - (c)
 - (i) A health care facility is responsible for maintaining a record to demonstrate to the department that the health care facility has complied with the provisions of this section.
 - (ii) The records described in Subsection (7)(c)(i) shall be:
 - (A) maintained for at least two years; and
 - (B) made available to the department for inspection upon request by the department.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-233 Treatment of miscarried remains.

- (1) As used in this section, "miscarried fetus" means a product of human conception, regardless of gestational age, that has died from a spontaneous or accidental death before expulsion or extraction from the mother, regardless of the duration of the pregnancy.
- (2)
 - (a) A health care facility having possession of a miscarried fetus shall provide for the final disposition of the miscarried fetus through:
 - (i) cremation as that term is defined in Section 58-9-102; or
 - (ii) interment.
 - (b) A health care facility may not conduct the final disposition of a miscarried fetus less than 72 hours after a woman has her miscarried fetus expelled or extracted in the health care facility unless:
 - (i) the parent authorizes the health care facility, in writing, to conduct the final disposition of the miscarried fetus less than 72 hours after the miscarriage occurs; or
 - (ii) immediate disposition is required under state or federal law.
 - (c) A health care facility may serve as an authorizing agent as defined in Section 58-9-102 with respect to the final disposition of a miscarried fetus if:
 - (i) the parent provides written authorization for the health care facility to act as the authorizing agent; or
 - (ii)
 - (A) more than 72 hours have passed since the miscarriage occurs; and
 - (B) the parent did not exercise their right to control the final disposition of the miscarried fetus under Subsection (4)(a).
 - (d) Within 120 business days after the day on which a miscarriage occurs, a health care facility possessing miscarried remains shall:
 - (i) conduct the final disposition of the miscarried remains in accordance with this section; or
 - (ii) ensure that the miscarried remains are preserved until final disposition.
 - (e) A health care facility shall conduct the final disposition under this section in accordance with applicable state and federal law.
- (3)
 - (a) No more than 24 hours after a woman has her miscarried fetus expelled or extracted in a health care facility, the health care facility shall provide information to the parent or parents of the miscarried fetus regarding:
 - (i) the parents' right to determine the final disposition of the miscarried fetus;

- (ii) the available options for disposition of the miscarried fetus; and
 - (iii) counseling that may be available concerning the death of the miscarried fetus.
- (b) A health care facility shall:
- (i) provide the information described in Subsection (3)(a) through:
 - (A) a form approved by the department;
 - (B) an in-person consultation with a physician; or
 - (C) an in-person consultation with a mental health therapist as defined in Section 58-60-102;and
 - (ii) if the parent or parents make a decision under Subsection (4)(b), document the parent's decision under Subsection (4)(b) in the parent's medical record.
- (4) The parents of a miscarried fetus:
- (a) have the right to control the final disposition of the miscarried fetus;
 - (b) if the parents have a preference for disposition of the miscarried fetus, shall inform the health care facility of the parents' decision for final disposition of the miscarried fetus; and
 - (c) are responsible for the costs related to the final disposition of the miscarried fetus at the chosen location if the parents choose a method or location for the final disposition of the miscarried fetus that is different from the method or location that is usual and customary for the health care facility.
- (5) The form described in Subsection (3)(b)(i) shall include the following information:
- "You have the right to decide what you would like to do with the miscarried fetus. You may decide for the provider to be responsible for disposition of the fetus. The provider may dispose of the miscarried fetus by burial or cremation. You can ask the provider if you want to know the specific method for disposition."
- (6)
- (a) A health care facility may not include a miscarried fetus with other biological, infectious, or pathological waste.
 - (b) Fetal tissue that is sent for permanently fixed pathology or used for genetic study is not subject to the requirements of this section.
 - (c)
 - (i) A health care facility is responsible for maintaining a record to demonstrate to the department that the health care facility has complied with the provisions of this section.
 - (ii) The records described in Subsection (6)(c)(i) shall be:
 - (A) maintained for at least two years; and
 - (B) made available to the department for inspection upon request by the department.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-234 Resident consumer protection.

- (1) As used in this section:
- (a) "Eligible requester" means:
 - (i) a resident;
 - (ii) a prospective resident;
 - (iii) a legal representative of a resident or prospective resident; or
 - (iv) the department.
 - (b) "Facility" means an assisted living facility or nursing care facility.
 - (c) "Facility's leadership" means a facility's:
 - (i) owner;
 - (ii) administrator;

- (iii) director; or
 - (iv) employee that is in a position to determine which providers have access to the facility.
 - (d) "Personal care agency" means a person that provides assistance with activities of daily living.
 - (e) "Provider" means a home health agency, hospice provider, medical provider, or personal care agency.
 - (f) "Resident" means an individual who resides in a facility.
- (2) Subject to other state or federal laws, a facility may limit which providers have access to the facility if the facility complies with Subsection (3).
- (3)
- (a) A facility that prohibits a provider from accessing the facility shall:
 - (i) before or at the time a prospective resident or prospective resident's legal representative signs an admission contract, inform the prospective resident or prospective resident's legal representative that the facility prohibits one or more providers from accessing the facility;
 - (ii) if an eligible requester requests to know which providers have access to the facility, refer the eligible requester to a member of the facility's leadership; and
 - (iii) if a provider requests to know whether the provider has access to the facility, refer the provider to a member of the facility's leadership.
 - (b) If a facility refers an eligible requester to a member of the facility's leadership under Subsection (3)(a)(ii), the member of the facility's leadership shall inform the eligible requester:
 - (i) which providers the facility:
 - (A) allows to access the facility; or
 - (B) prohibits from accessing the facility;
 - (ii) that a provider's access to the facility may change at any time; and
 - (iii) whether a person in the facility's leadership has a legal or financial interest in a provider that is allowed to access the facility.
 - (c) If a facility refers a provider to a member of the facility's leadership under Subsection (3)(a)(iii), the member of the facility's leadership:
 - (i) shall disclose whether the provider has access to the facility; and
 - (ii) may disclose any other information described in Subsection (3)(b).
 - (d) If a resident is being served by a provider that is later prohibited from accessing the facility, the facility shall:
 - (i) allow the provider access to the facility to finish the resident's current episode of care; or
 - (ii) provide to the resident a written explanation of why the provider no longer has access to the facility.
- (4) This section does not apply to a facility operated by a government unit.
- (5) The department may issue a notice of deficiency if a facility that denies a provider access under Subsection (2) does not comply with Subsection (3) at the time of the denial.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-235 Sepsis protocols for general acute hospitals -- Presenting protocols upon inspection.

- (1) As used in this section, "sepsis" means a life-threatening complication of an infection.
- (2) A general acute hospital may develop protocols for the treatment of sepsis and septic shock that are consistent with current evidence-based guidelines for the treatment of severe sepsis and septic shock.
- (3) When developing the protocols described in Subsection (2), a general acute hospital shall consider:

- (a) a process for screening and recognizing patients with sepsis;
 - (b) a process to screen out individuals for whom the protocols would not be appropriate for treating sepsis;
 - (c) timeline goals for treating sepsis;
 - (d) different possible methods for treating sepsis and reasons to use each method;
 - (e) specific protocols to treat children who present with symptoms of sepsis or septic shock; and
 - (f) training requirements for staff.
- (4) A general acute hospital may update the general acute hospital's sepsis protocols as new data on the treatment of sepsis and septic shock becomes available.
- (5) The department, or an entity assigned by the department to inspect a general acute hospital, may request a copy of the sepsis protocols described in this section when inspecting a general acute hospital.

Renumbered and Amended by Chapter 305, 2023 General Session

26B-2-236 Monitoring device -- Installation, notice, and consent -- Admission and discharge -- Liability.

- (1) As used in this section:
- (a) "Facility" means:
 - (i) an assisted living facility; or
 - (ii) a secure memory care unit inside of:
 - (A) a nursing care facility; or
 - (B) any other medical or mental health facility.
 - (b) "Legal representative" means an individual who is legally authorized to make health care decisions on behalf of another individual.
 - (c)
 - (i) "Monitoring device" means:
 - (A) a video surveillance camera; or
 - (B) a microphone or other device that captures audio.
 - (ii) "Monitoring device" does not include:
 - (A) 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
 - (B) a device that is connected to the Internet or that is set up to transmit data via an electronic communication.
 - (d) "Resident" means an individual who receives health care from a facility.
 - (e) "Room" means a resident's private or shared primary living space.
 - (f) "Roommate" means an individual sharing a room with a resident.
- (2) 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.

- (3) 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.
- (4)
 - (a) 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.
 - (b) 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.
 - (c) A facility shall prohibit all employees of a facility from deactivating, repositioning, or otherwise interfering with the operation of a monitoring device in an individual's room.
 - (d) 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.
- (5) 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.

Amended by Chapter 310, 2024 General Session

26B-2-237 Transfer or discharge from an assisted living facility.

- (1) As used in this section:
 - (a) "Ombudsman" means the same as that term is defined in Section 26B-2-301.
 - (b) "Resident" means an individual who receives health care from an assisted living facility.
 - (c) "Responsible person" means an individual who:
 - (i) is designated in writing by a resident to receive communication on behalf of the resident; or
 - (ii) is legally authorized to make health care decisions on behalf of the resident.
- (2) A facility is subject to the requirements in Subsection (3) if the transfer or discharge:
 - (a) is initiated by the facility for any reason;
 - (b) is objected to by the resident or the resident's responsible person;
 - (c) was not initiated by a verbal or written request from the resident; or
 - (d) is inconsistent with the resident's preferences and stated goals for care.
- (3) Before a transfer or discharge described in Subsection (2) occurs, the assisted living facility from which the resident is transferred or discharged shall:
 - (a) 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:
 - (i) the reasons for the transfer or discharge;
 - (ii) the effective date of the transfer or discharge;
 - (iii) the location to which the resident will be transferred or discharged, if known; and
 - (iv) the name, address, email, and telephone number of the ombudsman;
 - (b) send a copy, in English, of the notice described in Subsection (3)(a) to the ombudsman on the same day on which the assisted living facility delivers the notice described in Subsection (3)
 - (a) to the resident and the resident's responsible person;

- (c) provide the notice described in Subsection (3)(a) at least 30 days before the day on which the resident is transferred or discharged, unless:
 - (i) notice for a shorter period of time is necessary to protect:
 - (A) the safety of individuals in the assisted living facility from endangerment due to the medical or behavioral status of the resident; or
 - (B) the health of individuals in the assisted living facility from endangerment due to the resident's continued residency;
 - (ii) an immediate transfer or discharge is required by the resident's urgent medical needs; or
 - (iii) the resident has not resided in the assisted living facility for at least 30 days;
 - (d) 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;
 - (e) orally explain to the resident:
 - (i) the services available through the ombudsman; and
 - (ii) the contact information for the ombudsman; and
 - (f) provide and document the provision of preparation and orientation for the resident, in a language and manner the resident is most likely to understand, to ensure a safe and orderly transfer or discharge from the assisted living facility.
- (4) In the event of an assisted living facility closure, the assisted living facility shall provide written notification of the closure to the ombudsman, each resident of the facility, and each resident's responsible person.

Amended by Chapter 268, 2023 General Session

Renumbered and Amended by Chapter 305, 2023 General Session

Amended by Chapter 305, 2023 General Session, (Coordination Clause)

26B-2-238 Definitions for Sections 26B-2-238 through 26B-2-241.

As used in this section and Sections 26B-2-239, 26B-2-240, and 26B-2-241:

- (1) "Certification for direct patient access" means approval by the department under Section 26B-2-239 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) "Rap back system" means a system that enables authorized entities to receive ongoing status notifications of any criminal history reported on individuals who are registered in the system.
- (13) "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.

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

Amended by Chapter 310, 2024 General Session

26B-2-239 Certification for direct patient access required -- Application by covered providers, covered contractors, and individuals.

- (1) The definitions in Section 26B-2-238 apply to this section.
- (2)
 - (a) A covered provider may engage a covered individual only if the individual has certification for direct patient access.
 - (b) A covered contractor may supply a covered individual to a covered employer or covered provider only if the individual has certification for direct patient access.
 - (c) A covered employer may engage a covered individual who does not have certification for direct patient access.
- (3)
 - (a) Notwithstanding Subsections (2)(a) and (b), if a covered individual does not have certification for direct patient access, 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 certification for direct patient access for the individual is pending.
 - (b) For purposes of Subsection (3)(a), an application is pending if the following have been submitted to the department for the individual:
 - (i) an application for certification for direct patient access;
 - (ii) the personal identification information specified by the department under Subsection 26B-2-240(4)(b); and
 - (iii) any fees established by the department under Subsection 26B-2-240(9).
- (4)
 - (a) As provided in Subsection (4)(b), each covered provider and covered contractor operating in this state shall:
 - (i) collect from each covered individual the contractor engages, and each individual the contractor intends to engage as a covered individual, the personal identification information specified by the department under Subsection 26B-2-240(4)(b); and
 - (ii) submit to the department an application for certification for direct patient access for the individual, including:
 - (A) the personal identification information; and
 - (B) any fees established by the department under Subsection 26B-2-240(9).
 - (b) Certification for direct patient access granted for an individual pursuant to an application submitted by a covered provider or a covered contractor is valid for 180 days after the date on which the engaged employment lapses.
 - (i) two years after the individual is no longer engaged as a covered individual; or
 - (ii) the covered provider's or covered contractor's next license renewal date.
- (5)
 - (a) A covered provider that provides services in a residential setting shall:

- (i) collect the personal identification information specified by the department under Subsection 26B-2-240(4)(b) for each individual 12 years old or older, other than a resident, who resides in the residential setting; and
 - (ii) submit to the department an application for certification for direct patient access for the individual, including:
 - (A) the personal identification information; and
 - (B) any fees established by the department under Subsection 26B-2-240(9).
 - (b) A covered provider that provides services in a residential setting may allow an individual 12 years old or older, other than a resident, to reside in the residential setting only if the individual has certification for direct patient access.
- (6)
- (a) An individual may apply for certification for direct patient access by submitting to the department an application, including:
 - (i) the personal identification information specified by the department under Subsection 26B-2-240(4)(b); and
 - (ii) any fees established by the department under Subsection 26B-2-240(9).
 - (b) Certification for direct patient access granted to an individual who makes application under Subsection (6)(a) is valid for 180 days after the date the engaged employment lapses unless the department determines otherwise based on the department's ongoing review under Subsection 26B-2-240(4)(a).

Amended by Chapter 240, 2024 General Session

26B-2-240 Department authorized to grant, deny, or revoke clearance -- Department may limit direct patient access -- Clearance.

- (1) The definitions in Section 26B-2-238 apply to this section.
- (2)
 - (a) As provided in this section, the department may grant, deny, or revoke certification for direct patient access for an individual, including a covered individual.
 - (b) The department may limit the circumstances under which a covered individual granted certification for direct patient access may have direct patient access, based on the relationship factors under Subsection (4) and other mitigating factors related to patient and resident protection.
 - (c) The department shall determine whether to grant certification for direct patient access for each applicant for whom it receives:
 - (i) the personal identification information specified by the department under Subsection (4)(b); and
 - (ii) any fees established by the department under Subsection (9).
 - (d) The department shall:
 - (i) 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; and
 - (ii) require that a certification for direct patient access include a fingerprint-based criminal history background check in the databases described under Subsection (3)(a), including the inclusion of the individual's fingerprints in a rap back system.
- (3) The department may review the following sources to determine whether an individual should be granted or retain certification for direct patient access, 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 Division of Child and Family Services Licensing Information System described in Section 80-2-1002;
 - (e) child abuse or neglect findings described in Section 80-3-404;
 - (f) the Division of Aging and Adult Services vulnerable adult abuse, neglect, or exploitation database described in Section 26B-6-210;
 - (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 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 certification for direct patient access:
 - (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 under Section 80-6-701 if the individual is over 28 years old 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 old; 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 certification for direct patient access, 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 Division of 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 certification for direct patient access.

- (8) The department may disclose personal identification information specified under Subsection (4)(b) to other divisions and offices within the department 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 certification for direct patient access, 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 26B-2-241; 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 certification for direct patient access should be retained.

Amended by Chapter 310, 2024 General Session

26B-2-241 Direct Access Clearance System database -- Contents and use -- Department of Public Safety retention of information and notification -- No civil liability for providing information.

- (1) The definitions in Section 26B-2-238 apply to this section.
- (2) 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 an application for certification for direct patient access under this part; and
 - (b) indicates whether an application is pending and whether clearance has been granted and retained for an applicant under this part.
- (3)
 - (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 (2)(a)(i) and (2)(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 26B-2-240(9), an initial set-up fee, an ongoing access fee, and a per-use fee.
- (4) The Criminal Investigations and Technical Services Division within the Department of Public Safety shall:
 - (a) retain, separate from other division records, personal information, including any fingerprints, sent to the division by the department pursuant to Subsection 26B-2-240(3)(a); and
 - (b) notify the department upon receiving notice that an individual for whom personal information has been retained is the subject of:
 - (i) a warrant for arrest;
 - (ii) an arrest;

- (iii) a conviction, including a plea in abeyance; or
 - (iv) a pending diversion agreement.
- (5) A covered body is not civilly liable for submitting to the department information required under this section, Section 26B-2-239, or Section 26B-2-240, or refusing to employ an individual who does not have certification for direct patient access to have direct patient access under Section 26B-2-240.

Amended by Chapter 240, 2024 General Session

26B-2-242 Visitation policy.

- (1) As used in this section:
- (a) "Patient" means an individual who receives care or services from a health care facility.
 - (b) "Personal representative" means an individual described in 45 C.F.R. Sec. 164.502(g).
 - (c) "Primary visitor" means an individual who a patient designates under Subsection (3).
- (2) A health care facility shall establish visitation policies and procedures that shall, at a minimum, include provisions regarding:
- (a) infection control;
 - (b) infection control education for visitors;
 - (c) personal protective equipment requirements when necessary for infection control;
 - (d) for a visitor who is not a primary visitor:
 - (i) maximum duration of visits;
 - (ii) maximum number of visitors a patient may have each day;
 - (iii) maximum number of visitors a patient may have at one time; and
 - (e) the individual or position at the health care facility that is responsible for ensuring that staff adhere to the policies and procedures.
- (3)
- (a) A patient or the patient's personal representative may designate one individual as a primary visitor.
 - (b) Except as provided in Subsection (5), a health care facility may not limit the duration or frequency of a primary visitor's visits to the designating patient.
- (4) A health care facility may not:
- (a) require a visitor or primary visitor to comply with infection control measures that are more restrictive than the infection control measures the health care facility requires of the health care facility's staff;
 - (b) require a visitor or primary visitor to show proof of vaccination or immunization status;
 - (c) except as provided in Subsection (5), prohibit physical contact between the visitor and the patient the visitor is visiting; or
 - (d) deny a visitor or primary visitor access to the patient unless visitation is denied, modified, or limited as provided in Subsection (5).
- (5) A health care facility may:
- (a) exclude certain areas of the health care facility from visitor and primary visitor access;
 - (b) require a visitor or a primary visitor to agree in writing to follow the health care facility's visitation policies and procedures before allowing access to the patient;
 - (c) suspend or refuse in-person visitation for a visitor or a primary visitor if the visitor or primary visitor violates the health care facility's visitation policies and procedures;
 - (d) remove a visitor or primary visitor or deny visitation, if the patient is undergoing a procedure or receiving treatment that would be impeded by visitation;

- (e) deny visitation for a visitor or primary visitor if the patient or personal representative objects to the visit; or
- (f) prohibit physical contact or visitation if:
 - (i) the visit or physical contact is prohibited by law;
 - (ii) the patient is in the custody of the state; or
 - (iii) the health care facility determines the visit or physical contact:
 - (A) creates a physical safety risk to the patient, the visitor or primary visitor, or the health care facility's staff;
 - (B) is counter therapeutic to the patient's well-being; or
 - (C) is disruptive to the patient's care or treatment.
- (6) A health care facility shall provide the department with a copy of the health care facility's visitation policies and procedures:
 - (a) upon the department's request; and
 - (b) when the health care facility:
 - (i) obtains a license to operate from the department;
 - (ii) renews the license from the department; and
 - (iii) changes ownership.
- (7) A health care facility shall make visitation policies and procedures created in accordance with this section available on the health care facility's website.
- (8) The department shall provide:
 - (a) a description of the requirements of this section on the department's website; and
 - (b) a method for the public to report a violation of this section.
- (9) This section does not apply to the Utah State Hospital.

Enacted by Chapter 276, 2023 General Session

26B-2-243 Data collection and reporting requirements concerning incidents of abuse, neglect, or exploitation.

- (1) As used in this section, "facility" means the same as that term is defined in Section 26B-2-236.
- (2) In addition to the requirements in Section 26B-6-205 or 80-2-602, the department shall require a facility to report any incident of abuse, neglect, or exploitation of a resident:
 - (a) to the department; and
 - (b) to the Division of Child and Family Services or Adult Protective Services, if appropriate, or a law enforcement agency with jurisdiction over the covered provider in which the alleged incident occurred.
- (3) The department shall collect and compile all reported incidents described in Subsection (2)(a) and annually on or before June 30 report the data to the Health and Human Services Interim Committee.

Enacted by Chapter 310, 2024 General Session