§ 2803. Commissioner and council; powers and duties. 1. (a) The commissioner shall have the power to inquire into the operation of hospitals and to conduct periodic inspections of facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and by-laws, standards of medical care, hospital service, including health-related service, system of accounts, records, and the adequacy of financial resources and sources of future revenues. The commissioner or persons designated by him shall conduct at least one unannounced comprehensive inspection of each residential health care facility not later than fifteen months after the previous such inspection to determine the adequacy of care being rendered. Such comprehensive inspection shall include, but not be limited to, a survey to determine compliance by the facility with applicable statutes and regulations, and observation of a representative sample of all patients or residents and their medical records to determine the quality and adequacy of the care and treatment provided. Additional visits shall be made to facilities as needed to determine whether violations or deficiencies have been corrected, to investigate any report made pursuant to section twenty-eight hundred three-d of this article or any other complaint, and for any other purpose deemed necessary and appropriate by the commissioner. Any employee of the department who gives or causes to be given advance notice of such unannounced inspection to any unauthorized person shall, in addition to any other penalty provided by law, be suspended by the commissioner from all duties without pay for at least five days or for such greater period of time as the commissioner shall determine. Any such suspension shall be made by the commissioner in accordance with all other applicable provisions of law.

(b) The purpose of such inspection shall be to determine compliance by residential health care facilities with statutes, and with regulations promulgated under the provisions of those statutes, governing minimum standards of construction, quality and adequacy of care, rights of patients, rates of payment and reimbursement. At least one such inspection every fifteen months shall include, but shall not be limited to, full on-site examination of the medical, nursing care, dietary and social services records of the facility.

(c) The commissioner shall establish, in consultation with the state office for the aging, a consumer information system for residential

health care facilities with respect to their compliance with the standards set forth in this section designed to provide accurate and comprehensible information to consumers on the quality of facilities which shall incorporate a summary of the findings and results of the inspections conducted pursuant to the provisions of this section. Such summary of results and findings shall include, but need not be limited to, a listing of areas in which items were found at the time of such inspections to be not in compliance with such standards and the nature of such non-compliance. Each residential health care facility shall be issued a summary of the findings of inspections of such facility conducted since the issuance of the previous summary of findings, which shall be posted conspicuously within such facility, and any other information relating to the facility available through the consumer information system. The commissioner shall promulgate rules and regulations necessary to implement the provisions of this paragraph. A facility may appeal the accuracy of a summary findings to the commissioner within twenty days after receipt of such summary. The results and findings of any prior inspections, and any penalties thereby assessed, which have not been previously appealed and overruled, shall not be subject to review.

(d) (i) Notwithstanding any inconsistent provision of law, the commissioner or his designee shall determine the necessity and appropriateness of care and services provided by hospitals to patients eligible for medical assistance pursuant to title eleven of article five of the social services law and shall further determine whether a general hospital has taken an action that results in the admission of patients unnecessarily, unnecessary multiple admissions of the same patients, inappropriate discharge of patients, inappropriate transfer of patients between hospitals or between distinct units of a hospital, inappropriate diagnosis-related group coding, or other inappropriate medical or other practices with respect to hospitalized inpatients eligible for medical assistance pursuant to title eleven of article five of the social services law. In making such determinations the commissioner may utilize the services of department personnel or other authorized representatives. The hospitals shall provide such information, facilities and services as may be required by the commissioner to make such determinations. The commissioner, in implementing this paragraph,

shall adopt necessary rules and regulations including but not limited to those for determining the necessity or appropriate level of admission, controlling the length of stay, the provision of surgery and other services, and the methods and procedures for making such determinations.

(ii) In the event the commissioner or his designee makes a determination pursuant to this paragraph that a general hospital or physician has taken an inappropriate action resulting in a denial or adjustment of payment determined in accordance with section twenty-eight hundred seven-c of this article, the general hospital or physician which is the subject of such determination shall be entitled to a review before the commissioner or an appeal agent designated for such purposes by the commissioner at which such hospital or physician may challenge such determination. In order to be entitled to such review, such hospital or physician must provide the commissioner or his designee, as appropriate, with a written request for such review within thirty days of receipt of the written determination. During such review, the hospital or physician may present documentation or evidence in support of its challenge to the determination, and representatives of the commissioner or his designee may present documentation or evidence in support of the determination. In the event that the determination is sustained, the hospital or physician may seek judicial review of the decision pursuant to article seventy-eight of the civil practice law and rules.

(iii) The commissioner shall certify to the social services officials responsible for making payments for authorized hospital services that specified items of care and services for specified individuals eligible for medical assistance pursuant to title eleven of article five of the social services law are inappropriate or unnecessary and are not authorized for payment or are authorized for payment at the appropriate level of care under the medical assistance program and, for general hospitals, for rate periods beginning on or after January first, nineteen hundred eighty-eight through March thirty-first, nineteen hundred ninety-seven, at the appropriate case based rate of payment determined pursuant to section twenty-eight hundred seven-c of this article.

(e) Notwithstanding any inconsistent provision of law, the commissioner or his designee shall, not later than July first, nineteen

hundred seventy-six, determine on an individual patient basis whether identifiable periods of in-patient care in a general hospital are required beyond the maximum length of stay established pursuant to section three hundred sixty-five-a of the social services law, and whether deferral of surgical procedures specified by such commissioner in accordance with paragraph (c) of subdivision five of such section may jeopardize life or essential function, or cause severe pain. In making such determinations the commissioner may utilize the services of department personnel or other authorized representatives. The hospitals shall provide such information, facilities and services as may be required by the commissioner to make such determinations. The commissioner, in implementing this paragraph, shall adopt necessary rules and regulations including but not limited to the methods and procedures for making such determinations and the utilization of any department staff or other authorized representatives located at such hospital in performing other functions relating to assuring that public funds for medical assistance are utilized exclusively to provide items of care and services in amount, duration and scope specifically authorized under the medical assistance program. The commissioner shall certify to the social services officials responsible for making payments for authorized hospital services that specified items of care and services for specified individuals are not authorized for payment under the medical assistance program.

(f) Notwithstanding any inconsistent provision of law, the commissioner shall establish standards for determining the necessity of care and service for alcoholism and alcohol abuse provided by hospitals. In implementing this paragraph the commissioner, in consultation with the director of the division of alcoholism and alcohol abuse, shall adopt necessary rules and regulations including but not limited to those for determining the necessity or appropriate level of admission, controlling the length of stay, the provision of services and establishing the methods and procedures for making such determinations.

(g) The commissioner shall require that every general hospital adopt and make public an identical statement of the rights and responsibilities of patients, in accordance with applicable law, including, but not limited to:

(i) a patient complaint and quality of care review process;

(ii) a right to receive all information necessary to give informed consent for any proposed intervention, procedure, or treatment, including information regarding the foreseeable and clinically significant risks and benefits of the proposed intervention, procedure, or treatment;

(iii) a right to receive complete information regarding the patient's condition, prognosis, and clinical indications for the proposed intervention, procedure, or treatment;

(iv) a right to receive information regarding alternative treatment options including the foreseeable and clinically significant risks and benefits of such alternative treatment options, taking into consideration any known preconditions;

(v) a right to be informed of the name, position, and functions of any persons, including medical students and physicians exempt from New York state licensure pursuant to section sixty-five hundred twenty-six of the education law, who provide face-to-face care to or direct observation of the patient;

(vi) a right to refuse the proposed intervention, procedure, or treatment and to be informed of the clinical effects of such refusal;

(vii) a right to meaningfully engage and participate in the informed consent process, which shall mean, but not be limited to, affording the patient or their representative time to ask questions and have them answered satisfactorily to the extent reasonable;

(viii) a right to be informed of any human subjects research that the attending physician taking care of the patient participates in and may directly affect a procedure or treatment to be received by the patient, and to provide voluntary written informed consent to participate, should the patient be an appropriate candidate for such human subjects research in the clinical judgment of the attending physician. The informed consent referred to here shall conform with federal requirements regarding protection for human research subjects, and any other applicable laws or regulations;

(ix) a right to an appropriate patient discharge plan; and

(x) for patients other than beneficiaries of title XVIII of the federal social security act (medicare), a right to a discharge review in accordance with section twenty-eight hundred three-i of this article. The form and content of such statement shall be determined in accordance

with rules and regulations adopted by the council and approved by the commissioner. A patient who requires continuing health care services in accordance with such patient's discharge plan may not be discharged until such services are secured or determined by the hospital to be reasonably available to the patient. Each general hospital shall give a copy of the statement to each patient, or the appointed personal representative of the patient at or prior to the time of admission to the general hospital, as long as the patient or the appointed personal representative of the patient receives such notice no earlier than fourteen days before admission. Such statement shall also be conspicuously posted by the hospital and shall be a part of the patient's admission package. Nothing herein contained shall be construed to limit any authority vested in the commissioner pursuant to this article related to the operation of hospitals and care and services provided to patients.

* (h) Every hospital providing treatment to alleged victims of family offenses as defined in article eight of the family court act and section 530.11 of the criminal procedure law shall be responsible for providing a copy of a notice to victims of family offenses as described in section eight hundred twelve of the family court act and subdivision six of section 530.11 of the criminal procedure law. The commissioner shall promulgate such rules and regulations as may be necessary and proper to carry out effectively the provisions of this paragraph.

* NB There are 2 (h)'s

* (h) The statement regarding patient rights and responsibilities which the commissioner shall approve as provided under paragraph (g) of this subdivision shall include a provision stating that every patient shall have the right to authorize those family members and other adults who will be given priority to visit consistent with the patient's ability to receive visitors.

* NB There are 2 (h)'s

(i) The statement regarding patient rights and responsibilities, required pursuant to paragraph (g) of this subdivision, shall include provisions informing the patient of his or her right to make organ, tissue or whole body donations, and the means by which the patient may make such a donation. The commissioner shall promulgate any rules and regulations necessary to implement the provisions of this paragraph.

* (j) As used with regard to applicable regulations issued by the department implementing the statement regarding patient rights and responsibilities required pursuant to paragraph (g) of this subdivision, the term "itemized bill" shall, for all periods on and after January first, two thousand eleven, be defined as reflecting a charges schedule developed by each hospital for all ancillary patient services, which schedule shall set forth separate charges for each ancillary service provided.

* NB There are 2 (j)'s

* (j) The commissioner shall require that the statement regarding patient rights and responsibilities, described in paragraph (g) of this subdivision, shall include a provision informing the patient of his or her right to not be discriminated against on account of age.

* NB There are 2 (j)'s

(k) The statement regarding patient rights and responsibilities, required pursuant to paragraph (g) of this subdivision, shall include provisions informing the patient of his or her right to choose to submit surprise bills or bills for emergency services to the independent dispute process established in article six of the financial services law, and informing the patient of his or her right to view a list of the hospital's standard charges and the health plans the hospital participates with consistent with section twenty-four of this chapter.

(l) The statement regarding patient rights and responsibilities, required pursuant to paragraph (g) of this subdivision, shall include provisions informing the patient of his or her right to choose to identify a caregiver pursuant to article twenty-nine-cccc of this chapter.

2. (a) The council, by a majority vote of its members, shall adopt and amend rules and regulations, subject to the approval of the commissioner, to effectuate the provisions and purposes of this article, including, but not limited to:

(i) the establishment of requirements for a uniform statewide system of reports and audits relating to the quality of medical and physical care provided, hospital utilization, and costs in accordance with section twenty-eight hundred three-b of this article,

(ii) establishment by the department of schedules of rates, payments,

reimbursements, grants and other charges for hospital and health-related services as provided in sections twenty-eight hundred seven, twenty-eight hundred seven-a, twenty-eight hundred seven-c and twenty-eight hundred eight of this article. The schedules established shall be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. In adopting regulations related to the computation of general hospital inpatient payments, the council shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital is located, costs of hospitals of comparable size, and the need for incentives to improve services and institute economies. The council shall exclude from consideration in the regulations adopted nonallowable costs such as the costs for research and those parts of the costs for educational salaries which the council determines to be not directly related to hospital service,

(iii) the identification of appropriate and reasonable standards for the development of acceptable collection procedures used by general hospitals in an effort to collect unpaid bills prior to the determination that the unpaid bill is a bad debt eligible for reimbursement consideration pursuant to paragraphs (e) and (f) of subdivision eight of section twenty-eight hundred seven-a or paragraph (b) of subdivision fourteen of section twenty-eight hundred seven-c and twenty-eight hundred seven-k of this article,

(iv) subject to the provisions of paragraph (e) of subdivision eleven of section twenty-eight hundred seven-a of this article or subdivision nine of section twenty-eight hundred seven-c of this article, the establishment of guidelines regarding the time to resolve appeals submitted by general hospitals. The council may consider different periods depending upon whether the basis for the appeal is related to a general hospital's existing costs or anticipated future costs,

(v) standards and procedures relating to hospital operating certificates, provided however, that the council shall establish minimum acceptable standards and procedures equal to the standards and procedures which federal law and regulation require for hospitals to qualify as providers pursuant to titles XVIII and XIX of the federal social security act. The existing state standards and procedures in

effect on the date that this subdivision becomes effective shall be deemed to constitute maximum standards and procedures for purposes of limiting medical assistance reimbursement pursuant to the social services law. Such standards and procedures may thereafter be changed or added to by the council only upon the recommendation of the commissioner. For the purposes of ensuring that the health and safety of the residents of hospitals are not endangered, the council may promulgate changes in the minimum acceptable standards and procedures referred to herein upon recommendation of the commissioner, and

(vi) the establishment of a system of accounts and cost findings to be used by hospitals, including a classification of such hospitals and the prescription of a system of accounts and cost finding for each class in accordance with sections twenty-eight hundred three-b and twenty-eight hundred five-a of this article.

(b) The commissioner may propose rules and regulations and amendments thereto for consideration by the council.

3. The commissioner may enter into contracts with any political subdivision, voluntary non-profit agency or health systems agency and such entities are authorized to enter into contracts with the commissioner to effectuate the purposes of this article, however, contracts with voluntary non-profit agencies may not provide for payment for general hospital out-patient and emergency services or for treatment or diagnostic center services unless the commissioner is satisfied that the costs incurred for such services are approvable pursuant to the provisions of section twenty-eight hundred seven of this article.

4. At the request of the commissioner, hospitals shall furnish to the department such reports and information as it may require to effectuate the provisions of this article.

5. The commissioner may institute or cause to be instituted in a court of competent jurisdiction proceedings to compel compliance with the provisions of this article or the determinations, rules, regulations and orders of the commissioner or the council.

6. The council, by a majority vote of its members and subject to the

approval of the commissioner, shall adopt rules and regulations to establish (a) a system of penalties of up to one thousand dollars per day for continuing violations of rules and regulations promulgated pursuant to article twenty-eight of this chapter and pertaining to patient care by residential health care facilities, specifying the violations and the amount of the penalty to be assessed in connection with each such violation, and (b) a system by which the rate of payment approved for a residential health care facility pursuant to section twenty-eight hundred seven of this chapter and certified to the department of social services for purposes of reimbursement in the medical assistance program, is reduced in sufficient amount to collect such penalties. Any reduction of rate to collect penalties shall be limited to five percent of the otherwise established per diem rate or that portion of the per diem rate which represents the owner's return on equity, as defined by regulation, whichever is less.

7. The commissioner shall have the power to assess penalties in accordance with the system of penalties adopted pursuant to subdivision six of this section and pursuant to a hearing conducted in accordance with section twelve-a of this chapter. No penalty shall be assessed pursuant to subdivision six of this section unless the facility has received at least thirty days written notice of the existence of the violation, the amount of the penalty for which it may become liable and the steps which must be taken to rectify the violation. If the facility fails to rectify the violation within said thirty day period, it shall thereafter be liable for such penalty. Any such penalties shall be subject to release and compromise by the commissioner in the same manner as a penalty provided by subdivision one of section twelve of this chapter. Any penalty assessed pursuant to subdivision six of this section shall be subject to recovery in the same manner as a penalty provided by subdivision one of section twelve of this chapter or pursuant to the system for reduction of the rate of payment to the facility adopted pursuant to clause (b) of subdivision six of this section. Any such penalty assessed pursuant to subdivision six of this section shall be additional and cumulative to all other penalties or remedies existing for violations of rules and regulations promulgated pursuant to article twenty-eight of this chapter. The provisions of this

subdivision shall not be applicable to nor limit any power to assess penalties pursuant to section twelve of this chapter; provided, however, that if a penalty is assessed for a violation pursuant to this subdivision, no penalty shall be assessed for such violation pursuant to section twelve of this chapter, and if a penalty is assessed for a violation pursuant to section twelve of this chapter, no penalty shall be assessed for such violation pursuant to this subdivision.

8. (a) Notwithstanding any inconsistent provision of law, the commissioner shall establish procedures to be followed by hospitals for notification to mothers and reporting under section three hundred sixty-six-g of the social services law.

(b) Notwithstanding any inconsistent provision of section twelve of this chapter or any other law, the commissioner may impose a civil penalty of up to three thousand five hundred dollars for each violation of the requirements of subdivision one of section three hundred sixty-six-g of the social services law or the rules and regulations promulgated pursuant to such section, pertaining to reporting to the department, or such other entity designated by the department, of each live birth to a woman receiving medical assistance. Any such civil penalties shall be assessed subject to the applicable provisions of sections twelve and twelve-a of this chapter.

8-a. Notwithstanding any inconsistent provision of law to the contrary, the commissioner shall develop a program to facilitate the use of a triage system of care in emergency rooms of hospitals that are subject to the provisions of this article. In developing such program the commissioner shall consider the manner in which such a system would be coordinated, how such a system would provide greater efficiency, provide cost savings to public health programs and a higher quality of care. Within one year from the enactment of such program, the commissioner shall submit a report to the temporary president of the senate and the speaker of the assembly regarding: the impact of such a system on the cost of Medicaid covered services in the hospital setting; quality of care in facilities; along with any other data as may be appropriate.

9. (a) General hospitals shall, no later than April first, two thousand, submit to the commissioner a plan for compliance with part four hundred five of the official compilation of codes, rules and regulations of the state of New York regarding the working conditions of and limits on working hours for certain members of a hospital's medical staff and postgraduate trainees in such form and manner as specified by the commissioner.

(b) The commissioner shall audit each hospital for compliance with its plan and the applicable regulation on an annual basis. Based upon an initial written audit finding of noncompliance the commissioner shall assess a civil penalty of six thousand dollars for each instance of noncompliance identified in such initial audit.

(c) Within thirty days after the hospital's receipt of written notice of noncompliance the hospital shall submit a plan of correction in such form and manner as specified by the commissioner for achieving compliance with its plan and with the applicable regulations. The commissioner shall audit each such hospital for compliance with its plan and the applicable regulations within a reasonable time after submission of such plan of correction. Upon a written finding by the commissioner within one hundred eighty days of the initial audit finding of noncompliance that the hospital has failed to substantially adhere to its plan of correction the commissioner shall assess the hospital a civil penalty of twenty-five thousand dollars. Upon a further subsequent written finding by the commissioner within one hundred eighty days of the initial audit finding of noncompliance that the hospital has failed to substantially adhere to its plan of correction the commissioner shall assess the hospital a civil penalty of fifty thousand dollars. Upon each and every subsequent written finding by the commissioner within three hundred sixty days of the initial audit finding of noncompliance that the hospital has failed to substantially adhere to its plan of correction the commissioner shall assess the hospital a civil penalty of fifty thousand dollars.

(d) The penalties assessed pursuant to paragraph (c) of this subdivision shall be subject to the provisions of section twelve-a of this chapter.

(e) Hospitals shall submit to the commissioner any data necessary to perform audits pursuant to this subdivision. Any hospital which fails to

produce data or documentation requested in furtherance of such audit within thirty days of such request may be assessed by the commissioner a civil penalty of ten thousand dollars.

10. (a) All civil penalties assessed and collected pursuant to section twelve of this chapter for violations of this article and regulations promulgated thereunder related to the operation of residential health care facilities, and all civil monetary penalties related to the operation of nursing facilities received from the federal government in accordance with subdivision (h) of section nineteen hundred nineteen of the federal social security act, shall be deposited by the commissioner and credited to the quality of care improvement account which shall be established by the comptroller in the special revenue fund-other. To the extent of funds appropriated therefor, funds shall be made available to the department for expenditures related to the protection of the health or property of residents of residential health care facilities that are found to be deficient.

(b) Any funds available pursuant to paragraph (a) of this subdivision, not used for the purposes of paragraph (a) of this subdivision, shall be used, at the commissioner's discretion, to support activities and initiatives intended to improve resident quality of care at residential health care facilities found to be deficient, as well as for such other purposes as are described in this paragraph. Such activities may include, but are not limited to, relocation of residents to other facilities and the maintenance and operation of a facility pending correction of deficiencies or closure. The commissioner may also make grants to residential health care facilities that support facilities' activities and initiatives intended to improve residential quality of care pursuant to a request for proposals process.

* 11. (a) The commissioner shall make regulations relating to midwifery birth centers, including relating to establishment, construction, and operation, considering the standards of state and national professional associations of midwifery birth centers, in consultation with representatives of midwives, midwifery birth centers, and general hospitals providing obstetric services.

(b) (i) As used in this subdivision, "accrediting organization" means a national accrediting organization that provides accreditation to

midwifery birth centers, recognized by the commissioner in consultation with representatives of midwives, midwifery birth centers, and general hospitals providing obstetric services. The commissioner shall not unreasonably withhold recognition of an organization seeking to be recognized under this paragraph.

(ii) Where a proposed midwifery birth center demonstrates the intent and capability to obtain and maintain accreditation by an accrediting organization, and fully completes and files an application with the public health and health planning council on forms provided by the department, it shall be deemed upon approval of the public health and health planning council to meet the requirements of this article for a midwifery birth center for approval of a certificate of incorporation, articles of organization and establishment, contingent on obtaining and maintaining that accreditation. Notwithstanding any other provision of this article to the contrary, such application to the public health and health planning council shall include information to: (A) satisfy the character and competence criteria found in subdivision three of section twenty-eight hundred one-a of this article; (B) demonstrate that the legal structure of the proposed operator of the midwifery birth center complies with the requirements for establishment of hospitals under section twenty-eight hundred one-a of this article; (C) evidence the capability to fund any acquisition, renovations, and construction costs; and (D) demonstrate that the premises and equipment comply with required life safety and building standards necessary to protect the life, safety and welfare of patients and staff. Upon receipt of a completed application, the department shall schedule such application for consideration at the next available and appropriate committee meeting by the public health and health planning council. If the department receives an incomplete application, the department shall communicate with the applicant until such time as the application is completed and filed with the public health and health planning council for its approval or disapproval, or the applicant withdraws the application.

(iii) Regulations and requirements of the commissioner under paragraph (a) of this subdivision for approval of a certificate of incorporation, articles of organization, establishment, and operation of a midwifery birth center established or seeking to be established under this article, including a determination of public need and compliance with

operational and physical plant standards, shall not be inconsistent with: (A) article one hundred forty of the education law; (B) the standards of the accrediting organization from which the midwifery birth center proposes to seek, seeks or has obtained accreditation; (C) life safety code or other building standards the commissioner deems necessary to protect the life, safety and welfare of patients and staff; and (D) subparagraph (ii) of this paragraph. Regulations, requirements and guidance under this subparagraph shall be made by the commissioner after consultation with representatives of midwives, midwifery birth centers, and general hospitals providing obstetric services. To the extent any of the standards in this subparagraph conflict, the commissioner shall accommodate or modify the application of any standard to harmonize and maximize the intent of the standards.

* NB There are 2 sb 11's

* 11. Notwithstanding any provision of this article, or any rule or regulation under this article to the contrary, the commissioner shall allow outpatient clinics of general hospitals and diagnostic and treatment centers to provide off-site primary care services that are:

(a) primary care services ordinarily provided to patients on-site at the outpatient clinic or diagnostic and treatment center and are not home care services defined in subdivision one of section thirty-six hundred two of this chapter or the professional services enumerated in subdivision two of such section;

(b) provided by a primary care professional to a patient with a pre-existing clinical relationship with the outpatient clinic or diagnosis and treatment center, or with the health care professional providing the service; and

(c) provided to a patient who is unable to leave his or her residence to receive services at the outpatient clinic or diagnostic and treatment center without unreasonable difficulty due to circumstances, including but not limited to, clinical impairment.

Nothing in this subdivision shall preclude a federally qualified health center from providing off-site services in accordance with department regulations.

* NB There are 2 sb 11's

12. (a) Each residential health care facility shall, no later than ninety days after the effective date of this subdivision and annually thereafter, or more frequently as may be directed by the commissioner, prepare and make available to the public on the facility's website, and immediately upon request, in a form acceptable to the commissioner, a pandemic emergency plan which shall include but not be limited to:

(i) a communication plan:

(A) to update authorized family members and resident representatives of infected residents at least once per day and upon a change in a resident's condition and at least once a week to update all residents and authorized families and resident representatives on the number of infections and deaths at the facility, and to update all residents, authorized family members, and resident representatives at the facility not later than five o'clock p.m. the next calendar day following the detection of a confirmed infection of a resident or staff member, or at such earlier time as guidance from the federal centers for Medicaid and medicare services or centers for disease control and prevention may provide, by electronic or such other means as may be selected by each resident, authorized family member or resident representative; and

(B) that includes a method to provide all residents with daily access, at no cost, to remote videoconference or equivalent communication methods with family members and guardians; and

(C) that includes a method, consistent with any guidance and regulations issued by the commissioner, to provide all residents with access, at no cost, to state long-term care ombudsman program staff and volunteers, and that provides state long-term care ombudsman program staff and volunteers with access to the facility; and

(ii) protection plans against infection for staff, residents and families, including:

(A) a plan for hospitalized residents to be readmitted to such residential health care facility after treatment, in accordance with all applicable laws and regulations; and

(B) a plan for such residential health care facility to maintain or contract to have at least a two-month supply of personal protective equipment; and

(C) a plan or procedure, consistent with any guidance issued by the federal centers for Medicaid and medicare services or centers for

disease control and prevention, for placement or grouping of residents within a facility to reduce transmission of the pandemic disease during an infectious disease outbreak in the residential health care facility; and

(iii) a plan for preserving a resident's place in a residential health care facility if such resident is hospitalized, in accordance with all applicable laws and regulations.

(b) The residential health care facility shall prepare and comply with the pandemic emergency plan. Failure to do so shall be a violation of this subdivision and may be subject to civil penalties pursuant to section twelve and twelve-b of this chapter. The commissioner shall review each residential health care facility for compliance with its plan and the applicable regulations in accordance with paragraphs (a) and (b) of subdivision one of this section.

(c) Within thirty days after the residential health care facility's receipt of written notice of noncompliance such residential health care facility shall submit a plan of correction in such form and manner as specified by the commissioner for achieving compliance with its plan and with the applicable regulations. The commissioner shall ensure each such residential health care facility complies with its plan of correction and the applicable regulations.

(d) The commissioner shall promulgate any rules and regulations necessary to implement the provisions of this subdivision.

13. The commissioner shall require each residential health care facility to provide residents and their families with a separate document, as part of an intake application, in no less than twelve-point font, that includes information on how a potential resident and their family members can look up complaints, citations, inspections, enforcement actions, and penalties taken against the facility including the web address for the New York state nursing home profiles website that is maintained by the department and the nursing home compare website maintained by the United States department of health and human services, if applicable.

14. (a) The commissioner, in consultation with the state long-term care ombudsman, shall establish policies and procedures for: (i)

reporting to the department, by staff and volunteers of the long-term care ombudsman program, on issues identified or witnessed by such staff and volunteers that relate to actions, inactions or decisions that may adversely affect the health, safety and welfare of residents at residential health care facilities licensed or certified by the department in this state. Such policies and procedures shall include, but not be limited to, establishing a telephone hotline number and reporting form on the department's website for use by long-term care ombudsman program staff and volunteers for the submission of reports;

(ii) timely and regular resolution to any such issues reported to the department pursuant to subparagraph (i) of this paragraph. No later than sixty days after the receipt of any such issue, the department shall provide the state long-term care ombudsman a report on the status of such issue. Following the initial report, the department shall provide additional reports to the state long-term care ombudsman no less than every ninety days thereafter until such issue is resolved. Upon resolution of such issue, the department shall provide a timely report to the state long-term care ombudsman indicating the manner in which the issue was resolved; and

(iii) requiring the department to notify the local ombudsman entity as defined in paragraph (c) of subdivision one of section two hundred eighteen of the elder law after the department conducts a recertification survey of a facility.

(b) Nothing in this subdivision shall be construed to limit in any way a resident's right to privacy and confidentiality pursuant to the regulations of the long-term care ombudsman program or the right to refuse to consent to the involvement of the long-term care ombudsman.

(c) As used in this subdivision: (i) "resolution" shall mean closure of a complaint by the department, whether closed as substantiated or unsubstantiated; and (ii) "status" shall mean whether the complaint has been assigned to department staff for investigation, whether the complaint remains open under active investigation, or whether the complaint has reached resolution.