State of California—Health and Human Services Agency
California Department of Public Health

RON CHAPMAN, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

November 12, 2014

AFL 14-28
(Supersedes AFL 13-19)

TO: Nursing Facilities
Skilled Nursing Facilities

SUBJECT: Optional Services and Posting of Licenses

AUTHORITY: Assembly Bill (AB) 1974 (Chapter 288, Statutes of 2014)
Health and Safety Code (HSC) Sections 1252 and 1253
Title 22, California Code of Regulations (CCR), Sections 72201, 72209 and 72401

This notice supersedes All Facilities Letter (AFL) 13-19. Effective January 1, 2015, occupational therapy, physical therapy, and speech pathology and audiology services will no longer be considered special services when provided to inpatients residing in federally certified nursing facilities (NF) or skilled nursing facilities (SNF), pursuant to the passage of AB 1974 (Chapter 288, Statutes of 2014).

Health and Safety Code (HSC) section 1252 previously defined special services as “a specific type or types of patient care and which has been identified by regulations of the state department and for which the state department has established special standards for quality of care.” The California Code of Regulations (CCR) refers to “special services” as “optional services.” Optional services may include physical therapy, occupational therapy, speech pathology and audiology, social work and special treatment program services. However, AB 1974 amended HSC section 1252 and redefined special services.

Federally Certified Nursing Facilities

Effective January 1, 2015, optional services will no longer include inpatient physical therapy, occupational therapy, and speech pathology and audiology services when these services are provided to meet federal conditions of participation in a federally certified nursing facility (NF) or skilled nursing facility (SNF), as defined by HSC section 1250 (k).

The Federal Nursing Home Act of 1987 (OBRA ’87), requires federally certified SNFs/NFs to provide physical therapy services, occupational therapy services, and/or speech pathology and audiology services to residents as indicated by their

comprehensive care plan in order to obtain federal certification. AB 1974 amends state law to reflect that providing these services is not optional for certified SNFs/NFs.

All SNFs/NFs must continue to comply with all state and federal requirements pertaining to physical therapy services, occupational therapy services, or speech pathology and audiology services. Federally certified facilities providing these services to residents solely to meet federal requirements are not required to list the inpatient physical therapy, occupational therapy, and speech pathology and audiology services on their facility license.

Although optional services will no longer include the specified inpatient services, those services, when provided to non-residents on an outpatient basis will continue to be considered optional services.

Upon receipt of your “Notice of Expiration and Application for Facility License Renewal” (Attachment A), please review it carefully to ensure that all appropriate services are listed. To remove any of the specified inpatient services from your license, complete forms HS 200 and HS 609, and submit the forms to the District Office (DO).

State Licensed Only Skilled Nursing Facilities

Physical therapy, occupational therapy, speech pathology and audiology, social work and special treatment program services in licensed-only SNFs will continue to be considered optional services by the California Department of Public Health (CDPH) Licensing and Certification (L&C) Program. All special/optional services must continue to be surveyed and approved by L&C prior to the provision of services.

All Nursing Facilities and Skilled Nursing Facilities

Pursuant to Title 22 California Code of Regulations (CCR) Sections 72401 (d) and (e) and 72209, SNFs/NFs must submit an application to the District Office (DO) prior to providing optional services and upon approval, post a copy of the facility’s license that includes a list of its optional services in a location accessible for public view. An application must be submitted each time a facility adds or deletes an optional service.

An application is also required in the following cases (Title 22 CCR Section 72201 (b)):

- A facility constructs a new or replaces a SNF,
- An increase in licensed bed capacity,
- A change in the facility name,
- A change of licensed category,
- A change of the facility’s location, or
- A change in bed classification.

If a facility adds or modifies an optional service in the SNF/NF, the following steps should be followed:

- Complete forms HS 200 and HS 609, and submit the forms to the DO. The forms may be located at: http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/hs200.pdf and; http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph609.pdf

- If your facility currently provides optional services, please verify that those optional services are listed on your license. If the applicable optional services are not listed, please promptly complete the forms above and submit the forms to the DO.

Before the DO issues an updated license with the optional services listed, a survey of the facility may be conducted. Following the survey, a facility may be requested to correct any deficiencies with a Plan of Correction. Once the DO has finalized the survey and/or deficiencies, the facility will receive an updated license. Replace the old license and post the updated license in the facility. Please shred and discard the old license.

Please Note: The Department of Health Care Services reviews Special Treatment Programs. If you have specific questions regarding program requirements, contact the Program Oversight and Compliance Branch at (916) 319-0985.

Facilities are responsible for following all applicable laws. The CDPH's failure to expressly notify facilities of statutory or regulatory requirements does not relieve facilities of their responsibility for following all California and federal laws and regulations.

If you have any questions, please contact your local District Office.

Sincerely,

Original signed by Jean Iacino

Jean Iacino

Interim Deputy Director

Attachment

Attachment A

State of California-Department of Public Health

License Number:
Expiration Date:
Invoice Date:
Invoice Number:
Date of Notice:

Facility:

Notice of Expiration and Application for Facility License Renewal

Licensee:

RENEWAL FEE INFORMATION 02/21/2015 to

Period of: 02/20/2016
Total Fees Due: **$2,761.90**
Due On: 01/20/2015

Total fees due based on:

2,761.90 1 location(s) at a Fixed Fee of $2761.90 for each location

NOTE: All fees must be postmarked no later than 02/20/2015 to avoid late payment penalty fees. Make check or money order payable to "The Department of Public Health". DO NOT SEND CASH

If you have any questions about fees, please email RCollection@cdph.ca.gov or call our office at (800) 236-9747

Detach this portion and return with payment

Facility: License Number:

Period of: 02/21/2015 to 02/20/2016 Invoice Number:

Final Due Date: 02/20/2015 Total Due: **$2,761.90**

California Department of Public Health
Licensing and Certification Program Grant and Fiscal Assessment Unit
P.O. Box 997434 MS 3202
Sacramento, CA 95899-7434

State of California-Department of Public Health

License Number:
Expiration Date:
Invoice Date:
Invoice Number:
Date of Notice:

Notice of Expiration and Application for Facility License Renewal

LICENSE AND FACILITY CHANGES

Skilled Nursing and Intermediate Care facilities, please disclose:

(a) Enter Administrator and Director of Nursing information below [HSC 1422 (d)]:

Administrator: First:__________________________MI:____Last:______________________

Date of Hire:______________/___/ NHA License Number: _______________________

Director of Nursing: First:_______________________MI:____Last: ___________________

Date of Hire:______________/___/ RN License Number: _______________________

Note: If the District Office does not have a HS 215A Applicant Individual Information, for the administrator, please submit one.

(b) Financial Triggers [(HSC 1421.1)]:

_____Yes ___No Has the facility encountered any of the occurrences listed in HSC 1421.1(b) since the last previous renewal?

If Yes, Please describe the occurrences. (If necessary, attach a separate page.):

____

(c) Bankruptcy (HSC 1421.5):

_____Yes ___No Has the facility filed a bankruptcy petition since the last license renewal notice?

If Yes: Date bankruptcy declared:_____/___/____
Trustee's Name: ____
Type of Filing: ____

ALL FACILITIES: Please mark the appropriate box if any changes to the following have occurred:
_____Yes_____No 1. General partner (if the applicant is a partnership).

_____Yes_____No 2. Director or officer (if the applicant is a corporation).

_____Yes ___No 3. Member, manager or company officer (if the applicant is a limited liability company)

If yes to the above, submit a HS 215A and HS 309, Administrative Organization.

continued on next page

State of California-Department of Public Health

License Number:
Expiration Date:
Invoice Date:
Invoice Number:
Date of Notice:

Notice of Expiration and Application for Facility License Renewal

Facility:

LICENSE AND FACILITY CHANGES

_____Yes ____No 4. Any ***new*** individual(s) having a 5 percent or more beneficial ownership interest in the applicant corporation, limited liability company or partnership.

If yes to the above, submit a HS 200 Licensure & Certification Application, (*fill out Section A, item 1d, Section B, Section C and Section F*), HS 215A and HS 309 (*fill out page 1 and page 2, #5*).

_____Yes ____No 5. Is the facility managed by a management company approved by the Department?

If yes: Name of Management Company ____________Effective Date:____/___/____

If you have any questions regarding the approval of a management company, contact the Department's Centralized Applications Unit at (916) 552-8632.

_____Yes ____No 6. Is your surgical clinic owned in whole or in part by a private licensed physician?

If yes, Licensing & Certification no longer licenses these surgical clinics pursuant to Section 1206 (a) of the Health and Safety Code; therefore, you are not required to submit a renewal fee.

If no, please submit your renewal fee.

_____Yes ____No 7. Is your primary care clinic accredited by the Joint Commission on Accreditation of Healthcare Organization (The Joint Commission)?

_____Yes ____No 8. Is your clinic federally designated as a Rural Health Clinic?

Please provide the following information for your facility:
Email (preferably one associated with the facility rather than an individual):

____

Fax Number: ______________________________

You may download Forms HS 200, HS 215A, and HS309 from
http://www.cdph.ca.gov/pubsforms/forms/Documents/LicCert-HealthFacility/LC-AllFormsPage.pdf

The California Department of Public Health Licensing
and Certification
Fresno District Office
285 West Bullard Avenue, Suite 101
Fresno, CA 93704

Phone: (559)437-1500

Note: Send these pages and continuation sheet of these pages to the office address noted above.

State of California-Department of Public Health

License Number:
Expiration Date:
Invoice Date:
Invoice Number:
Date of Notice:

Notice of Expiration and Application for Facility License Renewal

Facility Information

Administrator:
Telephone:

Approved Services

Medical Social Services	Occupational Therapy
Physical Therapy	Speech Therapy

License Conditions:

None

LICENSEE ACKNOWLEDGEMENT

I/we understand that I/we are required to complete and submit FORM HS 200 Application for Facility License, if applicable; or, FORM HS 215A Applicant Individual Information (for SNF's, ICFs, ICF/DDHs, ICF/DDNs and Clinics), if appropriate, to disclose any changes in program, licensed capacity, or ownership information. Failure to provide the required information timely may result in disciplinary action against my/our license.

I/we accept responsibility to (a) comply with local ordinances concerning zoning, sanitation, building, and other appropriate ordinances; (b) comply with the labor code on employment practice concerning wages, hours, non-discrimination, liability insurance, and working conditions; (c) comply with health and safety codes and regulations concerning licensing and fire safety. I/we declare under penalty of perjury that the statements on this notice and any accompanying attachments are correct to my/our best knowledge.

SIGNATURE ______________________________

TITLE ___________________________

PRINT NAME ________________________ DATE ____________

The California Department of Public Health Licensing and Certification
Fresno District Office
285 West Bullard Avenue, Suite 101
Fresno, CA 93704