Department of Public Health (DPH) – Licensing and Certification (L&C) Division
Within DPH, the Licensing and Certification Division oversees the licensing, regulation, and inspection of all health care facilities, including hospitals. In addition, the L&C division certifies the following health care providers: nurse assistants, home health aides, hemodialysis technicians, and nursing home administrators.

Primary Purposes
L&C ensures health care facilities are in compliance with state laws and regulations, including overseeing administrative penalties and reporting of adverse events. Further, L&C works with the Centers for Medicare and Medicaid Services (CMS) to monitor facilities that receive Medicare and Medi-Cal funding are meeting federal standards and requirements.

Organization and Structure
L&C is housed within the Department of Public Health, which is located in Sacramento. There are several field offices throughout the State, which oversee health care facilities in their jurisdiction. One of their roles is to receive complaints about health care facilities and providers in their area. The director of the Department of Public Health is Dr. Mark Horton. The Deputy Director of the Center for Healthcare Quality, which oversees Licensing and Certification Division, is Kathleen Billingsley.

- **Provider and Facility Relation Information**
  L&C has set up their website to include all the form required for health care facilities and providers to file for licensure and certification. Two important branches within the L&C division are the Central Applications Unit and the Professional Certification Branch, which contain checklists, All Facility Letters (federal regulations and laws), and application forms. Under each link, there are a number of forms and checklists that health care facilities and providers must follow to ensure their compliance with the licensing and certification processes.

- **Consumer Related Information**
  The website contains information for consumers to compare hospitals and nursing home facilities, file a complaint against a facility, and provides a link to a “know your rights” brochure for nursing home residents. The website is relatively simple to use. Information about disciplinary actions is available on the website. There is a link to an online complaint form or a form that is printable and must be sent to one of the field offices.

Websites
L&C Home: [http://www.cdph.ca.gov/programs/Pages/LnC.aspx](http://www.cdph.ca.gov/programs/Pages/LnC.aspx)
Central Applications Unit: [http://www.cdph.ca.gov/pubsforms/forms/Pages/LicensingandCert.aspx](http://www.cdph.ca.gov/pubsforms/forms/Pages/LicensingandCert.aspx)
Professional Certification Branch: [http://www.cdph.ca.gov/certlic/occupations/Pages/AidesAndTechs.aspx](http://www.cdph.ca.gov/certlic/occupations/Pages/AidesAndTechs.aspx)
Consumer Complaints: [https://hfcis.cdph.ca.gov/LongTermCare/ConsumerComplaint.aspx](https://hfcis.cdph.ca.gov/LongTermCare/ConsumerComplaint.aspx)
Disciplinary actions: [http://ww2.cdph.ca.gov/certlic/facilities/Pages/default.aspx](http://ww2.cdph.ca.gov/certlic/facilities/Pages/default.aspx)
The following hospitals received penalties:
1. **Brotman Medical Center, Culver City, Los Angeles County**. The hospital failed to implement policies and procedures to ensure safe and effective administration of medications. This is the facility’s first administrative penalty.
2. **Clovis Community Medical Center, Clovis, Fresno County**. The hospital failed to implement policies and procedures for the administration of medications with potential fatal adverse effects and did not provide for appropriate follow-up assessments, prompt monitoring and intervention. This is the facility’s first administrative penalty.
3. **Hollywood Presbyterian Medical Center, Los Angeles, Los Angeles County**. The hospital failed to accurately implement its blood transfusion policies and procedures. This is the facility’s first administrative penalty.
4. **John Muir Medical Center, Concord, Contra Costa County**. The hospital failed to follow its own policies and procedures for restraining a patient for radiological exams. This is the facility’s first administrative penalty.
5. **Los Angeles County, Harbor-UCLA Medical Center, Torrance, Los Angeles County**. The hospital failed to ensure the health and safety of a patient when the hospital did not follow its surgical policies and procedures. This resulted in a patient having to undergo a second surgery to remove a retained foreign object. This is the facility’s fourth administrative penalty.
6. **Saint Agnes Medical Center, Fresno County**. The health and safety of a patient was jeopardized when the patient’s condition was not assessed while in decline and interventions were not initiated. This is the facility’s third administrative penalty.
7. **Saint Francis Medical Center, Lynwood, Los Angeles County**. The hospital failed to execute policies and procedures to ensure safe and effective use of medications. This is the facility’s first administrative penalty.
8. **Scripps Mercy Hospital, San Diego, San Diego County**. The hospital failed to follow its policies and procedures for the use and maintenance of respiratory equipment. This is the facility’s second administrative penalty.
9. **St. Jude Medical Center, Fullerton, Orange County**. The hospital failed to ensure the health and safety of a patient when the hospital did not follow its surgical policy and procedure. This resulted in a patient having to undergo a second surgery to remove a retained foreign object. This is the facility’s first administrative penalty.
10. **University of California Irvine Medical Center, Irvine, Orange County**. The health and safety of a patient was jeopardized when the hospital failed to follow its policies and procedures for fall prevention. This is the facility’s first administrative penalty.
11. **University of California Irvine Medical Center, Irvine, Orange County**. The hospital compromised the safety of a patient when an allegation of physical assault was not investigated timely. The right to considerate and respectful care was not ensured. This is the facility’s second administrative penalty.
12. **University of California, San Diego Medical Center, San Diego, San Diego County**. The hospital failed to ensure the health and safety of a patient when the hospital did not follow its surgical policies and procedures. This resulted in a patient having to undergo a second surgery to remove a retained foreign object. This is the facility’s second administrative penalty.
13. **University of California, San Francisco Medical Center, San Francisco, San Francisco County**. The hospital failed to ensure the safety of a patient by not establishing a safe and effective system for the administration of high-risk medications. This is the facility’s second administrative penalty.
14. **Whittier Hospital Medical Center, Whittier, Los Angeles County**. The hospital failed to ensure the health and safety of a patient when it did not follow established policies and procedures regarding identification of a patient prior to a surgical procedure. This is the facility’s first administrative penalty.