NOTICE OF PUBLIC HEARING

Intent to Adopt Regulations
(LCB File No. R109-18)

NOTICE IS HEREBY GIVEN that the State Board of Health will hold a public hearing to consider amendments to Chapter 449 of Nevada Administrative Code (NAC), Medical Facilities and Other Related Entities. This public hearing is to be held in conjunction with the State Board of Health meeting on Friday, December 7, 2018.

The State Board of Health will be conducted via videoconference beginning at 9:00 a.m. on Friday, December 7, 2018 at the following locations:

Division of Public and Behavioral Health 4150 Technology Way Room #303 Carson City, NV 89706	Grant Sawyer Office Building 555 E. Washington Ave Las Vegas, NV 89101

The proposed changes to Nevada Administrative Code (NAC) Chapter 449, LCB File No. R109-18, include the following:

- Bring NAC Chapter 449 into compliance with Senate Bill's (SB) 71, 324, 388 and 482 of the 2017 legislative session as all the bills require the Board to adopt regulations to carry out the provisions of the bills.
- Outline the requirements to license and regulate employment agencies that contract with persons to provide nonmedical services related to personal care to elderly persons or persons with disabilities in the home. It also prescribes the fees for the issuance and renewal of a license of such an employment agency. (SB 388)
- Prescribe the posting requirements of the Centers for Medicare and Medicaid Services star rating that a medical facility or facility for the dependent that receives a star rating is required to post and clarifies that a facility which does not receive a star rating is not required to post a star rating. (SB 482)
- Authorizes an employee of a residential facility for groups, an agency to provide personal care services in the home, a facility for the care of adults during the day or an intermediary services organization to check vital signs, administer insulin using an auto-injection device and perform blood glucose testing, subject to certain requirements, to perform those tasks, as well as being able to weigh residents, upon the consent of the resident. The proposed regulations also require an employee who performs such tasks to receive certain training, adhere to the manufacturer's instructions for any device used in performing the task, and refrain from using a device for monitoring blood glucose on more than one person. (SB 324)
- Increases the amounts of monetary penalties which may be imposed on a medical facility, facility for the dependent or other facility required by the Board to be licensed, increases the maximum amount of the monetary penalty for a day of noncompliance, and establishes an administrative penalty to be imposed for a violation that causes harm or a risk of harm to more than one person. (SB 71)
- Authorizes a facility to request to use all or a portion of an initial monetary penalty to correct the deficiency for which the penalty was imposed in lieu of paying the penalty and authorizes the Bureau of

Health Care Quality and Compliance to approve such a request if the deficiency results from the facility's first violation of a particular provision of law or regulation.

1. Anticipated effects on the business which NAC 449 regulates:

A. Adverse: It will have an adverse economic effect on facilities that receive a monetary penalty although it is anticipated only a small percentage (2% to 4%) of facilities would be impacted. The following information is based on all health facilities that have received at least one severity 3 or 4 citation over a one-year period. Based on this information, 4% of health facilities received at least one severity level 3 or 4 citation in 2015, 3% in 2016 and only 2% in 2017. It is possible that of the small percentage of facilities that receive a severity level 3 or 4, some may have difficulties paying or using the monetary penalties to correct violations resulting in a negative financial impact on their business.

B. Beneficial: The proposed regulations carry out the provisions of Senate Bill (SB) 324 which may result in financial benefits to certain industry by removing the requirement that a resident's glucose testing be performed by a medical laboratory licensed pursuant to chapter 652 of NRS; therefore, eliminating licensure as a laboratory with all the associated fees and state specific requirements to serve as a director of a laboratory. Industry that may not have been able to accept certain residents/clients requiring care may now be able to do so, potentially increasing the number of residents they can accept, or allowing residents/clients that may have needed to be transferred to a higher level of care to remain at the facility.

C. Immediate: The adverse effects may be immediate, upon passage of the proposed regulations, for those that receive a monetary penalty shortly after the passage of the proposed regulations. Upon passage of the proposed regulations, certain facilities will be able to immediately begin performing the tasks noted previously, after certain criteria are met, such as performing glucose testing using a glucometer and vital signs in their facilities, possibly allowing them to admit additional resident/clients they were not able to in the past or retain residents that may otherwise have to be transferred out of the facility to a higher level of care.

D. Long-term: Possible revenue increase from being able to admit or retain more residents than possible in the past. Possible increased costs negatively impacting facilities that receive monetary penalties.

2. Anticipated effects on the public:

A. *Adverse*: No anticipated adverse effects on the public is anticipated.

B. *Beneficial:* Benefits to the public include adding training requirements to perform certain tasks, requiring manufacturer's instructions be followed, and utilizing nationally recognized infection control guidelines when carrying out such tasks, to help ensure these activities are carried out in a safe and effective manner.

C. *Immediate*: Ability for certain members of the public, such as diabetics, to have a wider range of choices as to where they receive care. Greater transparency to the public who will be able to see a facility's Centers for Medicare and Medicaid services star rating, if applicable, at the entrance of facilities.

D. *Long-term:* The long-term effects would be a continuation of the immediate effects over time.

3. The estimated cost to the Division of Public and Behavioral Health for enforcement of the proposed regulations is estimated to cost $1,400 to conduct an initial inspection for each employment agency to provide

non-medical services in the home and cost $700 a year to continue to license and regulate each agency. As the Division does not know how many agencies would be licensed in accordance to this new rule, a total cost cannot be estimated at this time. Enforcement related to all other areas in the proposed regulations would be incorporated into current licensing and regulatory activities; therefore, it is not anticipated that these activities would result in additional costs to the Division.

There are no duplicative or more stringent provisions than federal, state or local standards regulating to the same activity.

Members of the public may make oral comments at this meeting. Persons wishing to submit written testimony or documentary evidence in excess of two typed, 8-1/2" x 11" pages must submit the material to the Board's Secretary, Julie Kotchevar, to be received no later than November 27, 2018 at the following address:

Secretary, State Board of Health
Division of Public and Behavioral Health
4150 Technology Way, Suite 300
Carson City, NV 89706

Written comments, testimony, or documentary evidence in excess of two typed pages will not be accepted at the time of the hearing. The purpose of this requirement is to allow Board members adequate time to review the documents.

A copy of the notice and proposed regulations are on file for inspection and/or may be copied at the following locations during normal business hours:

Nevada Division of Public and Behavioral Health
727 Fairview Drive, Suite E
Carson City, NV 89701

Nevada State Library
100 Stewart Street
Carson City, NV 89701

Nevada Division of Public and Behavioral Health
4220 S. Maryland Parkway, Suite 810, Building D
Las Vegas, NV 89119

A copy of the regulations and small business impact statement can be found on-line by going to:
http://dpbh.nv.gov/Reg/HealthFacilities/State_of_Nevada_Health_Facility_Regulation_Public_Workshops/

A copy of the public hearing notice can also be found at Nevada Legislature's web page:
https://www.leg.state.nv.us/App/Notice/A/

Copies may be obtained in person, by mail, or by calling the Division of Public and Behavioral Health at (775) 684-1030 in Carson City or (702) 486-6515 in Las Vegas.

Copies may also be obtained from any of the public libraries listed below:

Carson City Library
900 North Roop Street

Churchill County Library
553 South Main Street

Carson City, NV 89702

Fallon, NV 89406

Clark County District Library
1401 East Flamingo Road
Las Vegas, NV 89119

Douglas County Library
1625 Library Lane
Minden, NV 89423

Elko County Library
720 Court Street
Elko, NV 89801

Esmeralda County Library
Corner of Crook and 4th Street
Goldfield, NV 89013-0484

Eureka Branch Library
80 South Monroe Street
Eureka, NV 89316-0283

Henderson District Public Library
280 South Green Valley Parkway
Henderson, NV 89012

Humboldt County Library
85 East 5th Street
Winnemucca, NV 89445-3095

Lander County Library
625 South Broad Street
Battle Mountain, NV 89820-0141

Lincoln County Library
93 Maine Street
Pioche, NV 89043-0330

Lyon County Library
20 Nevin Way
Yerington, NV 89447-2399

Mineral County Library
110 1st Street
Hawthorne, NV 89415-1390

Pahrump Library District
701 East Street
Pahrump, NV 89041-0578

Pershing County Library
1125 Central Avenue
Lovelock, NV 89419-0781

Storey County Library
95 South R Street
Virginia City, NV 89440-0014

Tonopah Public Library
167 Central Street
Tonopah, NV 89049-0449

Washoe County Library
301 South Center Street
Reno, NV 89505-2151

White Pine County Library
950 Campton Street
Ely, NV 89301-1965

Per NRS 233B.064(2), upon adoption of any regulation, the agency, if requested to do so by an interested person, either prior to adoption or within 30 days thereafter, shall issue a concise statement of the principal reasons for and against its adoption, and incorporate therein its reason for overruling the consideration urged against its adoption.

REVISED PROPOSED REGULATION OF THE

STATE BOARD OF HEALTH

LCB File No. R109-18

August 23, 2018

EXPLANATION – Matter in ***italics*** is new; matter in brackets **[**~~omitted material~~**]** is material to be omitted.

AUTHORITY: §1, NRS 439.200, 449.03005, 449.0302, 449.0304, 449.165 and 449.1825; §§2-11 and 18, NRS 439.200 and 449.03005; §12, NRS 439.200, 449.0302 and 449.1825; §§13, 15, 16, 20-24 and 27-30, NRS 439.200, 449.0302 and 449.0304; §§14, 25 and 26, NRS 439.200, 449.4308, 449.4309 and 449.4327; §§17 and 31-34, NRS 439.200 and 449.165; §19, NRS 439.150, 439.200, 449.03005 and 449.050.

A REGULATION relating to health care; prescribing requirements concerning the licensing and operation of certain employment agencies that provide nonmedical services; prescribing requirements concerning the posting of ratings of medical facilities and facilities for the dependent; establishing a system for rating certain health care facilities on compliance with provisions relating to staffing; establishing procedures to appeal a finding of a violation of such provisions or request a follow-up inspection; authorizing certain uses of an initial monetary penalty to correct the deficiency for which the penalty was imposed; increasing certain monetary penalties; establishing monetary penalties for violations that cause harm or a risk of harm to more than one person; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the State Board of Health to license and regulate employment agencies that contract with persons to provide nonmedical services related to personal care to elderly persons or persons with disabilities in the home. (NRS 449.03005) **Sections 2-7** of this regulation define terms relating to the licensure and regulation of such employment agencies. **Section 8** of this regulation prescribes requirements relating to the scope and content of a license to operate such an employment agency and requires such an employment agency to maintain liability coverage. **Section 9** of this regulation requires each such employment agency to appoint an administrator and prescribes the qualifications and duties of an administrator.

Section 4 defines the term "attendant" to mean a person who is employed by or retained pursuant to a contract by an employment agency for the purpose of providing nonmedical services to a client. **Section 10** of this regulation prescribes the qualifications of and training requirements for an attendant of such an employment agency. **Section 11** of this regulation requires such an employment agency to: (1) provide records to the Division of Public and

Behavioral Health of the Department of Health and Human Services upon request; (2) perform certain duties relating to the evaluation and supervision of attendants; (3) provide certain information to clients; and (4) if the employment agency is located outside Nevada, pay necessary expenses incurred by the Division when conducting inspections and investigating complaints. **Section 18** of this regulation makes a conforming change. **Section 19** of this regulation prescribes the fees for the issuance and renewal of a license as such an employment agency.

Existing law requires a medical facility or facility for the dependent that receives a star rating from the Centers for Medicare and Medicaid Services to post the most recent star rating assigned to the facility in a conspicuous place near each entrance to the facility that is regularly used by the public. (NRS 449.1825) **Section 12** of this regulation: (1) prescribes requirements concerning the posting of the star rating; and (2) clarifies that a facility which does not receive a star rating is not required to post a star rating.

Existing law requires the Board to adopt regulations authorizing an employee of a residential facility for groups, an agency to provide personal care services in the home, a facility for the care of adults during the day or an intermediary services organization to check vital signs, administer insulin using an auto-injection device and perform blood glucose testing, subject to certain requirements. (NRS 449.0304, 449.4309) **Sections 13-16** of this regulation authorize an employee of such a facility, agency or organization to perform those tasks. **Sections 13-16 and 22** of this regulation require an employee who performs such tasks to: (1) receive certain training; (2) adhere to the manufacturer's instructions for any device used in performing the task and any applicable federal and state laws and regulations; and (3) refrain from using a device for monitoring blood glucose on more than one person. **Sections 13-16** additionally clarify that if a client of such a facility, agency or organization is physically or mentally incapable of performing a blood glucose test and an employee performs or assists with the performance of such a test, the employee is required to comply with those requirements as if he or she were performing the test. Finally, **sections 13-16** authorize an employee of a residential facility for groups, an agency to provide personal care services in the home, a facility for the care of adults during the day or an intermediary services organization to measure weight if the employee has received certain training and the person being weighed has consented. **Sections 20, 21 and 23-30** of this regulation make conforming changes.

Existing law authorizes the Division to impose a monetary penalty of not more than $5,000 per day for each violation on a medical facility, facility for the dependent or other facility required by the Board to be licensed that violates any provision related to its licensure or regulation of the Board. (NRS 449.163) Existing law also requires the Board to adopt regulations establishing the criteria for the imposition of monetary penalties and to establish an administrative penalty to be imposed for a violation that causes harm or a risk of harm to more than one person. (NRS 449.165) Existing regulations authorize the Bureau of Health Care Quality and Compliance of the Division to impose an initial monetary penalty based on the severity and scope of the violation and a monetary penalty of $10 for each day of noncompliance. (NAC 449.99896) **Section 17** of this regulation authorizes a facility to request to use all or a portion of an initial monetary penalty to correct the deficiency for which the penalty was imposed in lieu of paying the penalty. **Section 17** authorizes the Bureau of Health Care Quality and Compliance of the Division to approve such a request if the deficiency results from

the facility's first violation of a particular provision of law or regulation. **Sections 31 and 34** of this regulation make conforming changes. **Section 32** of this regulation: (1) revises the amount of each initial monetary penalty; and (2) establishes an initial monetary penalty for a violation that causes harm or a risk of harm to more than one person. **Section 33** of this regulation increases the maximum amount of the monetary penalty for a day of noncompliance.

Section 1. Chapter 449 of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 17, inclusive, of this regulation.

Sec. 2. ***"Employment agency to provide nonmedical services" means an employment agency that contracts with persons to provide "nonmedical services related to personal care to elderly persons or persons with disabilities," as that term is defined in NRS 449.01517.***

Sec. 3. ***As used in sections 3 to 11, inclusive, of this regulation, the words and terms defined in sections 4 to 7, inclusive, of this regulation have the meanings ascribed to them in those sections.***

Sec. 4. ***"Attendant" means a person who is employed by or retained pursuant to a contract by an employment agency for the purpose of providing nonmedical services to a client.***

Sec. 5. ***"Client" means an elderly person or a person with a disability who seeks to receive or receives nonmedical services in the home in which the person lives.***

Sec. 6. ***"Employment agency" means an employment agency to provide nonmedical services.***

Sec. 7. ***"Nonmedical services" means "nonmedical services related to personal care to elderly persons or persons with disabilities," as that term is defined in NRS 449.01517.***

Sec. 8. ***1. Except as otherwise provided in this subsection, each license issued to operate an employment agency must be issued to one person and designate the primary place of business of the employment agency. A person may operate an employment agency at multiple***

work stations if the employment agency maintains the records for the clients, attendants, other members of the staff of the employment agency and operations of the employment agency at the primary place of business designated on the license.

2. The name of the person to whom the license is issued must appear on the face of the license.

3. Each employment agency must retain proof that it has adequate coverage against liabilities to cover claims likely to be incurred in the course of operation. The proof of liability coverage must be verified at the time the employment agency submits its initial application to the Division for a license and upon request by the Division.

4. As used in this section, "work station" means a satellite office of an employment agency that is established for the sole purpose of providing a location:

(a) Where copies of records may be sent to an employment agency; and

(b) From which an attendant may work to serve a geographic area outside the geographic area in which the attendant normally works.

Sec. 9. *1. Each employment agency shall appoint an administrator who:*

(a) Is at least 18 years of age;

(b) Has a high school diploma or its equivalent;

(c) Is responsible and mature and exhibits empathy, listening skills and other personal qualities which will enable the administrator to understand the problems of elderly persons and persons with disabilities;

(d) Understands the provisions of this chapter and chapter 449 of NRS; and

(e) Has demonstrated the ability to read, write, speak and understand the English language.

2. The administrator of an employment agency shall oversee the daily operation of the employment agency and shall appoint another employee to assume the responsibilities of the administrator in the absence of the administrator. The responsibilities of an administrator include, without limitation:

(a) Employing qualified personnel and providing for their training;

(b) Ensuring that the employment agency refers only properly trained attendants to provide nonmedical services to clients;

(c) Ensuring that an initial assessment of the needs of each client is completed and that an attendant referred to provide nonmedical services to a client is capable of providing the services necessary to meet those needs;

(d) Ensuring that the clients of the employment agency receive needed nonmedical services; and

(e) Developing and implementing policies and procedures for the employment agency, including, without limitation, policies and procedures concerning terminating the nonmedical services provided to a client when they are no longer necessary.

Sec. 10. *Each attendant of an employment agency must:*

1. Be at least 18 years of age;

2. Provide to the Division, upon request, documentation that the attendant has taken the tests or obtained the certificates required by NAC 441A.375;

3. Be responsible and mature and exhibit empathy, listening skills and other personal qualities which will enable the attendant to understand the problems of elderly persons and persons with disabilities;

4. Understand the provisions of this chapter and chapter 449 of NRS;

5. Demonstrate the ability to read, write, speak and communicate effectively in the English language with the clients of the employment agency;

6. Demonstrate the ability to meet the needs of the clients of the employment agency; and

7. Within the 12 months immediately preceding the date on which the attendant begins providing nonmedical services to a client and annually thereafter, complete not less than 8 hours of training related to providing for the needs of the clients of the employment agency and limitations on the nonmedical services provided by the employment agency. The training must include, without limitation, training concerning:

(a) Duties and responsibilities of attendants and the appropriate techniques for providing nonmedical services;

(b) Recognizing and responding to emergencies, including, without limitation, fires and medical emergencies;

(c) Dealing with the adverse behaviors of clients;

(d) Nutrition and hydration, including, without limitation, special diets and meal preparation and service;

(e) Bowel and bladder care, including, without limitation, routine care associated with toileting, routine maintenance of an indwelling catheter drainage system such as emptying the bag and positioning of the system, routine care of colostomies such as emptying and changing the colostomy bag, signs and symptoms of urinary tract infections and common bowel problems, including, without limitation, constipation and diarrhea;

(f) Methods for preventing skin breakdown, contractures and falls;

(g) Hand washing and infection control;

(h) Basic body mechanics, mobility and techniques for transferring clients;

(i) Proper techniques for bathing clients;

(j) The rights of clients and methods to protect the confidentiality of information concerning clients as required by federal and state law and regulations;

(k) The special needs of elderly persons and persons with disabilities and sensory, physical and cognitive changes related to the aging process;

(l) Maintenance of a clean and safe environment; and

(m) First aid and cardiopulmonary resuscitation. A certificate in first aid and cardiopulmonary resuscitation issued to the attendant by the American Red Cross, its successor organization, or an organization determined by the Division to be equivalent shall be deemed adequate proof that the attendant has received the training required by this paragraph.

Sec. 11. *An employment agency shall:*

1. Provide any records of the employment agency to the Division upon request, including, without limitation, as part of an investigation of a complaint;

2. Evaluate each attendant to determine whether the attendant is competent in the required areas of training set forth in subsection 7 of section 10 of this regulation;

3. Ensure that each attendant does not provide services other than nonmedical services;

4. Before an attendant begins providing nonmedical services to a client, provide information to the client regarding the fees for those nonmedical services;

5. If the employment agency is located outside of this State, pay any necessary expenses, including, without limitation, travel expenses, incurred by the Division to conduct inspections and investigations of complaints; and

6. Inform each client that the employment agency is not an agency to provide nursing in the home and is not authorized to provide services other than nonmedical services.

Sec. 12. *1. Information posted by a medical facility or facility for the dependent to satisfy the requirements of subsection 2 of NRS 449.1825 must, in addition to meeting the requirements of that subsection:*

(a) Be posted on a sign that is not less than 8.5 inches in height and 11 inches in width, with margins not greater than 1 inch on any side;

(b) Be written using a single typeface in not less than 20-point type; and

(c) State the name of the facility and identify the star rating assigned by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services as the "Centers for Medicare and Medicaid Services Star Rating."

2. The requirements of subsection 2 of NRS 449.1825 apply to each entrance to a building where activity is conducted for which a license as a medical facility or facility for the dependent is required.

3. A medical facility or facility for the dependent is not required to post a star rating assigned by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services pursuant to subsection 2 of NRS 449.1825 if the facility did not receive such a rating, including, without limitation, if the facility received an asterisk instead of a star rating.

Sec. 13. *1. A caregiver of a residential facility may perform a task described in NRS 449.0304 if the caregiver:*

(a) Before performing the task, annually thereafter and when any device used for performing the task is changed:

(1) Has received training concerning the task that meets the requirements of subsection 5; and

(2) Has demonstrated an understanding of the manner in which the task must be performed;

(b) Follows the manufacturer's instructions when operating any device used for performing the task;

(c) Performs the task in conformance with the Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a, if applicable, and any other applicable federal law or regulation; and

(d) If the resident has diabetes, complies with the requirements of subsection 3 and NAC 449.2726.

2. If a person with diabetes who is a resident does not have the physical or mental capacity to perform a blood glucose test on himself or herself and a caregiver of the residential facility performs or assists with the performance of a blood glucose test on the resident:

(a) The caregiver shall be deemed to perform the blood glucose test and must comply with all applicable requirements prescribed by this section; and

(b) The Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a shall be deemed to be applicable for the purposes of paragraph (c) of subsection 1.

3. If a caregiver conducts a blood glucose test, the caregiver must ensure that the device for monitoring blood glucose is not used on more than one person.

4. A caregiver may weigh a resident of a residential facility only if:

(a) The caregiver has received training on the manner in which to weigh a person that meets the requirements of subsections 5 and 6; and

(b) The resident has consented to being weighed by the caregiver.

5. Any training described in this section must be provided by:

(a) A physician, physician assistant, licensed nurse; or

(b) An employee of the residential facility who has:

(1) Received training pursuant to paragraph (a) of subsection 1 or paragraph (a) of subsection 4, as applicable, from a physician, physician assistant or licensed nurse;

(2) At least 1 year of experience performing the task for which he or she is providing training; and

(3) Demonstrated competency in performing the task for which he or she is providing training.

6. Any training described in this section must include, without limitation:

(a) Instruction concerning how to accurately perform the task for which the caregiver is being trained in conformance with nationally recognized infection control guidelines which may include, without limitation, guidelines published by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;

(b) Instruction concerning how to accurately interpret the information obtained from performing the task; and

(c) A description of any action, including, without limitation, notifying a physician, that must be taken based on such information.

Sec. 14. *1. A personal assistant may perform a task described in NRS 449.4309 if the personal assistant:*

(a) Before performing the task, annually thereafter and when any device used for performing the task is changed:

(1) Receives training concerning the task that meets the requirements of subsection 6; and

(2) Demonstrates an understanding of the task;

(b) Follows the manufacturer's instructions when operating any device used for performing the task;

(c) Performs the task in conformance with the Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a, if applicable, and any other applicable federal law or regulation; and

(d) Complies with the requirements of subsection 3 or 4, if applicable.

2. If a person with diabetes who is a client of an intermediary service organization does not have the physical or mental capacity to perform a blood glucose test on himself or herself and a personal assistant performs or assists with the performance of a blood glucose test on the client:

(a) The personal assistant shall be deemed to perform the blood glucose test and must comply with all applicable requirements prescribed by this section; and

(b) The Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a shall be deemed to be applicable for the purposes of paragraph (c) of subsection 1.

3. In addition to satisfying the requirements of subsection 1, a personal assistant who conducts a blood glucose test must ensure that the device for monitoring blood glucose is not used on more than one person.

4. A personal assistant may assist a client in the administration of insulin prescribed to the client for his or her diabetes and furnished by a registered pharmacist through an auto-injection device approved by the United States Food and Drug Administration for use in the home in accordance with the requirements of subsection 1 if:

(a) A physician, physician assistant or advanced practice registered nurse has determined that the client's physical and mental condition is stable and following a predictable course; and

(b) The amount of the insulin prescribed to the client is at a maintenance level and does not require a daily assessment, including, without limitation, the use of a sliding scale.

5. A personal assistant may weigh a client of an intermediary service organization only if:

(a) The personal assistant has received training on the manner in which to weigh a person that meets the requirements of subsections 6 and 7; and

(b) The client has consented to being weighed by the personal assistant.

6. Any training described in this section must be provided by:

(a) A physician, physician assistant, licensed nurse; or

(b) An employee of the intermediary service organization who has:

(1) Received training pursuant to paragraph (a) of subsection 1 or paragraph (a) of subsection 5, as applicable, from a physician, physician assistant or licensed nurse;

(2) At least 1 year of experience performing the task for which he or she is providing training; and

(3) Demonstrated competency in performing the task for which he or she is providing training.

7. Any training described in this section must include, without limitation:

(a) Instruction concerning how to accurately perform the task for which the personal assistant is being trained in conformance with nationally recognized infection control guidelines which may include, without limitation, guidelines published by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;

(b) Instruction concerning how to accurately interpret the information obtained from performing the task; and

(c) A description of any action, including, without limitation, notifying a physician, that must be taken based on such information.

Sec. 15. *1. An attendant may perform a task described in NRS 449.4309 if the attendant:*

(a) Before performing the task, annually thereafter and when any device used for performing the task is changed:

(1) Receives training concerning the task that meets the requirements of subsection 6; and

(2) Demonstrates an understanding of the task;

(b) Follows the manufacturer's instructions when operating any device used for performing the task;

(c) Performs the task in conformance with the Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a, if applicable, and any other applicable federal law or regulation; and

(d) Complies with the requirements of subsection 3 or 4, if applicable.

2. If a person with diabetes who is a client of an agency does not have the physical or mental capacity to perform a blood glucose test on himself or herself and an attendant performs or assists with the performance of a blood glucose test on the client:

(a) The attendant shall be deemed to perform the blood glucose test and must comply with all applicable requirements prescribed by this section; and

(b) The Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a shall be deemed to be applicable for the purposes of paragraph (c) of subsection 1.

3. In addition to satisfying the requirements of subsection 1, an attendant who conducts a blood glucose test must ensure that the device for monitoring blood glucose is not used on more than one person.

4. An attendant may assist a client in the administration of insulin prescribed to the client for his or her diabetes and furnished by a registered pharmacist through an auto-injection device approved by the United States Food and Drug Administration for use in the home in accordance with the requirements of subsection 1 if:

(a) A physician, physician assistant or advanced practice registered nurse has determined that the client's physical and mental condition is stable and following a predictable course; and

(b) The amount of the insulin prescribed to the client is at a maintenance level and does not require a daily assessment, including, without limitation, the use of a sliding scale.

5. An attendant may weigh a client of an agency only if:

(a) The attendant has received training on how to accurately weigh persons that meets the requirements of subsections 6 and 7; and

(b) The client has consented to being weighed by the attendant.

6. Any training described in this section must be provided by:

(a) A physician, physician assistant, licensed nurse; or

(b) An employee of the agency who has:

(1) Received training pursuant to paragraph (a) of subsection 1 or paragraph (a) of subsection 5, as applicable, from a physician, physician assistant or licensed nurse;

(2) At least 1 year of experience performing the task for which he or she is providing training; and

(3) Demonstrated competency in performing the task for which he or she is providing training.

7. Any training described in this section must include, without limitation:

(a) Instruction concerning how to accurately perform the task for which the attendant is being trained in conformance with nationally recognized infection control guidelines which may include, without limitation, guidelines published by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;

(b) Instruction concerning how to accurately interpret the information obtained from performing the task; and

(c) A description of any action, including, without limitation, notifying a physician, that must be taken based on such information.

Sec. 16. *1. An employee of a facility may perform a task described in NRS 449.4309 if the employee:*

(a) Before performing the task, annually thereafter and when any device used for performing the task is changed:

(1) Receives training concerning the task that meets the requirements of subsection 6; and

(2) Demonstrates an understanding of the task;

(b) Follows the manufacturer's instructions when operating any device used for performing the task;

(c) Performs the task in conformance with the Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a, if applicable, and any other applicable federal law or regulation; and

(d) Complies with the requirements of subsection 3 or 4, if applicable.

2. If a person with diabetes who is a client of a facility does not have the physical or mental capacity to perform a blood glucose test on himself or herself and an employee of the facility performs or assists with the performance of a blood glucose test on the client:

(a) The employee shall be deemed to perform the blood glucose test and must comply with all applicable requirements prescribed by this section; and

(b) The Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a shall be deemed to be applicable for the purposes of paragraph (c) of subsection 1.

3. In addition to satisfying the requirements of subsection 1, an employee of a facility who conducts a blood glucose test must ensure that the device for monitoring blood glucose is not used on more than one person.

4. An employee of a facility may assist a client in the administration of insulin prescribed to the client for his or her diabetes and furnished by a registered pharmacist through an auto-

injection device approved by the United States Food and Drug Administration for use in the home in accordance with the requirements of subsection 1 if:

(a) A physician, physician assistant or advanced practice registered nurse has determined that the client's physical and mental condition is stable and following a predictable course; and

(b) The amount of the insulin prescribed to the client is at a maintenance level and does not require a daily assessment, including, without limitation, the use of a sliding scale.

5. An employee of a facility may weigh a client of the facility only if:

(a) The employee has received training on how to accurately weigh persons that meets the requirements of subsections 6 and 7; and

(b) The client has consented to being weighed by the employee.

6. Any training described in this section must be provided by:

(a) A physician, physician assistant, licensed nurse; or

(b) An employee of the facility who has:

(1) Received training pursuant to paragraph (a) of subsection 1 or paragraph (a) of subsection 5, as applicable, from a physician, physician assistant or licensed nurse;

(2) At least 1 year of experience performing the task for which he or she is providing training; and

(3) Demonstrated competency in performing the task for which he or she is providing training.

7. Any training described in this section must include, without limitation:

(a) Instruction concerning how to accurately perform the task for which the employee is being trained in conformance with nationally recognized infection control guidelines which

may include, without limitation, guidelines published by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;

(b) Instruction concerning how to accurately interpret the information obtained from performing the task; and

(c) A description of any action, including, without limitation, notifying a physician, that must be taken based on such information.

Sec. 17. ***1. A facility may submit to the Bureau a request to use all or a portion of an initial monetary penalty imposed upon the facility pursuant to NAC 449.99899 to correct the deficiency for which the penalty was imposed in lieu of paying the penalty to the Bureau. The Bureau may approve such a request if the deficiency results from the facility's first violation of a particular provision of law or regulation.***

2. If the Bureau approves a request pursuant to subsection 1, the facility must:

(a) Adhere to any requirements prescribed in a plan of correction approved pursuant to NAC 449.9987 concerning the use of the monetary penalty;

(b) Complete all corrections for which the monetary penalty is used not later than 1 year after the date on which the request was approved;

(c) Submit to the Bureau proof satisfactory to the Bureau that the monetary penalty was used to make corrections for which the use of the monetary penalty was approved by the Bureau pursuant to subsection 1; and

(d) Remit to the Bureau any portion of the monetary penalty that is not used to correct the deficiency.

Sec. 18. NAC 449.002 is hereby amended to read as follows:

449.002 As used in NAC 449.002 to 449.99939, inclusive, unless the context otherwise requires, the words and terms defined in NAC 449.0022 to 449.0072, inclusive, ***and section 2 of this regulation*** have the meanings ascribed to them in those sections.

Sec. 19. NAC 449.013 is hereby amended to read as follows:

449.013 1. Except as otherwise provided in NAC 449.0168, an applicant for a license to operate any of the following facilities, programs of hospice care or agencies must pay to the Division of Public and Behavioral Health the following nonrefundable fees:

(a) An ambulatory surgical center $9,784

(b) A home office or subunit agency of a home health agency 5,168

(c) A branch office of a home health agency 5,358

(d) A rural clinic 4,058

(e) An obstetric center 1,564

(f) A program of hospice care 7,054

(g) An independent center for emergency medical care 4,060

(h) A nursing pool 4,602

(i) A facility for treatment with narcotics 5,046

(j) A medication unit 1,200

(k) A referral agency 2,708

(l) A facility for refractive surgery 6,700

(m) A mobile unit 2,090

(n) An agency to provide personal care services in the home 1,374

(o) A facility for the care of adults during the day allowed to be occupied by not more than 50 clients at one time 1,164

(p) A facility for the care of adults during the day allowed to be occupied by more than 50 clients at one time 1,753

(q) A peer support recovery organization 1,000

(r) A community health worker pool 1,000

(s) An employment agency to provide nonmedical services 1,400

2. An applicant for the renewal of such a license must pay to the Division of Public and Behavioral Health the following nonrefundable fees:

(a) An ambulatory surgical center $4,892

(b) A home office or subunit agency of a home health agency 2,584

(c) A branch office of a home health agency 2,679

(d) A rural clinic 2,029

(e) An obstetric center 782

(f) A program of hospice care 3,527

(g) An independent center for emergency medical care 2,030

(h) A nursing pool 2,301

(i) A facility for treatment with narcotics 2,523

(j) A medication unit 600

(k) A referral agency 1,354

(l) A facility for refractive surgery 3,350

(m) A mobile unit 1,045

(n) An agency to provide personal care services in the home 687

(o) A facility for the care of adults during the day allowed to be occupied by not more than 50 clients at one time 814

(p) A facility for the care of adults during the day allowed to be occupied by more than 50 clients at one time 1,227

(q) A peer support recovery organization 500

(r) A community health worker pool 500

(s) An employment agency to provide nonmedical services 700

3. An application for a license is valid for 1 year after the date on which the application is submitted. If an applicant does not meet the requirements for licensure imposed by chapter 449 of NRS or the regulations adopted pursuant thereto within 1 year after the date on which the applicant submits his or her application, the applicant must submit a new application and pay the required fee to be considered for licensure.

Sec. 20. NAC 449.156 is hereby amended to read as follows:

449.156 As used in NAC 449.156 to 449.27706, inclusive, ***and section 13 of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 449.1565 to 449.178, inclusive, have the meanings ascribed to them in those sections.

Sec. 21. NAC 449.197 is hereby amended to read as follows:

449.197 ~~[A]~~ ***Except as otherwise provided in section 13 of this regulation, a*** member of the staff of a residential facility shall not provide medical services to a resident of the facility unless the member of the staff is a medical professional.

Sec. 22. NAC 449.2726 is hereby amended to read as follows:

449.2726 1. A person who has diabetes must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless:

(a) The resident's glucose testing is performed by:

(1) The resident himself or herself without assistance; or

(2) ~~[A medical laboratory licensed pursuant to chapter 652 of NRS;]~~ ***With the consent of the resident, a caregiver who meets the requirements of NAC 449.196;*** and

(b) The resident's medication is administered:

(1) By the resident himself or herself without assistance;

(2) By a medical professional, or licensed practical nurse, who is:

(I) ~~[Not employed by the residential facility;~~

~~(II)]~~ Acting within his or her authorized scope of practice and in accordance with all applicable statutes and regulations; and

~~[(III)]~~ ***(II)*** Trained to administer the medication; or

(3) If the conditions set forth in subsection 2 are satisfied, with the assistance of a caregiver employed by the residential facility.

2. A caregiver employed by a residential facility may assist a resident in the administration of the medication prescribed to the resident for his or her diabetes if:

(a) ~~[The]~~ ***A physician, physician assistant or advanced practice registered nurse has determined that the*** resident's physical and mental condition is stable and is following a predictable course.

(b) The amount of the medication prescribed to the resident for his or her diabetes is at a maintenance level and does not require a daily assessment ~~[.]~~ ***, including, without limitation, the use of a sliding scale.***

(c) A written plan of care by a physician or registered nurse has been established that:

(1) Addresses possession and assistance in the administration of the medication for the resident's diabetes; and

(2) Includes a plan, which has been prepared under the supervision of a registered nurse or licensed pharmacist, for emergency intervention if an adverse condition results.

(d) The medication prescribed to the resident for his or her diabetes is not administered by injection or intravenously ~~[.]~~ ***or is administered using an auto-injection device in accordance with the requirements of NRS 449.0304 and section 13 of this regulation.***

(e) The caregiver has successfully completed training and examination approved by the Division regarding the administration of such medication.

3. The caregivers employed by a residential facility with a resident who has diabetes shall ensure that:

(a) Sufficient amounts of medicines, equipment to perform tests, syringes, needles and other supplies are maintained and stored in a secure place in the facility;

(b) Syringes and needles are disposed of appropriately in a sharps container which is stored in a safe place; and

(c) The caregivers responsible for the resident have received instruction in the recognition of the symptoms of hypoglycemia and hyperglycemia by a medical professional who has been trained in the recognition of those symptoms.

4. The caregivers ~~[employed by]~~ ***of*** a residential facility with a resident who has diabetes and requires a special diet shall provide variations in the types of meals served and make available food substitutions in order to allow the resident to consume meals as prescribed by the resident's physician. The substitutions must conform with the recommendations for food exchanges contained in the *Exchange Lists For Meal Planning*, published by the American Diabetes Association, Incorporated, and the American Dietetic Association, which is hereby adopted by reference. A copy of the publication may be obtained from the American Diabetes

Association, Incorporated, Order Fulfillment Department, P.O. Box 930850, Atlanta, Georgia 31193-0850, at a cost of $2.50.

Sec. 23. NAC 449.2728 is hereby amended to read as follows:

449.2728 1. ~~[A]~~ ***Except as otherwise provided by NAC 449.2726, a*** person who requires regular intramuscular, subcutaneous or intradermal injections must not be admitted to a residential facility or be permitted to remain as a resident of the facility unless the injections are administered by:

(a) The resident; or

(b) A medical professional, or licensed practical nurse, acting within his or her authorized scope of practice and in accordance with all applicable statutes and regulations,

➥ who has been trained to administer those injections.

2. The caregivers employed by a residential facility with a resident who requires regular intramuscular, subcutaneous or intradermal injections shall ensure that:

(a) Sufficient amounts of medicines, equipment to perform tests, syringes, needles and other supplies are maintained and stored in a secure place in the facility; and

(b) Syringes and needles are disposed of appropriately in a sharps container which is stored in a safe place.

Sec. 24. NAC 449.2742 is hereby amended to read as follows:

449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall:

(a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility:

(1) Reviews for accuracy and appropriateness, at least once every 6 months, the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and

(2) Provides a written report of that review to the administrator of the facility.

(b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report.

(c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a).

(d) Develop and maintain a plan for managing the administration of medications at the residential facility, including, without limitation:

(1) Preventing the use of outdated, damaged or contaminated medications;

(2) Managing the medications for each resident in a manner which ensures that any prescription medications, over-the-counter medications and nutritional supplements are ordered, filled and refilled in a timely manner to avoid missed dosages;

(3) Verifying that orders for medications have been accurately transcribed in the record of the medication administered to each resident in accordance with NAC 449.2744;

(4) Monitoring the administration of medications and the effective use of the records of the medication administered to each resident;

(5) Ensuring that each caregiver who administers a medication is in compliance with the requirements of subsection 6 of NRS 449.0302 and NAC 449.196;

(6) Ensuring that each caregiver who administers a medication is adequately supervised;

(7) Communicating routinely with the prescribing physician or other physician of the resident concerning issues or observations relating to the administration of the medication; and

(8) Maintaining reference materials relating to medications at the residential facility, including, without limitation, a current drug guide or medication handbook, which must not be more than 2 years old or providing access to websites on the Internet which provide reliable information concerning medications.

(e) Develop and maintain a training program for caregivers of the residential facility who administer medication to residents, including, without limitation, an initial orientation on the plan for managing medications at the facility for each new caregiver and an annual training update on the plan. The administrator shall maintain documentation concerning the provision of the training program and the attendance of caregivers.

(f) In his or her first year of employment as an administrator of the residential facility, receive, from a program approved by the Bureau, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training and obtain a certificate acknowledging completion of such training.

(g) After receiving the initial training required by paragraph (f), receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training.

(h) Annually pass an examination relating to the management of medication approved by the Bureau.

2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator.

3. Before assisting a resident in the administration of any medication, including, without limitation, any over-the-counter medication or dietary supplement, a caregiver must obtain written information describing the side effects, possible adverse reactions, contraindications and toxicity of the medication.

4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of ~~[controlled]~~ ***:***

(a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met.

(b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met.

5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744.

6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident:

(a) The caregiver responsible for assisting in the administration of the medication shall:

(1) Comply with the order;

(2) Indicate on the container of the medication that a change has occurred; and

(3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744;

(b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and

(c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744.

7. If a resident refuses, or otherwise misses, an administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.

8. An employee of a residential facility shall not draw medication into a syringe or administer an injection unless authorized by law to do so.

9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744.

10. The administrator of a facility is responsible for any assistance provided to a resident of the residential facility in the administration of medication, including, without limitation, ensuring that all medication is administered in accordance with the provisions of this section.

Sec. 25. NAC 449.395 is hereby amended to read as follows:

449.395 As used in NAC 449.395 to 449.39561, inclusive, ***and section 14 of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 449.39501 to 449.39508, inclusive, have the meanings ascribed to them in those sections.

Sec. 26. NAC 449.3952 is hereby amended to read as follows:

449.3952 An intermediary service organization shall make available to a personal assistant employed by the intermediary service organization all training required pursuant to NAC 449.39519 and, at the request of a client, such additional training for a personal assistant as necessary to support the plan of care for the person with a disability, including, without limitation:

1. General training for the personal assistant;

2. Protocols for a personal assistant, including, without limitation, the rights and responsibilities of a client and of a personal assistant;

3. The manner in which to groom and dress the person with a disability;

4. Procedures for bathing and maintaining proper hygiene for a person with a disability, including, without limitation, bed-bath and tub-bath techniques;

5. Caring for the bowel, bladder and skin of a person with a disability, including, without limitation, information concerning caring for a catheter, the identification and control of infection, common bowel problems, the early recognition of skin problems, the prevention of pressure sores and the routine inspection of skin;

6. Assistive technology, including, without limitation, examples of assistive technology, how assistive technology can be used by the personal assistant and resources from which assistive technology may be obtained;

7. Nutrition and food preparation, including, without limitation, information about preparing balanced meals, addressing special dietary needs or restrictions, guidelines for hydration and the proper handling and storage of food; ~~[and]~~

8. The manner in which to maintain health records, including, without limitation, illustrations of how information should be conveyed in a written or dictated form to assure confidentiality and a means to ensure that the person with a disability receives services as outlined in the plan of care ~~[.]~~ ***; and***

9. Training described in section 14 of this regulation.

Sec. 27. NAC 449.396 is hereby amended to read as follows:

449.396 As used in NAC 449.396 to 449.3982, inclusive, ***and section 15 of this regulation,*** the words and terms defined in NAC 449.3961 to 449.3968, inclusive, have the meanings ascribed to them in those sections.

Sec. 28. NAC 449.3978 is hereby amended to read as follows:

449.3978 1. The administrator of an agency shall ensure that each attendant working for the agency is working within the attendant's scope of service and conducts himself or herself in a professional manner. An attendant is prohibited from providing any of the services listed in subsection 2 to a client.

2. The services an attendant must not provide to a client include, without limitation:

(a) Insertion or irrigation of a catheter;

(b) Irrigation of any body cavity, including, without limitation, irrigation of the ear, insertion of an enema or a vaginal douche;

(c) Application of a dressing involving prescription medication or aseptic techniques, including, without limitation, the treatment of moderate or severe conditions of the skin;

(d) ~~[Administration]~~ ***Except as authorized by section 15 of this regulation, administration*** of injections of fluids into veins, muscles or the skin;

(e) ~~[Administration]~~ ***Except as authorized by section 15 of this regulation, administration*** of medication, including, without limitation, the insertion of rectal suppositories, the application of a prescribed topical lotion for the skin and the administration of drops in the eyes;

(f) Performing physical assessments;

(g) ~~[Monitoring vital signs;~~

~~(h)]~~ Using specialized feeding techniques;

~~[(i)]~~ ***(h)*** Performing a digital rectal examination;

~~[(j)]~~ ***(i)*** Trimming or cutting toenails;

~~[(k)]~~ ***(j)*** Massage;

~~[(l)]~~ ***(k)*** Providing specialized services to increase the range of motion of a client;

~~[(m)]~~ ***(l)*** Providing medical case management, including, without limitation, accompanying a client to the office of a physician to provide medical information to the physician concerning the client or to receive medical information from the physician concerning the client; and

~~[(n)]~~ ***(m)*** Any task identified in chapter 632 of NRS and the regulations adopted by the State Board of Nursing as requiring skilled nursing care, ~~[including, without limitation,]~~ ***except*** any services that are within the scope and practice of a certified nursing assistant.

Sec. 29. NAC 449.4061 is hereby amended to read as follows:

449.4061 As used in NAC 449.4061 to 449.4089, inclusive, ***and section 16 of this regulation,*** unless the context otherwise requires:

1. "Division" means the Division of Public and Behavioral Health of the Department of Health and Human Services.

2. "Facility" means a facility for the care of adults during the day as defined in NRS 449.004.

Sec. 30. NAC 449.4081 is hereby amended to read as follows:

449.4081 1. ~~If~~ ***Except as otherwise authorized by section 16 of this regulation, if*** the facility accepts a client who cannot administer his or her own medication, an employee licensed to administer medications must administer the medication to the client.

2. The next of kin or guardian or other person responsible for the client must be notified immediately in case of any accident, injury or illness involving the client.

3. Each client must be treated with dignity and respect and not subjected to verbal or physical abuse of any kind.

4. Restraints or sedatives in lieu of restraints may not be used or given to any client, except by a physician's order.

Sec. 31. NAC 449.99898 is hereby amended to read as follows:

449.99898 If the Bureau imposes a monetary penalty, the penalty must be imposed as provided in NAC 449.99899 to 449.99908, inclusive ~~.~~ ***, and section 17 of this regulation.*** In imposing the monetary penalty, the total penalty assessed against any facility bears interest at the rate of 10 percent per annum.

Sec. 32. NAC 449.99899 is hereby amended to read as follows:

449.99899 1. In determining the amount of an initial monetary penalty, the Bureau shall consider the severity alone if the severity level is four. In determining the amount of the monetary penalty where the severity level is less than four, both severity and scope must be considered. In determining whether to impose a daily monetary penalty, the Bureau shall

consider the severity and scope and the factors indicated for increased and decreased penalties provided in NAC 449.99902 and 449.99904.

2. For initial deficiencies with a severity level of four ~~[,]~~ ***:***

(a) If the violation creates harm or a risk of harm to one person, an initial monetary penalty of ~~[$1000]~~ ***$2,500*** per deficiency must be imposed.

(b) If the violation creates harm or a risk of harm to more than one person, an initial monetary penalty of $5,000 per deficiency must be imposed.

3. For initial deficiencies rated with a severity level of three and a scope level of three ~~[,]~~ ***:***

(a) If the violation creates harm or a risk of harm to one person, a monetary penalty of ~~[$800]~~ ***$2,000*** per deficiency must be imposed.

(b) If the violation creates harm or a risk of harm to more than one person, an initial monetary penalty of $4,000 per deficiency must be imposed.

4. For initial deficiencies with a severity level of three and a scope level of two or less ~~[,]~~ ***:***

(a) If the violation creates harm or a risk of harm to one person, an initial monetary penalty of ~~[$400]~~ ***$1,500*** per deficiency must be imposed.

(b) If the violation creates harm or a risk of harm to more than one person, an initial monetary penalty of $3,000 per deficiency must be imposed.

5. For initial deficiencies with a severity level of two and a scope level of three, an initial monetary penalty of ~~[$200]~~ ***$1,000*** per deficiency may be imposed. The payment of this monetary penalty must be suspended if the facility has corrected the deficiencies within the time specified in the plan of correction approved by the Bureau.

6. In addition to any monetary penalty imposed pursuant to this section, the Bureau may impose a monetary penalty of not more than $10 per recipient per day for each day the deficiency continues.

Sec. 33. NAC 449.999 is hereby amended to read as follows:

449.999 In no event may the principal amount of the total daily monetary penalty assessed against any facility exceed ~~[$1,000]~~ ***$5,000*** per deficiency per day.

Sec. 34. NAC 449.99911 is hereby amended to read as follows:

449.99911 1. If the facility fails to pay a monetary penalty ~~[,]~~ ***and the Bureau has not approved the use of the penalty for corrections pursuant to section 17 of this regulation,*** the Division may suspend the license of the facility.

2. The Division shall, in accordance with the requirements of NAC 439.345, provide notice of its intention to suspend the license of the facility.

3. If the facility fails to pay the monetary penalty, including any additional costs incurred in collection of the penalty, within 10 days after receipt of the notice ~~[,]~~ ***and the Bureau has not approved the use of the penalty for corrections pursuant to section 17 of this regulation,*** the Division shall suspend the license of the facility. The suspension must not be stayed during the pendency of any administrative appeal.

Errata – LCB File No. R109-18.

Blue italic = Proposed language found in LCB File No. R109-18
~~[Red italic bold bracketed strikethrough]~~ = Proposed omission in Errata to current LCB File No. R109-18 draft.

Sec. 13. ***1. A caregiver of a residential facility may perform a task described in NRS 449.0304 if the caregiver:***
(a) Before performing the task, annually thereafter and when any device used for performing the task is changed:
(1) Has received training concerning the task that meets the requirements of subsection 5; and
(2) Has demonstrated an understanding of the manner in which the task must be performed;
(b) Follows the manufacturer's instructions when operating any device used for performing the task;
(c) Performs the task in conformance with the Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a, if applicable, and any other applicable federal law or regulation; and
(d) If the resident has diabetes, complies with the requirements of subsection 3 and NAC 449.2726.
2. If a person with diabetes who is a resident does not have the physical or mental capacity to perform a blood glucose test on himself or herself and a caregiver of the residential facility performs ~~[or assists with the performance of]~~ a blood glucose test on the resident:
(a) The caregiver shall be deemed to perform the blood glucose test and must comply with all applicable requirements prescribed by this section; and
(b) The Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a shall be deemed to be applicable for the purposes of paragraph (c) of subsection 1.
3. If a caregiver conducts a blood glucose test, the caregiver must ensure that the device for monitoring blood glucose is not used on more than one person.
4. A caregiver may weigh a resident of a residential facility only if:
(a) The caregiver has received training on the manner in which to weigh a person that meets the requirements of subsections 5 and 6; and
(b) The resident has consented to being weighed by the caregiver.
5. Any training described in this section must be provided by:
(a) A physician, physician assistant, licensed nurse; or
(b) An employee of the residential facility who has:
(1) Received training pursuant to paragraph (a) of subsection 1 or paragraph (a) of subsection 4, as applicable, from a physician, physician assistant or licensed nurse;
(2) At least 1 year of experience performing the task for which he or she is providing training; and
(3) Demonstrated competency in performing the task for which he or she is providing training.
6. Any training described in this section must include, without limitation:
(a) Instruction concerning how to accurately perform the task for which the caregiver is

being trained in conformance with nationally recognized infection control guidelines which may include, without limitation, guidelines published by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
(b) Instruction concerning how to accurately interpret the information obtained from performing the task; and
(c) A description of any action, including, without limitation, notifying a physician, that must be taken based on such information.

Sec. 14. *1. A personal assistant may perform a task described in NRS 449.4309 if the personal assistant:*
(a) Before performing the task, annually thereafter and when any device used for performing the task is changed:
(1) Receives training concerning the task that meets the requirements of subsection 6; and
(2) Demonstrates an understanding of the task;
(b) Follows the manufacturer's instructions when operating any device used for performing the task;
(c) Performs the task in conformance with the Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a, if applicable, and any other applicable federal law or regulation; and
(d) Complies with the requirements of subsection 3 or 4, if applicable.
2. If a person with diabetes who is a client of an intermediary service organization does not have the physical or mental capacity to perform a blood glucose test on himself or herself and a personal assistant performs ***[~~or assists with the performance of~~]*** *a blood glucose test on the client:*
(a) The personal assistant shall be deemed to perform the blood glucose test and must comply with all applicable requirements prescribed by this section; and
(b) The Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a shall be deemed to be applicable for the purposes of paragraph (c) of subsection 1.
3. In addition to satisfying the requirements of subsection 1, a personal assistant who conducts a blood glucose test must ensure that the device for monitoring blood glucose is not used on more than one person.
4. A personal assistant may assist a client in the administration of insulin prescribed to the client for his or her diabetes and furnished by a registered pharmacist through an autoinjection device approved by the United States Food and Drug Administration for use in the home in accordance with the requirements of subsection 1 if:
(a) A physician, physician assistant or advanced practice registered nurse has determined that the client's physical and mental condition is stable and following a predictable course; and
(b) The amount of the insulin prescribed to the client is at a maintenance level and does not require a daily assessment, including, without limitation, the use of a sliding scale.
5. A personal assistant may weigh a client of an intermediary service organization only if:
(a) The personal assistant has received training on the manner in which to weigh a person that meets the requirements of subsections 6 and 7; and
(b) The client has consented to being weighed by the personal assistant.

6. Any training described in this section must be provided by:
(a) A physician, physician assistant, licensed nurse; or
(b) An employee of the intermediary service organization who has:
(1) Received training pursuant to paragraph (a) of subsection 1 or paragraph (a) of subsection 5, as applicable, from a physician, physician assistant or licensed nurse;
(2) At least 1 year of experience performing the task for which he or she is providing training; and
(3) Demonstrated competency in performing the task for which he or she is providing training.
7. Any training described in this section must include, without limitation:
(a) Instruction concerning how to accurately perform the task for which the personal assistant is being trained in conformance with nationally recognized infection control guidelines which may include, without limitation, guidelines published by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
(b) Instruction concerning how to accurately interpret the information obtained from performing the task; and
(c) A description of any action, including, without limitation, notifying a physician, that must be taken based on such information.

Sec. 15. *1. An attendant may perform a task described in NRS 449.4309 if the attendant:*
(a) Before performing the task, annually thereafter and when any device used for performing the task is changed:
(1) Receives training concerning the task that meets the requirements of subsection 6; and
(2) Demonstrates an understanding of the task;
(b) Follows the manufacturer's instructions when operating any device used for performing the task;
(c) Performs the task in conformance with the Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a, if applicable, and any other applicable federal law or regulation; and
(d) Complies with the requirements of subsection 3 or 4, if applicable.
2. If a person with diabetes who is a client of an agency does not have the physical or mental capacity to perform a blood glucose test on himself or herself and an attendant performs ~~*[or assists with the performance of]*~~ *a blood glucose test on the client:*
(a) The attendant shall be deemed to perform the blood glucose test and must comply with all applicable requirements prescribed by this section; and
(b) The Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a shall be deemed to be applicable for the purposes of paragraph (c) of subsection 1.
3. In addition to satisfying the requirements of subsection 1, an attendant who conducts a blood glucose test must ensure that the device for monitoring blood glucose is not used on more than one person.
4. An attendant may assist a client in the administration of insulin prescribed to the client for his or her diabetes and furnished by a registered pharmacist through an auto-injection device approved by the United States Food and Drug Administration for use in the home in

accordance with the requirements of subsection 1 if:
(a) A physician, physician assistant or advanced practice registered nurse has determined that the client's physical and mental condition is stable and following a predictable course; and
(b) The amount of the insulin prescribed to the client is at a maintenance level and does not require a daily assessment, including, without limitation, the use of a sliding scale.
5. An attendant may weigh a client of an agency only if:
(a) The attendant has received training on how to accurately weigh persons that meets the requirements of subsections 6 and 7; and
(b) The client has consented to being weighed by the attendant.
6. Any training described in this section must be provided by:
(a) A physician, physician assistant, licensed nurse; or
(b) An employee of the agency who has:
(1) Received training pursuant to paragraph (a) of subsection 1 or paragraph (a) of subsection 5, as applicable, from a physician, physician assistant or licensed nurse;
(2) At least 1 year of experience performing the task for which he or she is providing training; and
(3) Demonstrated competency in performing the task for which he or she is providing training.
7. Any training described in this section must include, without limitation:
(a) Instruction concerning how to accurately perform the task for which the attendant is being trained in conformance with nationally recognized infection control guidelines which may include, without limitation, guidelines published by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
(b) Instruction concerning how to accurately interpret the information obtained from performing the task; and
(c) A description of any action, including, without limitation, notifying a physician, that must be taken based on such information.

Sec. 16. *1. An employee of a facility may perform a task described in NRS 449.4309 if the employee:*
(a) Before performing the task, annually thereafter and when any device used for performing the task is changed:
(1) Receives training concerning the task that meets the requirements of subsection 6; and
(2) Demonstrates an understanding of the task;
(b) Follows the manufacturer's instructions when operating any device used for performing the task;
(c) Performs the task in conformance with the Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a, if applicable, and any other applicable federal law or regulation; and
(d) Complies with the requirements of subsection 3 or 4, if applicable.
2. If a person with diabetes who is a client of a facility does not have the physical or mental capacity to perform a blood glucose test on himself or herself and an employee of the facility performs ***[~~or assists with the performance of~~]*** *a blood glucose test on the client:*
(a) The employee shall be deemed to perform the blood glucose test and must comply with all applicable requirements prescribed by this section; and

(b) The Clinical Laboratory Improvement Amendments of 1988, Public Law 100-578, 42 U.S.C. § 263a shall be deemed to be applicable for the purposes of paragraph (c) of subsection 1.

3. In addition to satisfying the requirements of subsection 1, an employee of a facility who conducts a blood glucose test must ensure that the device for monitoring blood glucose is not used on more than one person.

4. An employee of a facility may assist a client in the administration of insulin prescribed to the client for his or her diabetes and furnished by a registered pharmacist through an auto-injection device approved by the United States Food and Drug Administration for use in the home in accordance with the requirements of subsection 1 if:

(a) A physician, physician assistant or advanced practice registered nurse has determined that the client's physical and mental condition is stable and following a predictable course; and

(b) The amount of the insulin prescribed to the client is at a maintenance level and does not require a daily assessment, including, without limitation, the use of a sliding scale.

5. An employee of a facility may weigh a client of the facility only if:

(a) The employee has received training on how to accurately weigh persons that meets the requirements of subsections 6 and 7; and

(b) The client has consented to being weighed by the employee.

6. Any training described in this section must be provided by:

(a) A physician, physician assistant, licensed nurse; or

(b) An employee of the facility who has:

(1) Received training pursuant to paragraph (a) of subsection 1 or paragraph (a) of subsection 5, as applicable, from a physician, physician assistant or licensed nurse;

(2) At least 1 year of experience performing the task for which he or she is providing training; and

(3) Demonstrated competency in performing the task for which he or she is providing training.

7. Any training described in this section must include, without limitation:

(a) Instruction concerning how to accurately perform the task for which the employee is being trained in conformance with nationally recognized infection control guidelines which may include, without limitation, guidelines published by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;

(b) Instruction concerning how to accurately interpret the information obtained from performing the task; and

(c) A description of any action, including, without limitation, notifying a physician, that must be taken based on such information.

Rationale

Removes wording so that the requirement to obtain a CLIA certificate is not more stringent than federal regulations. Keeps the requirement to obtain a CLIA certificate in line with federal requirements.

SMALL BUSINESS IMPACT STATEMENT 2018
PROPOSED AMENDMENTS TO NEVADA ADMINISTRATIVE CODE (NAC) 449

The Division of Public and Behavioral Health (DPBH) has determined that the proposed amendments (LCB File No. R109-18) may have different financial impacts on industry based on how each small business is impacted by the proposed regulations. The proposed regulations may have a beneficial financial impact on certain facilities that will be allowed to perform waived glucose testing in their facilities without having to pay laboratory licensing fees and may have a negative financial impact on facilities that are assessed a monetary penalty as outlined in the body of this document. It is possible that this may be a severe financial impact, resulting in negative financial consequences to facilities that are assessed citations with high severity scores (resulting from violations associated with serious harm) or when facilities are assessed monetary penalties for multiple deficiencies. Based on data from past monetary penalties, 2% to 4% of all licensed facilities are anticipated to be affected by monetary penalties. It may have a neutral impact on small businesses that are not assessed monetary penalties and will not benefit from the changes allowing certain facilities to perform glucose testing without a state laboratory license. No to minimal negative financial impact is anticipated as a direct result of the proposed regulations (LCB File No. R156-18) relating to the implementation of Senate Bill 482 of the 2017 legislative session. The proposed regulations were all revised to reduce the negative financial burden on facilities.

Overall, the proposed regulations should not prevent the formation, operation or expansion of a small business in Nevada but there are cases in which a small business may not be able to expand or may have operations impacted due to monetary penalties assessed to a small business.

A small business is defined in Nevada Revised Statutes NRS 233B as a "business conducted for profit which employs fewer than 150 full-time or part-time employees."

This small business impact statement is made pursuant to NRS 233B.0608 (3) and complies with the requirements of NRS 233B.0609. As required by NRS 233B.0608(3), this statement identifies the methods used by the agency in determining the impact of the proposed regulation on a small business in sections 1, 2, 3, and 4 below and provides the reasons for the conclusions of the agency in section 8 below followed by the certification by the person responsible for the agency.

Background

Senate Bill's 71, 324, 388 and 482 of the 2017 legislative session all require the Board of Health (Board) to adopt regulations to carry out the provisions of each bill. The proposed regulations bring the Board in compliance with the requirements of these bills.

Senate Bill 71: Revised NRS 449.163(1)(d) by increasing the administrative penalty that could be imposed from not more than $1,000 to not more than $5,000 per day for each violation, together with interest thereon at a rate not to exceed 10 percent per annum. The bill also requires the Board to adopt a new requirement to establish an administrative penalty to be imposed, if a monetary penalty is imposed, for a violation which causes harm or the risk of harm to more than one person.

Senate Bill 324: Requires the proposed regulations to authorize employees of facility types listed in the bill, with the consent of the person receiving services to check vital signs, administer insulin using an auto-injection device and conduct a blood glucose test on a person using a device for monitoring blood glucose approved by the FDA. The regulations adopted must require the tasks described above to be performed in conformance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988, Public Law No. 100-578, 42 USC 263a, if applicable, and any other applicable federal law or regulation. The bill also requires that the regulations prohibit the use of a blood glucose monitoring device on more than one person and may require a person to receive training before performing the tasks noted above.

Senate Bill 388: Requires the Board to adopt standards for licensing of employment agencies that provide nonmedical services related to personal care to elderly persons or persons with disabilities in the home; standards relating to the fees charged by such employment agencies; regulations governing the licensing of such employment agencies; and regulations establishing requirements for training the persons who contract with such employment agencies to provide such nonmedical services.
Senate Bill 482: Requires the Division to adopt regulations establishing a system for rating each health care facility located in a county whose population is 100,000 or more and which is licensed to have more than 70 beds on the compliance by the facility with the provisions of section 1.8 of SB 482 and NRS 449.241 to 449.2428, inclusive, including, without limitation, the number of resolved and unresolved violations and the severity of those violations. The rating system must provide for the assignment of a star rating of not more than five stars and not less than one star to each such facility. It also requires the Division to establish procedures by which a health care facility located in a county whose population is 100,000 or more and which is licensed to have more than 70 beds may, not later than 30 days after an investigation or inspection, appeal a finding concerning a violation of the provisions of section 1.8 of SB 482 and NRS 449.241 to 449.2428, inclusive, or request a follow-up inspection.

1) A description of the manner in which comment was solicited from affected small businesses, a summary of their response and an explanation of the manner in which other interested persons may obtain a copy of the summary.

Pursuant to NRS 233B.0608 (2)(a), the Division of Public and Behavioral Health (Division) has requested input from Nevada's licensed health care facilities and has made a concerted effort to determine whether the proposed regulations are likely to impose an economic burden upon a small business.

All licensed health facilities were sent an email notification on November 21, 2017 (an updated email was also sent on November 27, 2017 with an updated web link to the small business impact questionnaire), requesting that all interested individuals complete the small business impact questionnaire. A link to the small business impact questionnaire and proposed regulations was provided. The proposed regulations were also posted on Division's website. The questions on the questionnaire were:

1) How many employees are currently employed by your business?
2) Will a specific regulation have an adverse economic effect upon your business?
3) Will the regulation(s) have any beneficial effect upon your business?
4) Do you anticipate any indirect adverse effects upon your business?
5) Do you anticipate any indirect beneficial effects upon your business?

Summary of Response

Summary of Comments Received (115 responses were received out of 1,406 small business impact questionnaires distributed)			
Will a specific regulation have an adverse economic effect upon your business?	**Will the regulation (s) have any beneficial effect upon your business?**	**Do you anticipate any indirect adverse effects upon your business?**	**Do you anticipate any indirect beneficial effects upon your business?**
Yes- 114 No - 1	Yes - 6 No- 107 No Answer - 2	Yes - 112 No – 1 No Answer - 2	Yes - 2 No – 112 No Answer – 1

Below is a high-level summary of the comments received from the small business impact questionnaire. For a more detailed account of the comments received (includes breakdown by questions) please see Attachment 1.

Most respondents indicated that the proposed regulations would have an adverse economic effect upon their business and would not have any beneficial effect including:

- Increased monetary penalties placing a significant economic burden on facilities, severely impacting industry, leading to increased costs for residents and resulting in a higher burden on smaller facilities than larger ones with more resources.
- Adversely impacting businesses that receive a low star rating.
- Concerns that HCQC did not fully enact the bills as intended.
- Concerns with the costs associated with obtaining a CLIA waiver and that liability insurer premiums will go up substantially if a facility has a laboratory designation.
- Increased costs and staff time to carry out new training requirements.
- Increased costs related to posting star rating information and increased cost to maintain a daily staffing committee.

A minority of respondents felt the proposed regulations may have a beneficial effect upon their business including:

- Enhanced care outcomes through coordination of information on vital signs with physicians and related health care providers.
- Less expense to taxpayers by reducing reliance on ambulance services.
- Reduced costs to diabetic clients who will be able to be placed in a residential care type facility instead of a higher cost nursing facility.
- Enhanced quality of care to individuals in long term care facilities who rely on personal care attendants because they would be required to be licensed in accordance with 449 regulations.

Any other persons interested in obtaining a copy of the summary may e-mail, call, or mail in a request to Leticia Metherell, RN, CPM, HPM III at:

Division of Public and Behavioral Health
Bureau of Health Care Quality and Compliance
727 Fairview Drive, Suite E
Carson City, NV 89701
Leticia Metherell
Phone: 775-684-1045
Email: lmetherell@health.nv.gov

2) Describe the manner in which the analysis was conducted.

An analysis of the input collected was conducted by a Health Program Manager III. The analysis involved analyzing feedback obtained from the small business impact questionnaire, analysis of current regulations and of Senate Bill's (SB) 71, 324, 388 and 482 of the 2017 legislative session, consultation with the Centers for Medicare and Medicaid Services (CMS) to ensure only facilities that are required to be in conformance with CLIA are required to do so, review of feedback from the public workshop held on March 6, 2018, the assisted living advisory council held on January 25, 2018 and the personal care agencies advisory council held on March 13, 2018, and analysis of the percentage of facilities that received at least one severity three or four level citation in 2015, 2016 and 2017 to develop the proposed regulations in a manner that fulfilled the requirements of the bills while utilizing methods the Division identified to reduce the impact of the proposed regulation on small businesses. This information was then used to complete this small business impact statement and revise the proposed regulations, as noted in number 4 of this document, and to determine the conclusion on the impact of the proposed regulation on a small business found in number 8.

3) The estimated economic effect of the proposed regulation on the small business which it is to regulate including, without limitation both adverse and beneficial effects and both direct and indirect effects.

Direct Beneficial Effects: The proposed regulations carry out the provisions of Senate Bill (SB) 324 which may result in financial benefits to certain industry by removing the requirement that a resident's glucose testing be performed by a medical laboratory licensed pursuant to chapter 652 of NRS; therefore, eliminating licensure as a laboratory with all the associated fees and state specific requirements to serve as a director of a laboratory. Benefits to the public include adding training requirements to perform certain tasks and utilizing nationally recognized infection control guidelines when carry out such tasks, to help ensure these activities are carried out in a safe and effective manner.

Indirect Beneficial Effects: Industry that previously may not have been able to accept certain residents/clients requiring the care noted in the direct beneficial effects section may now be able to do so, potentially increasing the number of residents they can accept, or allowing residents/clients that may have needed to be transferred to a higher level of care to remain at the facility.

Direct Adverse Effects: It will have an adverse economic effect on facilities that receive a monetary penalty although it is anticipated only a small percentage (2% to 4%) of facilities would be impacted. The following information is based on all health facilities that have received at least one severity 3 or 4 citation over a one-year period. Based on this information, 4% of health facilities received at least one severity level 3 or 4 citation in 2015, 3% in 2016 and only 2% in 2017. This decline in the percentage of health facilities receiving at least one deficiency at a severity 3 or 4 should alleviate concerns expressed by industry that inconsistencies in how regulations are interpreted by inspectors may lead to an increase in monetary penalties.

Indirect Adverse Effects: It is possible that of the small percentage of facilities that receive a severity level 3 or 4, some may have difficulties paying or using the monetary penalties to correct violations resulting in a negative impact on their business.

The proposed regulations were revised to reduce the adverse financial impact on small businesses by:

- Authorizing a facility to request to use all or a portion of an initial monetary penalty to correct the deficiency for which the penalty was imposed in lieu of paying the penalty and authorizes the Bureau of Health Care Quality and Compliance to approve such a request if the deficiency results from the facility's first violation of a provision of law or regulation.
- Decreasing the amount of monetary penalties imposed from what was initially set in the proposed regulations.

4) Provide a description of the methods that the agency considered to reduce the impact of the proposed regulation on small businesses and a statement regarding whether the agency actually used any of those methods.

The Division utilized and used the following methods to reduce the financial impact of the proposed regulations:

- Based sanctions on a severity and scope tiered approach; therefore, reducing the number of small businesses that would have a negative financial impact. No monetary penalties are imposed on small businesses that have a severity level 1 violation (administrative type violations) or severity level 2 violations (indirectly threaten the health, safety, rights, security, welfare or well-being of a recipient. A potential for harm, as yet unrealized, exists) and that do not impact more than 50% of the facility's population. Monetary penalties are either not imposed or rarely imposed for severity level 2 violations which impact more than 50% of the population as the payment of this monetary penalty must be suspended if the facility has corrected the deficiencies within the time specified in the approved plan of correction. This leaves a very small percentage of all health facilities (2% to 4%) receiving a monetary penalty for more severe violations at a severity level 3 or severity level 4. Severity level 3 violations directly or indirectly threaten the health, safety, rights, security, welfare or well-being of one or more recipients. A severity level four violation creates a condition or incident that has resulted in or can be predicted with substantial probability to result in death or serious harm to a recipient. Industry noted that

prevalence should be considered when assessing monetary penalties and this is accomplished using scope when assessing monetary penalties, except for a severity level of four in which only severity is considered.

In response to feedback provided by small businesses the Division also:

- Authorized a facility to request to use all or a portion of an initial monetary penalty to correct the deficiency for which the penalty was imposed in lieu of paying the penalty and authorizes the Bureau of Health Care Quality and Compliance to approve such a request if the deficiency results from the facility's first violation of a provision of law or regulation. Although it is recognized that this still may present a burden for some facilities who did not budget for the items to be corrected, it still reduces the burden by not having to both pay the fine and use monies to correct a deficiency if needed, and the monies would stay with the facility to correct violations; therefore, helping a facility come back into compliance.
- Reduced the initial monetary penalty amounts from what was initially set in the proposed regulations except for a severity level of two and scope level of three violation which remained unchanged. These changes also resulted in a reduction in the monetary penalties which would be assessed if the violation creates harm or risk of harm to more than one person, except for a severity level of two and scope level of three violation which remains unchanged.

The Division did not address the following concerns related to adverse financial impacts to a facility:

- The issues related to the economic burden placed on a facility required to post or carry out staffing requirements in accordance with SB 482, as the bill, and not the proposed regulations establish these requirements.
- It was noted that "It is rather severe to decrease the star rating of a facility by one star for a single deficiency. No facility will be without a single minor deficiency, so it is unrealistic to impose such a harsh standard." It was felt this may result in an adverse effect because it may result in a low star rating impacting a client's decision to be placed in a facility. No change was made because the proposed star ratings only applies to compliance with NRS 449.241 to NRS 449.2428 (do not apply to residential type facilities, many of which are small businesses), so it is limited in the scope of violations that would be issued. In addition, it is not based only on a single deficiency but also considers the severity of the deficiency, so a one-star rating would not be given for a single minor deficiency, as a one-star rating is based on a severity level 4.

5) The estimated cost to the agency for enforcement of the proposed regulation.

It is estimated it would cost $1,400 to conduct an initial inspection for each employment agency to provide non-medical services in the home and cost $700 a year to continue to license and regulate each agency. As the Division does not know how many agencies would be licensed in accordance to this new rule, a total cost cannot be estimated at this time. Enforcement related to all other areas in the proposed regulations would be incorporated into current licensing and regulatory activities; therefore, it is not anticipated that these activities would result in additional costs to the Division.

6) If the proposed regulation provides a new fee or increases an existing fee, the total annual amount DPBH expects to collect and the manner in which the money will be used.

The proposed regulations provide for a new licensing fee to license employment agencies as directed in SB 388. The proposed new fee is $1,400 to conduct an initial inspection for each employment agency to provide non-medical services in the home and cost $700 a year to continue to license and regulate each agency. As the Division does not know how many agencies would be licensed in accordance to this new rule, we do not know the annual amount that would be collected. The fee would be used to license, inspect and otherwise regulate this new agency type.

The proposed regulations increase the monetary penalties, if imposed, that can be applied to health facilities as follows:

- For initial deficiencies with a severity level of four if the violation creates harm or a risk of harm to one person, an initial monetary penalty of $2,500 per deficiency must be imposed and if the violation creates harm or a risk of harm to more than one person an initial monetary penalty of $5,000 per deficiency must be imposed.
- For initial deficiencies rated with a severity level of three and a scope level of three if the violation creates harm or a risk of harm to one person, a monetary penalty of $2,000 per deficiency must be imposed and if the violation creates harm or a risk of harm to more than one person an initial monetary penalty of $4,000 per deficiency must be imposed.
- For initial deficiencies with a severity level of three and a scope level of two or less if the violation creates harm or a risk of harm to one person, an initial monetary penalty of $1,500 per deficiency must be imposed and if the violation creates harm or a risk of harm to more than one person an initial monetary penalty of $3,000 per deficiency must be imposed.
- For initial deficiencies with a severity level of two and a scope level of three, an initial monetary penalty of $1,000 per deficiency may be imposed. The payment of this monetary penalty must be suspended if the facility has corrected the deficiencies within the time specified in the plan of correction approved by the Bureau.

It is unknown what the annual amount would be as the number of citations and number of patients/residents/clients impacted vary yearly. To give a rough estimate based on 2017 numbers if all citations of a three or four only impacted one resident it was initially estimated to be $130,000 in a year and if all the citations impacted more than one resident it was initially estimated to be $202,500 per year, and if it was a mix of the number of persons impacted, sometimes one person and sometime more than one, it would fall in between. This is based on all facilities paying the full sanction amount but more likely the amounts would be lower because any facility that corrected the deficiencies, paid the penalty within 15 days and waived their right to a hearing would get a 25% reduction in their penalty.

In response to industry feedback the Division reduced the financial impact the proposed regulations would have on small businesses, as noted in number 4, which would further reduce the amounts estimated to be collected to approximately $65,000 in a year for citations that impact one resident and $130,000 per year for those that impact more than one resident. This may be further reduced if facilities use monetary penalties to correct first violations in lieu of paying a monetary penalty.

Also, there was concern expressed that a facility does not currently have the right to appeal. All facilities given a monetary sanction are issued a sanction notice which provides notice of the facility's right to appeal through a hearing process. The Division will set up a prehearing, an informal meeting to go over the issues, which often results in a resolution without going to hearing. This should alleviate the concern expressed that a facility would have to go directly to a hearing prior to having the facility's concerns being heard through an informal process. If the facility is not in agreement with the results of the pre-hearing meeting, the facility may proceed to the hearing process.

The money collected by the Division as administrative sanctions will be applied to the protection of the health, safety, well-being and property of recipients, including residents of facilities that the Division finds deficient.

7) An explanation of why any duplicative or more stringent provisions than federal, state or local standards regulating the same activity are necessary.

There are no duplicative or more stringent provisions than federal, state or local standards regulating to the same activity.

8) Provide a summary of the reasons for the conclusions of the agency regarding the impact of a regulation on small businesses.

The reasons for the Division's conclusion on the impact of the proposed regulation on small businesses is based on feedback received from the industry and the analysis conducted pursuant to number's two to four of this document. Based on all the information collected, it is concluded the proposed regulations (R109-18) may have a beneficial financial impact on certain facilities, for example, those that want to perform glucose testing in their facilities without having to pay laboratory licensing fees and may have a negative financial impact on facilities that are assessed a monetary penalty as outlined in the previous sections of this document. It is possible that this may result in a severe financial impact, resulting in negative financial consequences to facilities that receive citations with high severity scores or are assessed monetary penalties for multiple deficiencies. The Division did implement measurers, as noted in number 4, to reduce the financial burden on small businesses. No to minimal negative financial impact is anticipated as a direct result of the proposed regulations (LCB File No. R156-18) relating to the implementation of Senate Bill 482 of the 2017 legislative session.

Certification by Person Responsible for the Agency

I, Julie Kotchevar, Administrator of the Division of Public and Behavioral Health certify to the best of my knowledge or belief, a concerted effort was made to determine the impact of the proposed regulation on small businesses and the information contained in this statement was prepared properly and is accurate.

Signature:  Date: 10-15-18

SMALL BUSINESS IMPACT STATEMENT 2018
PROPOSED AMENDMENTS TO NEVADA ADMINISTRATIVE CODE (NAC) 449

ATTACHMENT 1: MORE DETAILED RESPONSES TO SMALL BUSINESS IMPACT QUESTIONNAIRE PER QUESTION

1) **Will a specific regulation have an adverse economic effect upon your business?**

We are concerned about the increase in monetary penalties. Because of the economic demands, group home rates are no longer commensurate with the quality of care required. Charging higher rates for deficiencies is not the answer to the problems. The best thing to do is for the regulators to educate homecare owners and administrators by sponsoring seminars or workshops that would help meet the current challenges we face in the homecare industry today.

Sec. 16 NAC 449.99899 and Sec. 17 NAC 449.999

The "THOUSANDS' of the 'LOW INCOME and THE MOST VULNERABLE CITIZENS OF THE STATE' being provided with care in Residential Facility for Groups with beds of 10 and below will be the most severely impacted by these proposed changes. The added increase in penalties will severely impact an already financially beleaguered industry (Mental Health has provided no increase since 2004 and Residential Facilities for Groups are the only ones accepting low income residents that Hospitals, SNFs, Assisted Living won't take care of anymore.)

Due to the high costs to operate a group home and the fact that the elderly do not have high incomes we barely make it. We have not raised our fees in over 5 years but our costs are going up and up.

You are increasing the fines so much that even with the money we are able to charge to our residents we won't be able to afford to pay.

We are concerned that many of the listed changes including: from the existing grade system to the new star system, the change in monetary penalties/fines, incomplete enactment of the SB 324 vital sign and finger stick monitoring, incomplete enactment of SB 477 fire safety legislation will ALL have a negative economic effect on both the business and the many seniors who rely on NRS 449 licensed Residential Facilities For Groups (RFFG) which make up a large part of the states Long Term Health Care System. If Nevadans have fewer safe cost effective RFFG beds to choose from they will pay more and get less in other less safe, less monitored, care options like non-licensed, state certified, Supported Living Arrangement (SLA)/Community Based Living Arrangement (CBLA) care. We also worry that in an environment of declining numbers of SNF Long Term Care beds (growing use of SNF LTC beds for short term rehab which reduces the number of SNF beds allocated for LTC use) the negative impact of these regulations on RFFG will also affect many elements of the state LTC health care system when they have reduced numbers of safe placement choices for Hospitals, ER's and the other elements of the LTC health care system with state wide economic costs. We do see a path forward if the regulators are able to provide us more supporting detail and work with us on these issues. We are concerned that regulators seem to be missing important aspects of the legislation which we sponsored and the legislature passed in their initial attempts to capture the intent of those bills. While the industry had hoped for more interaction with regulators in continuing to build upon the decades of nation leading regulation Nevada has already developed to date regulators have not provided adequate collaboration with the industry. We also note that the turnover in staff at the HCQC is a major contributing factor to the inconsistency in policy and policy enforcement.

Regulations 449.99899 and 449.999 monetary penalties:

There should be a difference between single complaint investigations and annual surveys and the initial deficiencies are outrageously high. Isolated deficiencies versus a pattern are greatly different. This is not a business where we produce widgets, where everything can be done the same way all the time – we tailor our services to meet needs, and hence, there are always situation that are out of the norm. No one wants to have a severity and scope that would determine such high penalties, however, ensuring that great care is provides is the most important, yet it is possible to collect enough deficiencies from paperwork mishaps that are not related to the direct care that a provider could get a penalty that she cannot afford. As a Medicaid provider, I currently have one level 1 resident, two level 2 residents and 1 level three. I roughly get $5,000 for these residents per month. The proposed fines would equal to loss of revenue for 2 of my residents per month. That is disproportionate and extreme hardship.

I believe that I should be proud of the service we provide. I tell my visiting families that we strive for the best, but we staff the place with humans, so errors are possible. We correct them right away, if they were to occur. Why can't this fact, that we are human, be part of the equation? If each survey means that I may be facing thousands in fines, I would feel like an adversary type of visit, as opposed to a partnership, which it should be. Even now I could be fined hundreds of dollars that would hurt overall, thousands would put me out of business. $3,000 per initial deficiency level 3 mandatorily imposed or 1 and ½ times that or $5,000 per deficiency per day would be catastrophic. Why make regulations that make us shut our doors? Let's create a system that keeps us giving good care and keeps us being able to provide safe and affordable care to elderly.

As a non-medical facility, I am being sanctioned at the same rate right now as medical facilities. I am being judged and fined at this same level as a larger facility, say 35-bed. However, that 35-bd facility has a much larger profit margin. Yes, their expenses are higher too, but overall, they make more a month. And if they have an opening, they still make all their payroll and pay the bills. Each fine, and unexpected expense, causes the same. How can we be expected to be fined/sanctioned/judged at the same level as a larger facility or a medical facility?

Each plan of correction (POC) requires that I sign it, accepting responsibility – what if I disagree? Surveyors make mistakes, too, which is OK, how can a business owner require a fair hearing, adjudication, or arbitration if he/she disagrees with the finding? In this society, we have a place for fair judgement, for hearing, for appeals in all areas of our lives – how is it possible that it is missing here?

Isn't it true that the rating Skilled Nursing facilities get – are not based on one single survey but multiple (I think 3 components) per year? So, an overall performance is viewed…why isn't that the case for a facility that provides less skilled care?

If a care home corrects the deficiencies as requested in the statement of deficiencies (SOD) and pays for a resurvey, the fines should be suspended. The point of all of this is to provide good care. Isn't it?

I am also a member of the ALAC, and am curious, how come these questions are not posed to that council? How is it possible that one email is sent out seeking answers, no follow up, reminder, and it is sent out at the busiest time of the year? I am surviving on 5 hours of sleep at night, looking for a new caregiver, keeping up with increasing care levels of a few of my residents, mourning the passing of another, looking to fill a vacancy, and shopping for Christmas gift for all my residents, planning holiday events for them, taking them to see Christmas Lights, and paying special attention to those, especially, who have no family (or family visits) …which is more than half of my residents.

Another adverse economic effect is the fee required to get a CLIA waiver, in order to comply with the new vital signs regulations. CLIA clearly states that non-shared home use equipment that is approved by the FDA do NOT require a CLIA waiver. This is an unnecessary expense and requirement to pose to business owners who

just want to be able to fully help our senior clients, especially those who have dementia and diabetes – which are a common combination, and sadly, an increasing percentage of the population. Up until now, their choice was expensive skilled care at a facility or at home. The point of the legislation for the vital signs was NOT to create barriers of service, but to make it easier to help this population.

Penalties in 3K – 5K range could be devastating for RFFGs.

Regulations 449.99899 and 449.999 monetary penalties:
The threshold needs to be lowered for initial deficiencies. The state should exercise a directed plan of correction as remediation first. Monetary penalties should not be issued for single complaint investigation only.

RFFG's need a written, formalized independent Dispute Resolution Process like the Skilled Nursing Facilities. RFFG's do not have resources to take to Administrative Hearing or Court. The current system is subjective and inconsistent depending on how we make contact within the Department. There is confusion from staff answering the phone who to even send inquiries to in the department. Human errors/mistakes have been made where deficiencies have been incorrectly cited and then reinstated. High turnover of surveyors and supervisors exists and tends to create a very defensive environment during the survey process. As an operator, we are driven to provide good care and abide by regulations yet, inexperienced surveyors tend to be unwilling to discuss situations to fully understand and/or allow our directors to understand the interpretation of the regulation in question. Monetary penalties should NOT be given for isolated complaint investigations verses a pattern. There needs to be the same mechanism as exists in SNFs whereby a severe finding on a complaint investigation triggers a full survey. SNF 5 Star Ratings through CMS are more fair and balanced and do not rate after isolated complaints but look at a full year's period of all. And Surveys are only one of the 3 components of their 5 Star Rating. Many complaints are filed by hostile terminated employees, hostile residents/families that cannot return for higher level or payment issues, or interviews with dementia residents/families who are not good reporters that are made to inexperienced guardians or surveyors. There has been high turnover in both of these areas of government.

Adverse economic impact can strike RFFGs at any time if these areas of inconsistencies are not resolved. $3,000 per initial deficiency level 3 mandatorily imposed or 1 and ½ times that or $5,000 per deficiency per day would be catastrophic.

The rate calculation should be different for nonmedical RFFG facilities as compared to Medical inpatient and outpatient facility types. The Medicaid rate per resident day for RFFG is $30 compared to 10-1000 times that for SNF/Hospital/Outpatient or Skilled Services. For every 6 Medicaid residents served in RFFG, a $3,000 mandatory fine imposed is the equivalent of lost revenue for half of those 6 residents for one month. That is disproportionate and extreme hardship to our industry.

These new regulations conflict with the long established existing rating system since 2005 for RFFG's at 449.277702 which remains intact. The grades are as follows: A for 0-15 combined severity/scope points on full survey with nothing greater than severity 3 and scope 2; B for at least 16 points for not more than 24 points, or any deficiency with a severity level of 3 and a scope level of 3; C for at least 25 points but not more than 34 points, or any deficiency with a severity level of 4 and a scope level of 1. When monetary penalties were assessed, it was for repeat deficiencies at $250. An RFFG made headline news with fines/sanctions in excess of $200,000 that were negotiated down to just over $100,000 back in 2008/2009 and resulted in that owner group shutting down 2 of its 5 cottages or 40% and selling off the business.

With the current RFFG system/state practices, a facility can pay a fee for resurvey of the deficient areas and then receive a new grade provided the areas are corrected. We would suggest that the language in #5 of the proposed regulations whereby the payment of a monetary penalty must be suspended if the facility has corrected

deficiencies within the time specified in the plan of correction approved by the Bureau be applied to ALL monetary penalties.

The State can calculate the dollar amount that this will cost the RFFG industry over a calendar year by applying this new formula with mandatory monetary fines to the historical survey data available on its website listing the prior year's severity/scope deficiencies. Preliminary estimates, even without the aforementioned headline news event in 2008/2009 exceeds hundreds of thousands of dollars.

Of note is the absence of bringing these proposed catastrophic changes to RFFG's to the Assisted Living Advisory Council. The ALAC council in previous years has been part of many discussions related to regulatory related issues, allowing those professionals with actual experience implementing the regulations the opportunity to explore concerns, offer suggestions and/or alternatives to avoid unintended consequences. It used to feel like we were all on the same side of improving operations and insuring good options for our senior populations. That is no longer the case and there has been a dramatic decrease in collaboration and discussions – Very disappointing and dangerous.

If we are to assume by the removal of 449.2726 of "A medical laboratory licensed pursuant to chapter 652 of NRS" and that "Clinical Laboratory Improvement Amendments (CLIA)" no longer precedes a 42 Code of Federal Regulations (CFR) Part 493 means that RFFG DOES NOT have to have a CLIA exempt laboratory certificate as the SNF's do with a Physician Director and test reporting or shared device quality controls by a staff nurse, then No Adverse economic effect would follow. Should the RFFGs be required to have a CLIA exempt laboratory certificate as the SNF's do with a Physician Lab Director and quality controls and test reporting by a staff nurse, then Adverse Economic Effect would be incurred as requiring expenses for a Physician with required CME/CLIA certificate oversite, expenses for nurse quality controls and reporting, additional fees, etc. We do not believe the intent of SB324 was to require a medical lab CLIA waiver to do finger sticks. The active practice doctors on the committees and members of the industry both were following CLIA interpretive guideline which expressly state that NO CLIA WAVIER IS REQUIRED FOR INDIVIDUAL USE GLUCOMETERS EVEN WITH THE ASSISTANCE BY STAFF. This is another example of how more discussion and closer relationship with providers by the State could have clarified this prior to getting to this point.

Many RFFG's have been advised by their liability insurers that premiums will go up substantially because the Lab designation would make the RFFG insured under medical. Currently they are considered non-medical in keeping with overall facility license which allow residents to live in the least restrictive, non-institutional, home-like setting possible. This could create additional financial burdens, reducing options available for an increasing number of seniors' due to fewer providers able to shoulder the financial implications of these new standards.

The thousands of low income and most vulnerable citizens of the state being provided with care in Residential Facility for Groups with beds of 10 and below will be the most severely impacted by these proposed changes. The added increase in penalties will severely impact an already financially burdened industry.

First, a formalized independent dispute resolution process should be created for RFFG's similar to that of SNFs. Monetary penalties should have a lower threshold than that of SNF's as economically RFFG's cannot afford high monetary penalties. The state should exercise a directed plan of correction as remediation first.

More organization and structure within the Surveyors and their Teams would be suggested. If we know what to expect with each survey we can better prepare our Communities and most importantly serve our residents. Monetary fines are not the solution.

Adverse economic impact can strike RFFG's at any time if these areas of inconsistencies are not resolved. $3000 per initial deficiency level 3 mandatorily imposed 1 and ½ times that or $5000 per deficiency per day would be devastating. The rate calculation should be different for non-medical RFFG facilities as compared to medical in-patient and out-patient facility types. The Medicaid rate per resident day for RFFS is $30 compared to 10 – 100 times that for SNF/Hospital/Out-patient or skilled services. For every 6 Medicaid residents served in RFFG, a $3000 mandatory fine imposed is the equivalent of lost revenue for half of those 6 residents for one month. This is disproportionate and an extreme hardship to our industry.

Force us to put up rents! This new regulation will force people to keep their elderly at home possible left alone all day because they cannot afford care in a home.

Regulations 449.196, 449.2726, 449.2728 – The draft regulations need to be consistent throughout with the "resident who has provided consent for the caregiver to do" language. 449.196 is missing it in 1 (h). The draft regulations need to be consistent throughout with the "by a medical professional or licensed practice nurse" 449.2726 1(2) (b) (2) (l) "Not employed by the residential facility" needs to be stricken so that 449.2726 1, (2) (b) (2) reads as follows: "By a medical professional or licensed practical nurse who is acting within his or her authorized scope of practice and…"

Description of vitals able to now perform should include weights.

Sec. 11 NAC 449.361 #10 It is rather severe to decrease the star rating of a facility by one star for a single deficiency. No facility will be without a single minor deficiency, so it is unrealistic to impose such a harsh standard. Customers want to see five stars, anything less will lead to a potential customer to question the quality of a facility, without knowing how minor the deficiency, and will lead to loss of clients. I would recommend a working group of administrators and legislators to be created to work out a more reasonable rating system. Sec. 16 NAC 449.99899 #2 – 6 Increases in deficiency penalties between 400% and 900% in a single year is exorbitant and will lead to possibly not being to pay employees, when the minimum penalty is $2,000. I would suggest reverting to the old fine amounts, which are more reasonable. Sec. 17 NAC 449.999 Again, an increase of 400% to a maximum daily fee of $5,000 is extremely excessive and could put a facility out of business, when this daily fine accounts for nearly all the facility's monthly revenues. I would suggest reverting to the old fine amount, which is more reasonable.

Regulations 449 Licensure of an Employment agency to provide non-medical services in the home/ attendant's background checks and training requirements. The draft regulations with one exception are reasonable and supported by SB 388. On Page 3 Sec. 6 .3. "The term does not include a provider of supported living arrangement services during any period in which the provider of supported living arrangement services is engaged in providing supported living arrangement services and are limited to services authorized at NRS 449.1935 as modified by SB 388, Section 12 of the 2017" would have adverse economic effect. The term "supported living arrangement services" is not used within the entire body of the bill. The overwhelming votes for this bill requiring licensure for agencies to provide certain nonmedical services to elderly and disabled in the home supports their intent to license all providers of this service.

SB 388 defines the services as "Nonmedical services related to personal care to elderly persons or persons with disabilities" includes, without limitation: 1. The elimination of wastes from the body; 2. Dressing and undressing; 3. Bathing; 4. Grooming; 5. The preparation and eating of meals; 6. Laundry; 7. Shopping; 8. Cleaning; 9. Transportation; and 10. Any other minor needs related to the maintenance of personal hygiene.

SB 388 defines that the act does not apply to:
Any facility conducted by and for the adherents of any church or religious denomination for the purpose of providing facilities for the care and treatment of the sick who depend solely upon spiritual means through

prayer for healing in the practice of the religion of the church or denomination, except that such a facility shall comply with all regulations relative to sanitation and safety applicable to other facilities of a similar category. Foster homes as defined in NRS 424.014. Any medical facility or facility for the dependent operated and maintained by the United States Government.

SB 388 defines actions against the following who do not have appropriate 449 licensure:
The Division may bring an action in the name of the State to enjoin any person, state or local government unit or agency thereof from operating or maintaining any facility within the meaning of NRS 449 .030 to 449.2428, inclusive [:], and sections 2 to 5, inclusive, of this act: (a) Without first obtaining a license therefor; or (b) After his or her license has been revoked or suspended by the Division.
It is sufficient in such action to allege that the defendant did, on a certain date and in a certain place, operate and maintain such a facility without a license. The State can calculate the dollar amount that this will cost this industry (and other licensed industries) over a calendar year by applying the costs for licensure, workforce, and training that the state has knowledge of as operating without a license that meets 449 license definitions. It also constitutes an unfair business practice to not require all that meet the definitions of SB388 and are providing nonmedical services in the home to Nevada's elderly and disabled to be licensed. There are also ripple effects to other industries that bear calculation as well. Preliminary estimates exceed hundreds of thousands of dollars.

Small care homes (facilities for groups) barely even make a profit at the end of the day. After paying employee salaries, payroll taxes, state licensing fees, liability and worker's comp insurance policies, there is barely anything left to add to the bottom line. Small businesses have enough to deal with including corporate America and even struggling to stay open most of the time. If there were no care homes, it would be detrimental to potential residents/seniors that need a home like atmosphere/environment that would help them thrive. So, if we get slammed with $3,000 + monetary penalties, we might as well shut our doors!!! This proposed monetary policy does not give us any reason or hope to keep our doors open and provide the kind of care that we do!! RFFG's need to be given the chance to correct any deficiency and learn from it and improve or correct that specific deficiency. RFFG's, and I'm sure I speak for pretty much all of them; do NOT have this kind of money to be able to keep on operating while providing quality care.

NAC 449.99899 – Monetary Penalties - I will be opening my first 10 bed residential group home for the elderly in about 6 months. These prospective monetary penalties would seriously jeopardize the success of the business. Some of those fines equate to a full month rent of one of my residents. It would not be sustainable. Despite having very well-trained staff, I think it is fair to say that a new owner/operator may incur some deficiencies simply out of naivete. It would be heartbreaking to have to close the business. These 10 beds (or less) AGC homes do not make enough income to handle these exorbitant penalties.

NAC 449.196 G & H: If the new training is going to be provided by medication management training programs, we will have to invest in equipment (BP cuff, stethoscope, glucose meters). I wouldn't say it's an adverse effect, but there will be a financial investment.

2) Will the regulation (s) have any beneficial effect upon your business?

The regulation changes will not have any benefit to our business or in the care of our elderly population, in fact we feel that it will have an adverse effect on the entire homecare industry. We have attached an income and Expense Statement which our group prepared to show that a Residential Facility for Group (RFFG) business is not a profitable venture. Especially since a majority of our residents are low paying Medicaid recipients such as $20 per day for a Level 1 level of care; $45 per day for a Level II level of care; and $60 per day for a Level III level of care. In addition, with low Medicaid payments, higher penalties and more regulations, the RFFG industry is no longer a viable business venture. Many group homes will close as our elderly will have limited choices and will suffer dramatically.

Increase in fines will not help financially nor will it help the "THOUSANDS' of the 'LOW INCOME and THE MOST VULNERABLE CITIZENS OF THE STATE' being provided with care in Residential Facility for Groups with beds of 10 and below will be the most severely impacted by these proposed changes.

We will not be able to pay these high fines. This could potentially put some of the care homes out of business.

Increasing fines will not help financially.

No benefit at all. It would be very expensive for us to think it would benefit us.

As written the following regulatory changes will not have any benefit and stand to do substantial harm to our business and the entire RFFG industry. The specific proposed regulations include but are not limited to a change in the 5-star rating from the existing grade system, change in monetary penalties/fines, incomplete enactment of the SB 324 vital signs and finger stick monitoring, incomplete enactment of SB 477 fire safety regulations and other proposed regulations. All will have negative impact on our business and the entire industry.

These changes will continue to add to the burden of providing care in an already challenging industry and could force current providers out of business and discourage others from entering or expanding services at the same time we are facing increasing need for such services. These services will allow the providers to meet the needs of an ever-increasing population of seniors requiring assistance with diabetic related support.

I have never been fined but I am not perfect. Something could get forgotten albeit minor…. But rent increases have to be implemented to protect our business!

Enhanced care outcomes through coordination of information on vitals to physicians and related health care providers within the RFFG's.

Less expense to taxpayer where REMSA has to be utilized now to do simple blood glucose test if symptomatic or unable.

Less expense to taxpayer where diabetic residents have to be discharged from their RFFG home to more costly SNF.

Allowing facilities to administer insulin to residents with diabetes will allow us to serve those clients afflicted with this ailment at more reasonable costs to them, as they do not have to find a specialized nursing facility, which is more expensive.

RFFG families utilize personal care attendants through agencies and so licensing them under 449 enhances the quality of care given these Nevadans in long term care settings.

NAC 449.196 G&H: We would recoup the investment through an increase in the cost of our training.

3) Do you anticipate any indirect adverse effects upon your business?

Indirect adverse effects on our homecare business include the reduced transparency and consistency in the implementation of the regulations in the healthcare industry. Requiring numerous regulations in NRS 449 and imposing excessive penalties will be detrimental to our industry compared to the SLA/CBLA which are much less regulated and more highly compensated. We do believe that changing the working guide system to a new star system will only confuse this population we serve. The high turnover of staff at the BHCQC, which results

in the inconsistency of the regulators, has had a severe effect on the homecare providers. The excessive fees and penalties will result in the shortage of options for our seniors who really thrive in a home like setting.

Possible closure, rather than pay fines. This is totally not business friendly and contrary to what the Governor wanted. Further the displacement of the "THOUSANDS' of the 'LOW INCOME and THE MOST VULNERABLE CITIZENS OF THE STATE' being provided with care in Residential Facility for Groups with beds of 10 and below will be the most severely impacted by these proposed changes.

As it is it is hard to cash flow, much more if we have to pay these astronomical fines.

Totally not business friendly. Displacement of low income elder people.

Increased cost could mean closing the business due to unaffordable.

I would have to close my business against government goals.

Will not be able to afford best facility for residents. May not be able to operate.

We do anticipate many indirect adverse effects on our business including reduced transparency and consistency in standards within the community on the quality and types of services they are currently receiving from licensed NRS 449 providers. We believe changing a working grade system to a new star system and then not applying any grading system to the similar services offered in certified but non licensed SLA/CBLA's will confuse seniors, consumers, and others on how the standards of care, monitoring, enforcement and methods to complain among these two overlapping system of care (NRS 449 Licensed care vs NRS 435 state certified, un-licensed, SLA/CBLA) for patients with similar need for help with ADL's, medication assistance, and protective supervision arising from various combinations of physical, cognitive or mental health care needs. We are also deeply concerned that the proposed regulation changes make less clear the distinction among and between various types of overlapping care for seniors and the disabled as they begin to need help with medication, ADL's, and help with cognitive or mental health care needs. We are concerned that the lack of transparency and informed understanding of the difference in licensed and non-licensed care will risk seniors not being able to make informed, safe, choices when faced with needing help with ADL's, medications or protective supervision. Each of the other proposed regulations have negative impacts which are both direct and indirect. We hope that many of the dis benefits are unintended and stem from the lack of involvement of the industry with HCQC in drafting these regulation changes. Moreover, it is concerning that the intent of the bills/legislation the industry proposed and worked out with the state legislatures are not being implemented with the same intent they were created. It is unclear that HCQC working by itself is aware of the intent of the various bills. Of note, the ALAC committee repeatedly requested a legislative update and work item be added to the standing agenda of meetings but that request was never realized.
One example is for the SB 324 which allows finger sticks and vital sign testing. I can provide equally lengthy discussion for the others as I have in the past but will use the finger stick, SB324 and medical lab CLIA waiver as one example. The HCQC remains confused and unclear about the Federal stance on medical labs and the need for CLIA waivers for FDA approved, individual use, glucometers, designed and approved for unshared, individual home use. The Federal CLIA interpretive guidelines are very clear that YOU DO NOT NEED A CLIA waiver for using an FDA approved, home, individual use glucometer. Including for cases when the individual gets help or assistance to use the device. If the HCQC has a special federal ruling that modifies that we have not seen it. As a doctor and having called CLIA I doubt CLIA's objection to the very simple and narrow focus of using non-shared, home glucometer, as needing a CLIA medical lab waiver. Now HCQC seems to be trying to mix their own CLIA medical lab waiver with a bill the industry and legislators, two of whom are active practice doctors, clearly understand non-shared, home use, glucometers, are a separate and distinct item. Moreover, CMS has said finger stick testing is so safe that even if it is done "incorrectly" there is

no risk. Notice that even if done incorrectly there is no risk and clearly doing it with education, training and a structured setting with already required recording and reporting system for other items the expected risks would be even less than that. (documented quotes available upon request that have been provided many times before) We agree and acknowledge that all other CLIA waived tests are riskier than FDA approved, individual glucose home testing even with assistance but those are not the issues in our bill. Requiring the medical lab certificate is an element that requires more discussion and federal CLIA ruling since the HCQC seems to be unclear with the current published guidelines.

A second part to this finger stick and medical lab ruling is the need for clarification of consistency in standard of care for all overlapping and related types of care where you are providing help with one or all the following aspects of care: help with ADL's, medication assistance, and protective supervision. The medical lab bill and SB 324 need to be clearly distinguished as for licensed NRS 449 and other care vs for non-licensed, state certified, SLA/CBLA care where they often provide care to the same type of residents as are cared for in Licensed facilities. The lack of distinction and building the second system of care clearly raised questions of two standards of care, lack of transparency for residents and health care professional who cannot know the dramatic differences in level of monitoring, care and safety for these two-overlapping systems of care. If SLA/CBLA are for transitional care then they should not offer help with medications, ADL's or protective supervision. You can't have it both ways. Either that is what they are or they must overlap with licensed, more monitored and safe care when they do offer those services. How is the new regulation allowing for and ensuring transparency, informed consent for professional who need to refer residents to one or the other settings? We believe strongly if HCQC were more active in reaching out to the industry the industry could help clarify many material issues of omission and misinformation to make a draft of the regulations that all will understand at the NRS, NAC, interpretive guideline and then implementation levels. However, at this time the industry has little idea what follows these proposed regulation changes. We also note that a chief concern for HCQC is the increased turn over of management level staff throughout the department. Given the complexity of our industry and health care having a consistent staff at all levels in HCQC had been a main pillar of the State's nation leading regulation and safe, cost effective, implementation of them. We encourage supervisors of HCQC to revisit the reasons for staff turn over to improve consistency in enforcement. While our business and the industry are always looking for ways to build on Nevada's nation leading system of regulations and monitoring to building higher quality and more consistent standards of care for Nevadans the lack of a dispute resolution system for RFFG that can allow providers and the industry some ability to account for past good and bad actions is an issue that more unchecked regulations can indirectly worsen. While the industry has begun discussions with various regulators at several times over the last few years the high turnover and lack of consistency within the once stable regulatory body of HCQC has retarded progress on this and many fronts.

I found it extremely confusing to the community that SLA/CBLA's are allowed to operate without oversight or even penalties. This system does not provide equal opportunity housing to our disabled and elderly population.

Reduced transparency and consistency in standards. Consumer confusion because of non-licensed SLA/CBLAs.

We do anticipate many indirect adverse effects on our business including reduced transparency and consistency in standards within the community on the quality and types of services they are currently receiving from licensed NRS 449 providers. Not applying any grading system to the similar services offered in certified but non-licensed SLA/CBLA's will confuse seniors, consumers, and others on how the standards of care, monitoring, enforcement and methods to complain vary among those two overlapping systems of care for elderly and disabled Nevadans with similar needs. More providers will open up, non-licensed operations with ala carte services hired by residents and families with no oversite/access from Ombudsman or State Agencies.

Multiple including reduced transparency and consistency in standards within the community on the quality and types of services they are currently receiving licensed providers. Without a grading system to the similar services offered in a certified but non-licensed SLA/CBLA's will confuse seniors, consumers and others on how the standard of care, monitoring, enforcement and methods to complain vary among the systems.

As a Management company of Assisted Living and Memory Care Communities it is our job to help support our Communities while serving and providing the best care to our residents. To do that there needs to be more transparency and consistency within the state surveyors and their outcomes. There needs to be transparency of seeing the grade and being able to read it. We cannot properly support and help if results/regulations are constantly inconsistent or changing.

We do expect there will be many indirect adverse effects on our business due to inconsistency in standards within the community on the quality and types of services they are currently receiving from licensed NRS 449 providers. By not applying a grading system to services provided in non-licensed care homes this will confuse seniors and their families on the standards of care, monitoring, enforcement and oversight by state agencies.

If I have to close (displace) 10 residents I can assure you I would not be the only business doing so. Where do these vulnerable people go? Live on the streets or at home being neglected or abused???

This could potentially increase vulnerability to litigation from consumers.

Increasing regulations and fines will inevitably force facilities to raise their rates, making care less affordable for consumers. With care being unaffordable, those in need may not seek care, which could result in more injuries and premature deaths among the elderly, or lead them to relocate to a more affordable city, putting facilities out of business.

Any time services to elderly and disabled are required to be licensed it creates an increase in the cost of services that is passed on to them. This increases the probability of outliving resources for more of our elderly and disabled Nevadans. If/when they do, the Medicaid rates/Budgeted dollars which are not adequate now, will need to be increased.

We do anticipate many indirect adverse effects on our business including, but not limited to compromising the quality of care we offer and serve to our seniors who deserve the best home like care environment without all this red tape that makes a business owner even wonder why they would even keep the doors open!

A poor rating could cause adverse effects.

I worry that out of fear of such steep penalties, that an unhealthy amount of time and focus will be put on following the rules and regulations which will result in a nervous staff that is now forced to focus more on tasks rather than good-hearted resident-centric care. In addition, an environment based in education is replaced by an environment based on punishment and fear.

4) Do you anticipate any indirect beneficial effects upon your business?

We at AHONN have discussed if there will be any indirect beneficial effect upon our business and all our members responded NO. We are hoping that the industry, legislators and regulators furnish educational opportunities as we had before to homecare providers to ensure the high quality of healthcare services. We believe that these opportunities will be a far greater benefit than simply implementing excessive fines and penalties.

How can the possible displacements of the "THOUSANDS' of the 'LOW INCOME and THE MOST VULNERABLE CITIZENS OF THE STATE' being provided with care in Residential Facility for Groups with beds of 10 and below who will be the severely impacted by these proposed changes reap any benefits?

Any regulations that increases costs, to already financially struggling care homes, particularly at the excessive levels proposed will force many homes out of business and as a result the most vulnerable low-income citizens will be severely impacted by lack of affordable care facilities. We strongly oppose said specific change under sections 16 & 17.

Absolutely, we will not be able to survive. Many group homes may have to start close down. So, sad, we are the most economical option but we keep on being pushed out.

How can the thousands of low-income be displaced?

No benefits as regulations are written!

While we do not anticipate any indirect beneficial effects from the proposed regulations as written we remain optimistic that the industry, providers, legislators and regulators can regain the strong, consistent, working relationship that use to exist between regulators and the industry when Nevada built its existing nation leading system of Licensed NRS 449 Residential Facility for Groups (RFFG).

I would anticipate that updated, created in partnership, these regulations may provide some benefits, but not as currently written. As an ALAC member, I would be happy to offer my time to brainstorm new ideas on how to create the best system possible.

We look forward to regaining a strong, consistent, working relationship between the industry, providers, legislators, and regulators.

Although, we are confident with some revisions and consistency it could positively impact our communities and more importantly our seniors.

As stated earlier, if I had to close because of a fine, people will be on the street, in private homes where families don't want them. Why are group homes always being targeted when we get better grades than some hospitals and nursing homes?

As written there is not benefit and substantial negative benefits. However, if we could rework the language to meet the intent for SB 324 it could improve consumer satisfaction, access to health care (especially for those with diabetes), with being able to remain in a less institutional, homelike RFFG setting vs. SNF. Moreover, it would help ease the growing crisis throughout Nevada from reduced numbers of safe, cost effective long-term care beds.

The processes to get SB 324 through, built new working relationships that can go forward to keep Nevada's nation leading system of Licensed NRS 449 Residential Facility for Groups (RFFG) a standard-bearer.

None. We do, however hope that our legislators and regulators realize how beneficial it is to even have RFFG's and we are hopeful that we can all work together for the benefit of our seniors and veterans included. There are not enough beds currently to even house the potential number of baby boomers, so to inflict such monetary penalties would drive RFFG's out of existence**!!**

Difficult to understand this regulation. Not aware of any star rating, or the website for quality reporting.

Adding time to the existing curriculum would require extending the course to 3 days. This would be a challenge for facilities to schedule.

Comments included with the small business impact questionnaire but not associated with a specific question:

Post information on website and inside the facility
This will require a new position to be developed and to maintain the website and posting of the most up to date star ratings. This will need to be someone that has the capabilities within the computer programming realm and clinical realm so that the unresolved and severity of the violations can be assigned. With the current undertone/number of Registered Nurses in this community that are over the average age of 50 at 53 percent and with the current number of Nurses nationwide that are heading into retirement (555,100) and the current projected new RN jobs (574,400) means that there are 1.13 million new RN's that are needed to keep our current pace with the current patient population needs. Having to comply with this current bill will put a stress on the current RN roles and responsibilities and finding such a nurse that will have both clinical and computer programming talents will be difficult at best to find. With the national average (mean) RN salary at $68,910 this would impose an extra $100,000 (with benefits) dollar expense to our facility.

Require the state board of health to establish a system for rating based on compliance with requirements concerning staffing; establish requirements concerning the membership of the staffing committee; requiring written policies for refusal of or objection to work assignments and document hospital staffing plans established by the staffing committee.
This regulation is horrible and will restrict the ability of the facility to manage its staffing appropriately for volume shifts and patient acuity. This part seems that it was developed by a union official that believes that staffing should be mitigated everyday by some overseeing committee. This will be burdensome and gives power to staff to run the business into default by burdening the facility with undo demands. This will allow the staffing committee to ruin the business aspect of running its business. With the highest amount of monies at 30 – 35% of total costs just for personnel salaries & benefits, the introduction of this bill will place more personnel resources into this category and increase these amounts well over the standard amount that a business can incur. I have worked in multiple facilities that were union and this staffing matrix that you are suggesting is right out of their play book. They ask for and want this at every upcoming renewal contract where they can sit on a committee and direct more staff into the patient staffing ratio to incur more revenue into their coffers via staffing direction. Management has the right to direct its staffing as necessary for the current volume and this needs to be maintained as a management right.

Another point that this bill will affect is the amount of monies that will be incurred by the facility to maintain these daily staffing committees. These will be daily staffing committees! For each day, the patient volume will dictate the number of staff needed. Currently each day a large portion (70%) of the day is spent by management working the daily staffing needs. You may think that this committee will meet once a quarter and make undue changes of how the staffing schedule should work but the only real way to make this work would to have this staffing committee meet daily to look at what the projected volume and patient needs (by acuity) will be. This will make for hiring more staff that would not be part of the regular staffing positions. So, if you expect there to be a "member representing each unit of the hospital" on this committee than it would increase the personnel salary budget up by each representative you are requiring the facility to place on this committee. So, the amount for each new committee member that is an RN to be represented will cost near $100,000 burden. This does not include the alternate members to be represented.

This bill also states that membership for the staffing committee will be elected. Who would elect them and how? Should it be someone that has a financial back ground? Someone who understands how patient volume and acuity affect staffing decisions? Someone that has knowledge of the current staff and their abilities to care for patients? Someone that has current knowledge of the ever-changing hospital legislative, CMS, State and Joint Commission guidelines/protocols? Or just a random staff member that has no knowledge base on how to staff the unit. With just a random staff member and no knowledge base this makes the committee not able to function at the level it needs to be proficient and consistent. So what provisions have been made for the election of these members? There needs to be a plan for this type of provision. Then what you end up with is an elected committee team that is made up of specialists who can impact the decision process. So, in the end you have a committee team that is specialized and formed and their only job is to do daily staffing. This is what we have right now with management making the staffing decisions. A refusal of a staff member to give patient care is not a right. When you go into the medical field you are taking a job where you will have to give care to any person from any walk of life during a traumatic time for that patient and you will need to place your own beliefs secondary to the patient's needs. You need to treat every person as if they were your own family member. There are already the necessary means for refusal of a work assignment. This can be brought forward to the ethical committee for resolution. This bill making policy for refusal will not be all encompassing. It will lead to more problems than solutions, it will give staff members the ability to not give care because of some ridiculous feeling/thought/objection. All patients deserve your care/attention regardless of your beliefs. Again, if you treat all patients like your family you will not object to give care for your loved one.