LCB File No. R051-99

NOTICE OF PUBLIC HEARING

NOTICE IS HEREBY GIVEN that the State Health Division will hold public hearing and act on amendments to Nevada Administrative Code (NAC) 445A, 449, 450B and 652. **The hearing is scheduled to begin at 9:00 a.m. on Friday, September 10, 1999, at the Grant Sawyer Building, Room 4410, 555 E. Washington Avenue, Las Vegas, Nevada.**

THIS HEARING IS TO MAKE TEMPORARY REGULATIONS PERMANENT.

RESIDENTIAL FACILITIES FOR GROUPS

In September of 1997 the Temporary Regulations for Residential Facilities for Groups were presented to the Board of Health as a Legislative Counsel Bureau file, for permanent adoption. Between the changes bureau staff proposed to the temporary regulations (after using them for almost one year) and changes that LCB made to the temporary regulations (during their preparation for permanent adoption) some language mistakes occurred and became evident during the past year. In addition the BOH has requested that we modify language at NAC 449.226.4 concerning call systems in large facilities in order to eliminate the need for variances to this particular requirement. The bureau decided it would wait until the regulations were codified by LCB before attempting to change any language.

We have established new language and modifications to existing language in the following areas:
NAC 449.0168, NAC 449.193, NAC 449.200, NAC 449.209, NAC 449.226, NAC 449.229, NAC 449.2704, NAC 449.2742, NAC 449.2744, NAC 449.2746, NAC 449.2749, NAC 449.275, NAC 449.2756, and NAC 449.2764

The changes are not substantial and are designed to clarify issues rather than create more requirements.

The changes present no anticipated effect to the public.

There is no anticipated additional cost to the agency for enforcement of the proposed regulation changes.

The regulations proposed for change will not effect changes to other governmental agencies and do not overlap/duplicate other regulations.

The regulations proposed for change do not overlap/duplicate federal regulations.

The regulations do not have a counterpart in the code of federal regulations.

The regulations will add two new fees to the fee schedule at NAC 449.0168.1, 1) one for

addition or change of facility type endorsements on a license and 2) one for change to the category on a license.

RESIDENTIAL FACILITIES FOR GROUPS - FEES

In September of 1997, the Temporary Regulations for Residential Facilities for Groups were presented to the Board of Health as a Legislative Counsel Bureau file, for permanent adoption. Between the changes bureau staff proposed to the temporary regulations (after using them for almost 1 year) and changes that LCB made to the temporary regulations (during their preparation for permanent adoption) it was identified that some language modification was required in the general provisions section of NAC Chapter 449. The Bureau decided it would wait until the regulations were codified by LCB before attempting to change any language.

In July the bureau received a copy of the codified regulations. The bureau subsequently drafted proposed changes to the regulations and will present these changes before the December BOH meeting.

We have established new language and modifications to existing language in the following areas:

NAC 449.0168

The changes are designed to establish standards for processing applications to change license endorsements, whereas currently there is no authority nor mechanism for the bureau to receive applications for the changes discussed. If the language is modified as presented the industry will benefit from the ability to apply for changes through the formal application process, rather than the current informal process.

The changes present no anticipated effect to the public. There is no anticipated additional cost to the agency for enforcement of the proposed regulation changes.

The regulations proposed for change will not effect changes to other governmental agencies and do not overlap/duplicate other regulations.

The regulations proposed for change do not overlap/duplicate federal regulations.

The regulations do not have a counterpart in the code of federal regulations.

The regulations will add two new fees to the fee schedule at NAC 449.0168.1, 1) a fee for addition or change of facility type endorsements on a license and 2) a fee for change to the category indicated on a license.

SURGICAL CENTERS FOR AMBULATORY PATIENTS

The proposed amendments are needed to update the current regulations originally adopted in 1988 relating to the licensing of surgical centers for ambulatory patients. The amendments also update the construction standards relating to ambulatory surgical centers.

The proposed regulations affect all services/departments in ambulatory surgical centers.

The proposed regulations will have a beneficial effect, recognized by the ambulatory surgical centers industry, on the ambulatory surgical centers because they were developed by utilizing current standards of care that are defined by the Medicare/Medicaid reimbursement participation standard. All currently licensed hospitals meet these standards at this time because all the hospitals participate in the Medicare/Medicaid reimbursement program.

The proposed regulations will have a beneficial effect on the public/consumer by assuring the public, through the state licensure process, that ambulatory surgical centers are meeting current standards of care.

There will be no change in cost to the facilities or to the Bureau of Licensure and Certification (BLC) for the change in the regulations for the licensing of ambulatory surgical centers. The current fee for initial and annual renewal of licenses will cover the cost to BLC.

The proposed regulations state that the facility must be in compliance with Nevada Revised Statutes (NRS) 449.700-449.730, NRS 453, NRS 652.217, and Nevada Administrative Code (NAC) 441 A and NAC 459. The duplication was necessary to assure certain statutes that affect the health and safety of residents and visitors to Nevada are being implemented by ambulatory surgical centers licensed by BLC.

The proposed regulations parallel the federal Medicare/Medicaid reimbursement participatory regulations governing ambulatory surgical centers (42 Code of Federal Regulations (CFR) Part 416, subpart A, B, and C) in certain sections and 42 CFR 489.24, Clinical Laboratory Improvement Amendment of 1988, Public Health Service Act (42 USC 274) and Life Safety Code, Standard 101.

The regulations are more stringent than the Federal regulations governing ambulatory surgical centers in certain areas: regulations for tuberculosis screening in employees, patient rights, and construction standards.

The regulations do not establish new fees or increase an existing fee.

POINT OF CARE TESTING

Proposed changes to Chapter 652 Medical Laboratories are necessary to allow healthcare professionals to perform waived and moderate complexity testing at the bedside in medical facilities licensed pursuant to Chapter 449.

Point of Care testing is defined and point of care device is described with limitations of use. Qualifications and activities of the point of care analyst are identified and certification fees are established. Continuing education requirements apply to the point of care analyst.

Anticipated benefits to both laboratories regulated by NAC 652 and the public (the patients) will be an overall cost reduction as a result of decreased length of stay due to rapid return of results to

the physician. These benefits are both immediate and long term. There are no adverse effects anticipated.

The increased cost to the agency will be funded by establishing a certification fee issued for point of care testing analyst.

NAC 652 and CLIA regulations (42 CFR Part 493 of the Code of Federal Regulations) have established requirements for the performance of laboratory testing, however, with the recent availability of small portable hand-held analyzers, bedside testing by healthcare professionals other than traditional laboratory technical staff required changes to existing regulations.

HOSPITALS

The proposed amendments are needed to update the current regulations originally adopted in 1969 relating to the licensing of hospitals. The amendments also update the construction standards relating to hospitals.

The proposed regulations affect all services/departments in acute hospitals. Current standards of care for those departments were addressed in the regulations.

The proposed regulations will have little if any effect on the acute hospitals because they were developed by utilizing current standards of care that are defined by the Medicare/Medicaid reimbursement participation standards. All currently licensed hospitals meet these standards at this time because all the hospitals participate in the Medicare/Medicaid reimbursement program.

The proposed regulations will have a beneficial effect on the public/consumer by assuring the public, through the state licensure process, that hospitals are meeting current standards of care.

There will be no change in cost to the facilities or to the Bureau of Licensure and Certification (BLC) for the change in the regulations for the licensing of hospitals. The current fee for initial and annual renewal of licenses will cover the cost to BLC.

The proposed regulations state that the facility must be in compliance with Nevada Revised Statutes (NRS) 449.700 – 449.730, NRS 439B.410, NRS 652.217, NRS 632, and Nevada Administrative Code (NAC) 441 A and NAC 459. The duplication was necessary to assure certain statutes that affect the health and safety of residents and visitors to Nevada are being implemented by hospitals licensed by BLC.

The proposed regulations parallel the federal Medicare/Medicaid reimbursement participatory regulations governing acute hospitals (42 Code of Federal Regulations (CFR) Part 482, Subpart A, B, C, and D) in certain sections and 42 CFR 489.24, Clinical Laboratory Improvement Amendment of 1988, Public Health Service Act (42 USC 274) and Life Safety Code, Standard 101.

The regulations are more stringent than the Federal regulations governing hospitals in certain areas: regulations for tuberculosis screening in employees, certain patient care areas, patient rights, and construction standards.

SKILLED NURSING REGULATIONS

The proposed amendments are needed to update the current regulations originally adopted in 1969 relating to the licensing of skilled nursing facilities. The amendments also update the construction standards relating to skilled nursing facilities.

The proposed amendments will incorporate resident rights, resident behavior and facility practices, quality of life, resident assessment, and quality of care requirements not included in the current regulations. Additionally, general requirements such as physician, nursing and dietary services will be addressed, as well as construction and design requirements.

The adoption of the proposed amendments should not create an economic or operational impact on licensed facilities because the proposed regulations parallel federal regulations the facilities have been following since 1990.

The proposed amendments are considered to provide a beneficial impact for the public by providing licensing standards for the care, safety and quality of life for nursing home residents consistent with current standards of practice.

The adoption of the proposed amendments should have no economic impact on the Bureau of Licensure and Certification because the proposed regulations parallel federal regulations that the agency has surveyed under contract with the Health Care Financing Administration.

These regulations do not duplicate the regulations of other state or local government entities. The regulations parallel federal regulations of the Health Care Financing Administration 42 C.F.R. 483.1 through 483.75, inclusive.

The proposed amendments include several sections that are more stringent than the federal regulations: Requirements for design and construction of skilled nursing facilities that are not addressed in federal regulation; requirements for TB testing of personnel.

The proposed amendments do not change existing fees or impose any new fees.

CONSTRUCTION STANDARDS

The proposed amendments are needed to update the current regulations originally adopted in 1969 relating to the construction standards of skilled nursing facilities and hospitals.

The proposed regulations affect all services/departments in acute hospitals.

The proposed regulations will have little effect on existing structures. All new construction and remodeling projects will be required to comply with the guidelines. The guidelines are used nationwide and will be beneficial to facilities in that architects or other design professionals are currently using the same guidelines in other states.

The proposed regulations will be beneficial to the general public by providing a nationally recognized standard for constructing a health care facility in a safe fashion.

There will be no change in cost to the facilities or to the Bureau of Licensure and Certification (BLC) for the change in the regulations for the licensing of hospitals. The current fee for initial and annual renewal of licenses will cover the cost to BLC.

The proposed regulations state that there are satisfactory assurances that the facility meets all applicable Federal, State and local laws and complies with all applicable life safety, environmental health, building and fire codes and zoning ordinances. If there are any differences between the State and local codes, the more restrictive standards apply. This is necessary to inform the facility that they are required to meet other codes or laws to pass the building inspection and zoning or certificate of occupancy requirements.

The proposed regulations reference the National Fire Protection Association (NFPA) as the basic codes of reference, in particular, the Life Safety Code NFPA 101, and the NFPA 99. These particular references and several others are included in "The Guidelines for Design and Construction of Hospitals and Health Care Facilities" on pages 3, 4 and 5.

The proposed regulations are more stringent than the federal regulations at 42 CFR 482.41 Condition of Participation – Physical Environment. This is necessary because the federal regulations do not address design and construction of facilities.

The proposed regulations do not establish new fees or increase an existing fee.

CERTIFICATION OF ENVIRONMENTAL TESTING LABORATORIES

The Administrative Code Chapter 445A pertaining to Certification of Environmental Laboratories analyzing drinking water in accordance with the Federal Safe Drinking Water Act as presently constituted has some defects that require resolution. The United States Environmental Protection Agency along with stakeholders throughout the nation has developed a consensus standard called the National Environmental Laboratory Accreditation Conference (NELAC) standard. The Bureau of Licensure and Certification has participated in the development of this standard. A program for laboratories to certify according to this nationally accepted standard has been put forth. It is called the National Environmental Laboratory Accreditation Program (NELAP). States may adopt the standard and they may participate in NELAP if they so choose.

Participation in NELAP necessitates subscribing to the NELAC standard which is organized in four distinct tiers, namely: 1.) Legal Identity and Mission; 2.) Testing Capability; 3.) Regulatory Program; 4.) Test Methods.

Each of these "tiers" are addressed in the current NAC but are not organized efficiently and items referenced therein create areas of confusion due to conflicting instructions or protocols. At one juncture the authority to revoke or downgrade certification based upon information obtained from site surveys was denied the Bureau because not all of the pertinent chapters of the referenced standard were included.

Some of the material included in the current NAC, though important, does not apply to laboratory certification. It should be separated from the certification portion of the code.

It is proposed that a completely new version of Chapter 445A pertaining to Environmental Laboratory Certification be adopted in accordance with a template provided by NELAC. This code follows the organizational pattern established by the NELAC standard and includes changes that are required for NELAP participation. Standards that are unique to Nevada will be retained. Since this version is new, the section identification numbers will not coincide with or relate to those of the current code. It is proposed to eliminate the current code and replace it with the new wording. Section numbers can be changed to fit into the surrounding code.

Anticipated effects on the environmental laboratory business are beneficial and immediate. Adoption of this revision will affect environmentally sensitive businesses in the following ways:

1. EPA involvement with the Performance Testing program has been changed. The NAC will reflect these changes.
2. Nevada will be able to participate in the NELAP program if it elects to do so.
3. Ambiguous language will be replaced so consistency in agency action will be assured.
4. Laboratories electing to participate in NELAP accreditation may do so with Nevada as their sponsoring authority.
5. NELAP accredited laboratories will have automatic reciprocity among all NELAP participation states. (So far twenty states have applied for NELAP participation and several more have committed.) *Nevada laboratory certification officers recommend that Nevada participate*.
6. NELAP participating laboratories will be held to a common standard.
7. NELAP participating laboratories will be able to participate in Federal contracts.
8. NELAP participating laboratories will not suffer a competitive disadvantage relative to participants.
9. NELAP participating laboratories will be assured a level playing field nationally.
10 NELAP participating laboratories will produce data of known, consistent and comparable quality.
11. Laboratories not electing NELAP accreditation will not be required to do so, but will be held to the NELAC standard in so far as it is appropriate.
12. Agencies and businesses requiring analyses of regulated parameters will be assured that data meet a rigorous nationally accepted standard.

Anticipated effects on the public are beneficial and long-term. The changes will assist in maintaining quality laboratory analytical capacity to ensure that measurements that affect the public health will be trustworthy.

The estimated cost to the agency for enforcement of the proposed regulation will not be any different than for the current regulation. In the event Nevada elects to have Bureau of Licensure and Certification Laboratory Certification Officers trained to become NELAP assessors, the cost will be limited to the training expense. The training is required every four years.

The regulations do not overlap or duplicate any federal regulations.
The regulations will maintain the existing fee structure.

DEFIBRILLATION - 450B.900-.936 (This regulation does not apply to EMS providers under the authority of Clark County Health District.)

These amendments are to repeal the existing regulations concerning defibrillation, add defibrillation to the authorized practices of emergency medical technicians, and add the definitions currently listed in sections .900 thru .914 to the "General Provisions" section of 450B.

This section of NAC 450B was placed in regulation because the use of automatic and semi-automatic defibrillation was introduced as a pilot program for emergency medical technicians and has since become a normal part of the emergency medical technician's scope of practice.

The National Highway Traffic Safety Administration of the United States Department of Transportation has adopted in the EMT Basic program training for the use of automatic and semi-automatic defibrillators. This eliminates the need for further training and certification in defibrillation for the EMT, as currently required in NAC 450B.918-.936.

This section of NAC 450B has generated unnecessary costs and training time for EMS services and personnel.

There are no anticipated effects on the business which NAC 450B regulates.

There are no anticipated effects on the public.

There are no anticipated additional costs to the Health Division for enforcement of the proposed regulation.

There are no existing regulations of other state or local governmental agencies which the proposed amendments to the regulations overlap or duplicate.

DO NOT RESUSCITATE - 450B.955

These amendments are to implement a fee for issuance of a Do Not Resuscitate Identification bracelet. This fee would cover the cost of the bracelet, including engraving and shipping the bracelet to the patient.

There are no anticipated effects on the business which NAC 450B regulates.

There are no anticipated effects on the public.

Estimated cost to the Health Division for enforcement of the proposed regulation:

Expenditure of $1,575.00 for purchasing an initial inventory of bracelets. This expenditure will be recouped in full through a fee to be determined by the health authority.

The amendment establishes a fee determined by the health authority not to exceed the actual cost of obtaining the medallion from a manufacturer, including the cost of engraving, shipping and handling.

There are no existing regulations of other state or local governmental agencies which the proposed amendments to the regulations overlap or duplicate.

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 by August 26, 1999.

Secretary, State Board of Health
Nevada State Health Division
Capitol Complex
505 E. King Street, Room 201
Carson City, NV 89701-4797

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.

Members of the public who are disabled and require special accommodations or assistance at the meeting are required to notify Yvonne Sylva, Secretary, Board of Health, in writing at the Nevada State Health Division, 505 E. King Street, Room 201, Carson City, NV 89701, or by calling (702) 687-4740.

A copy of this notice and the proposed regulation amendments are on file for inspection at the following locations during normal business hours:

Bureau of Licensure and Certification, 1550 E. College Pkwy, Suite 158, Carson City, Nevada (702) 687-4475).

Bureau of Licensure and Certification, 4220 S. Maryland Parkway, Suite 810, Las Vegas, Nevada (702) 486-6515.

Bureau of Licensure and Certification, 1755 E. Plumb Lane, Suite 241, Reno, Nevada (702) 688-2888

Emergency Medical Services, 850 Elm Street, Elko, Nevada (702) 753-1154.

Emergency Medical Services, 100 Frankie, Tonopah, Nevada (702) 482-3722.

Copies may be obtained in person, by mail, or by calling (702) 687-4475. Copies are also available for review at all physical locations of program offices (see above) or the following main public libraries in each county:

- Carson City Library, 900 North Roop St.
  Carson City, NV 89701
- Churchill County Library, 533 S. Main St.
  Fallon, NV 89406

- Clark County Library, 4020 Maryland Parkway,
  Las Vegas, NV 89119
- Douglas County Library, 1625 Library Lane, (PO Box 337)
  Minden, NV 89423
- Elko County Library, 720 Court St.
  Elko, NV 89801
- Goldfield Public Library (Esmeralda Co.), Corner of Crook and Ramsey, (PO Box 430)
  Goldfield, NV 89013
- Eureka Branch Library, 10190 Monroe St.,
  Eureka, NV 89316
- Humboldt County Library, 85 East 5th St.,
  Winnemucca, NV 89445
- Battle Mountain Branch Library (Lander Co.), 6255 Broad St.,
  Battle Mountain, NV 89820
- Lincoln County Library, 63 Maine St., (PO Box 330)
  Pioche, NV 89043
- Lyon County Library, 20 Nevin Way,
  Yerington, NV 89447
- Mineral County Library, 125 A St., (PO Box 1390)
  Hawthorne, NV 89415
- Pershing County Library, 125 Central, (PO Box 781)
  Lovelock, NV 89419
- Storey County Library, 95 South R St., (PO Box 14)
  Virginia City, NV 89440
- Tonopah Public Library (Nye Co.), 171 Central, (PO Box 449)
  Tonopah, NV 89049
- Washoe County Library, 301 South Center St., (PO Box 2151)
  Reno, NV 89505
- White Pine County Library, 950 Campton St.,
  Ely, NV 89301

Per NRS 233B.064(2), upon adoption of any regulations, 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.

To be published in the Las Vegas Review-Journal, Reno Gazette-Journal and Elko Daily Free Press on or before August 11, 1999.
Richard J. Panelli, Chief
July 27, 1999

PROPOSED REGULATION OF THE STATE BOARD OF HEALTH

SKILLED NURSING FACILITIES

Explanation-Italicized material is new; material in [ ] is to be deleted

Section 1. ***Definitions.***

As used in Section 1 to Section 26, inclusive, unless the context otherwise requires, the words and terms defined in Section 1 to Section 26, inclusive, have the meanings ascribed to them in those sections.

Section 2. ***"Bureau" defined.***

The "Bureau" means the Bureau of Licensure and Certification of the Nevada State Health Division.

Section 3. ***"Chemical restraint" defined.***

"Chemical restraint" means a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms.

Section 4. ***"Facility" defined.***

"Facility" means a facility for skilled nursing as defined in NRS 449.0039.

Section 5. ***"Governing body" defined.***

"Governing body" means the person, persons, board of trustees, directors or other body in whom the final authority and responsibility is vested for conduct of the facility for skilled nursing.

Section 6. ***"Physical restraint" defined.***

"Physical restraint" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

Section 7. ***"State mental health authority" defined.***

"State mental health authority" means the mental hygiene and mental retardation division of the department of human resources.

Section 8. ***"State mental retardation authority" defined.***

"State mental retardation authority" means the mental hygiene and mental retardation division of the department of human resources.

Section 9. *"State ombudsman program" defined.*

"State ombudsman program" means the advocates for residents of facilities for long term care in the Division for Aging Services, of the Department of Human Resources pursuant to NRS 427A.

Section 10. *Licensing Requirements.*

1. The facility must be operated and conducted in the name designated on the license with the name of the person responsible for its operation also appearing on the face of the license. The license is not transferable.

2. Each facility must retain proof that it is covered against liabilities resulting from claims incurred in the course of operation. Liability coverage must be verified at the time of the annual application.

3. No facility may have more patients than the number of beds for which it is licensed, except in emergencies. If this is necessary, the bureau must be notified.

4. Facilities will be considered to be in compliance with Section 25 of these regulations if:

(a) The facility is licensed on January 1, 1999, the use of the physical space does not change, and the existing construction does not have any deficiencies which are likely to cause serious injury, serious harm, or impairment to public health and welfare; or

(b) The facility has submitted architectural plans to the Bureau of Licensure and Certification by February 1, 1999 and begun construction by August 1, 1999. The plans must be determined by the bureau to be in compliance with NAC Chapter 449 Construction Standards that were in effect prior to December 11, 1998. The facility must be built in accordance with those standards and not have any deficiencies which are likely to cause serious injury, serious harm, or impairment to public health and welfare.

(c) If there are deficiencies that are likely to cause serious injury, serious harm, or impairment to public health and welfare, the facility must make changes before the facility can continue to operate.

5. Upon a change of ownership, change of use or change in construction, a facility must notify the bureau of changes and identify all areas of non-compliance with the guidelines before the change in ownership, use, or construction takes place.

6. Upon a change of use or change in construction the facility must come into compliance with the regulations before admitting residents to the area.

7. Determination of suitability for this state of revision of publication adopted by reference. If any publication adopted by reference pursuant to Section 1 to 26, inclusive, is revised, the state board of health will review the revision to determine its suitability for this state. If the board determines that the revision is not suitable for this state, it will hold a public hearing to review its determination and give notice of that hearing within 6 months after the date of the publication of the revision.

If, after the hearing, the board does not revise its determination, the board will give notice that the revision is not suitable for this state within 30 days after the hearing. If the board does not give such notice, the revision becomes part of the publication adopted by reference pursuant to Section 1 to 26, inclusive.

Section 11. *Correction of Deficiencies.*

1. The licensee will be notified in writing of the existence of any deficiencies and be required to correct them within a reasonable time.

2. With the exception of major deficiencies, such as those requiring structural alterations of a building or portion of the building, reasonable time means not more than 60 days.

3. Upon written request and just cause the Bureau may grant exceptions to subsection 2 of this section based on extenuating circumstances.

Section 12. *Resident Rights.*

The resident has a right to a dignified existence, self-determination,, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:

1. Exercise of rights.

(a) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(b) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

(c) In the case of a resident adjudged incompetent under the laws of a State by court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.

(d) In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.

2. Notice of rights and services.

(a) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;

(b) The resident or his or her legal representative has the right-

(i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours(excluding weekends and holidays); and

(ii) After receipt of his or her records for inspection, to purchase copies of the records or any portions of them upon request after 2 working days advance notice to the facility, at costs pursuant to NRS 629.061.

(c) The resident has the right to be fully informed in language he or she can understand of his or her total health status, including but not limited to, his or her medical condition;

(d) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (g) of this section; and

(e) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered by the facility's per diem rate.

(f) The facility must furnish a written description of legal rights which includes—

(i) A description of the manner of protecting personal funds, under paragraph (3) of this section;

(ii) A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the bureau, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and

(iii) A statement that the resident may file a complaint with the bureau concerning resident abuse, neglect, misappropriation of resident property in the facility.

(g) The facility must establish written policies and procedures regarding advance directives, consistent with the provisions of state law. These policies must include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive.

(h) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

(i) The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use social service programs such as, Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(j) Notification of changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is—

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in section 13 (1).

(ii) The facility must also promptly notify the resident and,if known, the resident's legal representative or interested family member when there is—

(A) A change in room or roommate assignment as specified in section 15(5)(b); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (2)(a) of this section.

(iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

3. Protection of resident funds.

(a) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

(b) Management of personal funds. Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (3)(c)-(h) of this section.

(c) Deposit of funds.

(i) Funds in excess of $50. The facility must deposit any residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

(ii) Funds less than $50. The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

(d) Accounting and records. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

(i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(ii) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

(e) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(f) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the bureau, to assure the security of all personal funds of residents deposited with the facility.

(g) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for:

(i) Room/bed maintenance services.

(ii) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight

infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.

(iii) Medically-related social services as required by section 15 (7).

(h) Items and services that may be charged to residents' funds. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge:

(i) Telephone.

(ii) Television/radio for personal use.

(iii) Personal comfort items, including smoking materials, notions and novelties, and confections.

(iv) Cosmetic and grooming items and services in excess of those items specified in paragraph (g) (ii) of this section.

(v) Personal clothing.

(vi) Personal reading matter.

(vii) Gifts purchased on behalf of a resident.

(viii) Flowers and plants.

(ix) Social events and entertainment offered outside the scope of the activities program, provided under section 15 (6).

(x) Noncovered special care services such as privately hired nurses or aides.

(xi) Private room, except when therapeutically required (for example,isolation for infection control).

(xii) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by section 19.

(i)Requests for items and services.

(i) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident.

(ii) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay.

(iii) The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.

4. Free choice. The resident has the right to—

(a) Choose a personal attending physician;

(b) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

(c)Unless adjudged noncompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

5. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

(a) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;

(b) Except as provided in paragraph (5)(c) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;

(c) The resident's right to refuse release of personal and clinical records does not apply when—

(i) The resident is transferred to another health care institution; or

(ii) Record release is required by law.

6. Grievances. A resident has the right to—

(a) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and

(b) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

7. Examination of survey results. A resident has the right to—

(a) Examine the results of the most recent survey of the facility conducted by Federal surveyors or the bureau and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents and must post a notice of their availability; and

(b) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

8. Work. The resident has the right to—

(a) Refuse to perform services for the facility;

(b) Perform services for the facility, if he or she chooses, when—

(i) The facility has documented the need or desire for work in the plan of care;

(ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;

(iii) Compensation for paid services is at or above prevailing rates; and

(iv) The resident agrees to the work arrangement described in the plan of care.

9. Mail. The resident has the right to privacy in written communications, including the right to-

(a) Send and promptly receive mail that is unopened; and

(b) Have access to stationery, postage, and writing implements at the resident's own expense.

(10) Access and visitation rights.

(a) The resident has the right and the facility must provide immediate access to any resident by the following:

(i) Any representative of the bureau;

(ii) The resident's individual physician;

(iii) The State long term care ombudsman established under NRS Chapter 427 A;

(iv) The agency responsible for the protection and advocacy system for developmentally disabled individuals;

(v) The agency responsible for the protection and advocacy system for mentally ill individuals;

(vi) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

(vii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

(b) The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(c) The facility must allow representatives of the State Ombudsman, described in paragraph (10)(a)(iii) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with State law.

11. Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

12. Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

13. Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

14. Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defined by section 16 (9)(b)(ii) has determined that this practice is safe.

Section 13. *Admission, Transfer And Discharge Rights.*

1. Transfer and discharge-

(a) Transfer and discharge includes movement of a resident to a bed outside of the licensed facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same licensed facility.

(b) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under insurance or a social service program) a stay at the facility; or

(vi)The facility ceases to operate.

(c) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (1)(b)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by—

(i) The resident's physician when transfer or discharge is necessary under paragraph (1)(b)(i) or paragraph (1)(b)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (1)(b)(iv) of this section.

(d) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (1)(f) of this section.

(e) Timing of the notice.

(i) Except when specified in paragraph (1)(e)(ii) of this section, the notice of transfer or discharge required under paragraph (1)(d) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when—

(A) the safety of individuals in the facility would be endangered under paragraph (1)(b)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (1)(b)(iv) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (1)(b)(ii) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (1)(b)(i) of this section; or

(E) A resident has not resided in the facility for 30 days.

(f) Contents of the notice. The written notice specified in paragraph (1)(d) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and telephone number of the State long term care ombudsman;

(vi) For facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals;

(vii) For facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.

(g) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

2. Notice of bed-hold policy and readmission—

(a) Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility must provide written information to the resident and a family member or legal representative that specifies—

(i) The duration of the bed-hold policy during which the resident is permitted to return and resume residence in the facility; and

(ii) The facility's policies regarding bed-hold periods, which must be consistent with paragraph (2)(c) of this section, permitting a resident to return.

(b) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (2)(a) of this section.

(c) Permitting resident to return to facility. A facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility.

3. Equal access to quality care.

(a) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of source of payment;

(b) The facility may charge any amount for services furnished to residents consistent with the notice requirement in section 12 (2) (e) describing the charges;

4. Admissions policy.

(a) The facility must—

(i) Not require residents or potential residents to waive their rights to social service programs such as Medicare or Medicaid; and

(ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, social service programs such as Medicare or Medicaid benefits.

(b) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(c) In the case of a person eligible for a social service program, a facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the program, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,--

(i) A facility may charge a resident who is eligible for a social service program for items and services the resident has requested and received, and that are not specified in the program so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and

(ii) A facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a resident eligible for a social service program or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for the resident.

Section 14. *Resident Behavior And Facility Practices.*

1. Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

2. Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

3. Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(a) The facility must—

(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion against a resident.

(ii) Not employ individuals who have been—

(A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or

(B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and

(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

(iv) Conduct a criminal history check pursuant to NRS 449.176 to 449.188, inclusive.

(b) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the bureau).

(c) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(d) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including the bureau) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Section 15. *Quality Of Life.*

A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

1. Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

2. Self-determination and participation. The resident has the right to—

(a) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

(b) Interact with members of the community both inside and outside the facility; and

(c) Make choices about aspects of his or her life in the facility that are significant to the resident.

3. Participation in resident and family groups.

(a) A resident has the right to organize and participate in resident groups in the facility;

(b) A resident's family has the right to meet in the facility with the families of other residents in the facility;

(c) The facility must provide a resident or family group, if one exists, with private space;

(d) Staff or visitors may attend meetings at the group's invitation;

(e) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings;

(f) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

4. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

5. Accommodation of needs. A resident has the right to—

(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

(b) Receive notice before the resident's room or roommate in the facility is changed.

6. Activities.

(a) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(b) The activities program must be directed by a qualified professional who—

(i) Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body; or

(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or

(iii) Is a qualified occupational therapist or occupational therapy assistant; or

(iv) Has completed a training course approved by the state.

7. Social Services.

(a) A facility must provide medically-related social services to assist resident to "enhance or restore their ability to function physically, socially, and economically," as defined in NRS 641B.030.

(b) The social service program must provide for the psychosocial assessment of each resident and identify and address medically related social and emotional needs.

(c) A facility with 70 beds or less must employ or contract with a qualified social worker.

(d) A facility with more than 70 beds must employ a full time social worker for each 70 beds.

(e) A qualified social worker must be licensed pursuant to NRS 614B.

8. Environment.

The facility must provide—

(a) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;

(b) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

(c) Clean bed and bath linens that are in good condition;

(d) Private closet space in each resident room;

(e) Adequate and comfortable lighting levels in all areas;

(f) Comfortable and safe temperature levels. Facilities must maintain a temperature range of 71-81 degrees Fahrenheit; and

(g) For the maintenance of comfortable sound levels.

Section 16. *Resident Assessment.*

The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

1. Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

2. Comprehensive assessments

(a) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the bureau. The assessment must include at least the following:

(i) Identification and demographic information.

(ii) Customary routine.

(iii) Cognitive patterns.

(iv) Communication.

(v) Vision.

(vi) Mood and behavior patterns.

(vii) Psychosocial well-being.

(viii) Physical functioning and structural problems.

(ix) Continence.

(x) Disease diagnoses and health conditions.

(xi) Dental and nutritional status.

(xii) Skin condition.

(xiii) Activity pursuit.

(xiv) Medications.

(xv) Special treatments and procedures.

(xvi) Discharge potential.

(xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.

(xviii) Documentation of participation in the assessment.

The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

(b) When required. A facility must conduct a comprehensive assessment of a resident as follows:

(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) The annual resident assessment must be completed within 365 days after completion of the most recent full resident assessment.

(iii) Not less than once every 12 months.

3. Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by the bureau not less frequently than once every 3 months.

4. Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's plan of care.

5. Coordination. A facility must coordinate assessments with any State-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.

6. Accuracy of assessments. The assessment must accurately reflect the resident's status.

7. Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

8. Certification.

(a) A registered nurse must sign and certify that the assessment is completed.

(b) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

9. Comprehensive care plans:

(a) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following—

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under section 17, and

(ii) Any services that would otherwise be required under section 17 but are not provided due to the resident's exercise of rights under section 12, including the right to refuse treatment under section 12 (2)(d).

(b) A comprehensive care plan must be—

(i) Developed within 7 days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(c) The services provided or arranged by the facility must—

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

10. Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes—

(a) A recapitulation of the resident's stay;

(b) A final summary of the resident's status to include items in paragraph (2)(a) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

(c) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

11. Preadmission screening for mentally ill individuals and individuals with mental retardation.

(a) A facility must not admit any new resident with—

(i) Mental illness as defined in paragraph (b)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Mental retardation, as defined in paragraph (b)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission—

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

(b) For purposes of this section—

(i) An individual is considered to have mental illness if the individual has a serious mental illness as defined in NRS 433.164.

(ii) An individual is considered to be mentally retarded if the individual is mentally retarded as defined in NRS 433.174.

Section 17. *Quality Of Care:*

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

1. Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that—

(a) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—

(i) Bathe, dress, and groom;

(ii) Transfer and ambulate;

(iii) Toilet;

(iv) Eat; and

(v) Use speech, language, or other functional communication systems.

(b) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (1)(a) of this section; and

(c) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

2. Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident—

(a) In making appointments, and

(b) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

3. Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that—

(a) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

(b) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

4. Urinary Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that—

(a) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and

(b) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

5. Range of motion. Based on the comprehensive assessment of a resident, the facility must ensure that—

(a) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

(b) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

6. Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility must ensure that—

(a) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and

(b) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

7. Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility must ensure that—

(a) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and

(b) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

8. Accidents. The facility must ensure that—

(a) The resident environment remains as free of accident hazards as is possible; and

(b) Each resident receives adequate supervision and assistance devices to prevent accidents.

9. Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident—

(a) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

(b) Receives a therapeutic diet when there is a nutritional problem.

10. Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

11. Special needs. The facility must ensure that residents receive proper treatment and care for the following special services:

(a) Injections;

(b) Parenteral and enteral fluids;

(c) Colostomy, ureterostomy, or ileostomy care;

(d) Tracheostomy care;

(e) Tracheal suctioning;

(f) Respiratory care;

(g) Foot care; and

(h) Prostheses.

12. Unnecessary drugs—

(a) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(i) In excessive dose (including duplicate drug therapy); or

(ii) For excessive duration; or

(iii) Without adequate monitoring; or

(iv) Without adequate indications for its use; or

(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) Any combinations of the reasons above.

(b) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that—

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

13. Medication Errors. The facility must ensure that—

(a) It is free of medication error rates of five percent or greater; and

(b) Residents are free of any significant medication errors.

Section 18. *Nursing Services:*

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The provision of

nursing service must be in compliance with applicable State statutes and regulations, including the Nevada Nursing Practice Act (NRS 632).

1. Sufficient staff.

(a) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Licensed nurses; and

(ii) Other nursing personnel.

(b) The facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

2. Registered nurse.

(a) The facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

(b) The facility must designate a registered nurse to serve as the chief administrative nurse on a full time basis. The chief administrative nurse must have three years of acute hospital or long term care nursing experience and have sufficient supervisory experience for the appointment.

(c) The chief administrative nurse may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

Section 19. *Dietary Services:*

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

1. Staffing. The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.

(a) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.

(b) A qualified dietitian is one who is qualified based upon registration by the Commission on Dietetic Registration of the American Dietetic Association.

2. Sufficient staff. The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.

3. Menus and nutritional adequacy. Menus must—

(a) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;

(b) Be prepared in advance; and

(c) Be followed.

4. Food. The facility must provide each resident with:

(a) Food prepared by methods that conserve nutritive value, flavor, and appearance;

(b) Food that is palatable, attractive, and at the proper temperature;

(c) Food prepared in a form designed to meet individual needs; and

(d) Substitutes offered of similar nutritive value to residents who refuse food served.

5. Therapeutic diets. Therapeutic diets must be prescribed by the attending physician.

6. Frequency of meals.

(a) The facility must provide each resident with at least three meals daily, at regular times comparable to normal mealtimes in the community.

(b) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (d) below.

(c) The facility must offer snacks at bedtime daily.

(d) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

7. Assistive devices. The facility must provide special eating equipment and utensils for residents who need them.

8. Sanitary conditions. The facility must—

(a) Comply with the standards prescribed in Chapter 446 of NAC; and

(b) Obtain the necessary permits from the Bureau of Health Protection Services of the Health Division.

(c) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;

(d) Store, prepare, distribute, and serve food under sanitary conditions; and

(e) Dispose of garbage and refuse properly.

Section 20. ***Physician Services:***

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

1. Physician supervision. The facility must ensure that—

(a) The medical care of each resident is supervised by a physician; and

(b) Another physician supervises the medical care of residents when their attending physician is unavailable.

2. Physician visits. The physician must—

(a) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (3) of this section;

(b) Write, sign, and date progress notes at each visit; and

(c) Sign and date all orders.

3. Frequency of physician visits.

(a) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(b) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

(c) Except as provided in paragraphs (3)(d) and (5) of this section, all required physician visits must be made by the physician personally.

(d) At the option of the physician, required visits in facilities after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (5) of this section.

4. Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

5. Physician delegation of tasks.

(a) Except as specified in paragraph (5)(b) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who—

(i) Is acting within the scope of practice as defined by State law; and

(ii) Is under the supervision of the physician.

(b) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.

Section 21. *Specialized Rehabilitative Services:*

1. Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must—

(a) Provide the required services; or

(b) Obtain the required services from an outside resource (in accordance with section 26 (8) of these regulations) from a provider of specialized rehabilitative services.

2. Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

Section 22. *Dental Services:*

The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility-

1. Must provide or obtain from an outside resource, in accordance with section 26 (8) of these regulations, routine and emergency dental services to meet the needs of each resident;

2. Must if necessary, assist the resident—

(a) In making appointments; and

(b) By arranging for transportation to and from the dentist's office; and

3. Promptly refer residents with lost or damaged dentures to a dentist.

Section 23. *Pharmacy Services:*

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in section 26 (8) of these regulations.

1. Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

2. Service consultation. The facility must employ or obtain the services of a licensed pharmacist who—

(a) Provides consultation on all aspects of the provision of pharmacy services in the facility;

(b) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(c) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

3. Drug regimen review.

(a) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(b) The pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon by the facility.

4. Labeling of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

5. Storage of drugs and biologicals.

(a) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(b) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

Section 24. *Infection Control*

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

1. Infection control program. The facility must establish an infection control program under which it—

(a) Investigates, controls, and prevents infections in the facility;

(b) Decides what procedures, such as isolation, should be applied to an individual resident; and

(c) Maintains a record of incidents and corrective actions related to infections.

2. Preventing spread of infection.

(a) When the facility determines, according to its infection control program, that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

(b) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(c) The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

3. Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

4. Tuberculosis testing. The facility must ensure that resident records contain documented evidence of surveillance and testing of residents for tuberculosis pursuant to NAC 441A.380.

Section 25. *Physical Environment:*

The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

1. Design and Construction.

(a) Newly constructed and existing facilities must be designed and maintained, to comply with the current edition of "The Guidelines for Design and Construction of Hospital and Healthcare Facilities". A copy of the guidelines may be obtained from AIA Rizzoli Bookstore, 1735 New York Avenue NW, Washington, D.C. 20006, for the price of $60.00 plus $6.00 for shipping. The telephone number is (202) 626-7541. These guidelines must be used when planning for sizing, arranging, and equipping of space that is being altered or newly constructed, with the following exceptions:

(i) Renovation Section 1.2 of the introduction to the guidelines.

(ii) Refurbishing (only making changes in paint, floor, window and/or wall coverings).

(b) The facility must meet all applicable federal, state and local laws and comply with all applicable life safety, environmental health, building, fire codes and zoning ordinances. If there are any differences between the state and local codes, the more restrictive standards apply.

(c) The bureau may review building plans for new construction or remodeling. A complete copy of the plans, drawn to scale, may be brought to the bureau for a plan review pursuant to the provisions set forth in NRS 449.050 and NAC 449.0165.

(d) Approval for licensing will not be given by the bureau until all construction has been completed and a survey is conducted at the site. The plan review does not constitute pre-licensing approval but is advisory only.

2. Life safety from fire. Newly constructed and existing facilities must be designed and maintained to comply with current National Fire Protection Association, Life Safety Code, Standard 101. A copy of the code may be obtained from the National Fire Protection Association, 11 Tracy Drive, Avon, Massachusetts 02322, for the price of $44.50, plus $4.84 for shipping and handling. A facility is considered to be in compliance with this requirement as long as the facility continues to comply with code current at the time it was initially licensed.

3. Emergency power.

(a) An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and for maintaining life support systems in the event the normal electrical supply is interrupted.

(b) When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in National Fire Protection Association Standard 99 for Health Care Facilities and National Fire Protection Association Standard 101 Life Safety Code) that is located on the premises. A copy of the code may be obtained from the National Fire Protection Association, 11 Tracy Drive, Avon Massachusetts 02322, for the price of $44.50, plus $4.84 for shipping and handling.

4. Space and equipment. The facility must—

(a) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these regulations and as identified in each resident's plan of care; and

(b) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

5. Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. The facility must provide each resident with—

(a) A separate bed of proper size and height for the convenience of the resident;

(b) A clean, comfortable mattress;

(c) Bedding appropriate to the weather and climate; and

(d) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

6. Resident call system. The nurse's station must be equipped to receive resident calls through a communication system from—

(a) Resident rooms; and

(b) Toilet and bathing facilities.

7. Dining and resident activities. The facility must provide one or more rooms designated for resident dining and activities. These rooms must—

(a) Be well lighted;

(b) Be well ventilated, with nonsmoking areas identified;

(c) Be adequately furnished; and

(d) Have sufficient space to accommodate all activities.

8. Other environmental conditions. The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must—

(a) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;

(b) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;

(c) Equip corridors with firmly secured handrails on each side; and

(d) Maintain an effective pest control program so that the facility is free of pests and rodents.

Section 26. *Administration:*

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

1. Licensure. A facility must be licensed under applicable State and local law.

2. Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

3. Discrimination prohibited. A resident of a facility shall not be segregated or restricted in the enjoyment of any advantage or privilege enjoyed by other residents, or provided with any assistance, service or other benefit which is different or provided in a different manner from that provided to other residents, on the ground of race, color, religion, national origin or disability.

4. Governing body.

(a) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and

(b) The governing body appoints the administrator who is—

(i) Licensed by the State pursuant to NRS 449.035(1); and

(ii) Responsible for the management of the facility.

5. Required training of nursing assistants.

(a) For the purposes of this section a-

(i) Professional staff means a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

(ii) "Nursing assistant" means a person who, under the direction of a licensed nurse in a medical facility and for compensation, performs basic restorative services and basic nursing services which are directed at the safety, comfort, personal hygiene, basic mental health and protection of patients and the protection of patients' rights.

(b) General rule. A facility must not use any individual working in the facility as a nurse assistant trainee for more than 4 months, on a full-time basis, unless that individual is certified pursuant to NAC 632.

(c) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (5)(b) of this section.

(d) Competency. A facility must not use any individual who has worked less than 4 months as a nurse assistant in that facility unless the individual—

(i) Is a full-time employee in a State-approved training and competency evaluation program; or

(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse assistant training and competency evaluation program.

(e) Registry verification. Before allowing an individual to serve as a nurse assistant, a facility must receive registry verification that the individual has met competency evaluation requirements pursuant to NRS 632.

(f) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training program.

(g) Regular in-service education. The facility must complete a performance review of every nurse assistant at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must—

(i) Be sufficient to ensure the continuing competence of the nurse assistant and be provided consistent with requirements set forth in NAC 632 but must be no less than 12 hours per year;

(ii) Address areas of weakness as determined in nurse assistant performance reviews and may address the special needs of residents as determined by the facility staff; and

(iii) For nurse assistants providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

6. Proficiency of nurse assistant. The facility must ensure that nurse assistants are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

7. Staff qualifications.

(a) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.

(b) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.

8. Use of outside resources.

(a) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in paragraph (8)(b) of this section.

(b) Agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for—

(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and

(ii) The timeliness of the services.

9. Medical director.

(a) The facility must designate a physician to serve as medical director.

(b) The medical director is responsible for—

(i) Implementation of resident care policies; and

(ii) The coordination of medical care in the facility.

10. Laboratory services.

(a) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in NRS and NAC Chapter 652 and 42 CFR 493.

(ii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must meet the applicable requirements of NRS and NAC Chapter 652 and be certified in the appropriate specialties and subspecialties of service in accordance with 42 CFR 493.

(iii) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of NRS and NAC Chapter 652 and is certified in the appropriate specialties and subspecialties of services in accordance with 42 CFR 493.

(b) The facility must—

(i) Provide or obtain laboratory services only when ordered by the attending physician;

(ii) Promptly notify the attending physician of the findings;

(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

(iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.

11. Radiology and other diagnostic services.

(a) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(i) If the facility provides its own diagnostic services, the services must meet the applicable Nevada Administrative Code for radiological services for hospitals.

(ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services.

(b) The facility must—

(i) Provide or obtain radiology and other diagnostic services only when ordered by the attending physician;

(ii) Promptly notify the attending physician of the findings;

(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

(iv) File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.

12. Clinical records.

(a) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are—

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized.

(b) Clinical records must be retained for—

(i) Five years from the date of discharge; or

(ii) For a minor, three years after a resident reaches legal age under State law.

(c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use;

(d) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by—

(i) Transfer to another health care institution;

(ii) Law;

(iii) Third party payment contract; or

(iv) The resident.

(e) The clinical record must contain—

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The plan of care and services provided;

(iv) The results of any preadmission screening conducted by the State; and

(v) Progress notes.

(f) The facility must assure that no individual willfully and knowingly falsifies (or causes another individual to falsify) any information entered into a resident's clinical record.

13. Disaster and emergency preparedness.

(a) The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(b) The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.

14. Transfer agreement.

(a) The facility must have in effect a written transfer agreement with one or more hospitals, licensed pursuant to NRS 449, that reasonably assures that-

(i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician; and

(ii) Medical and other information needed for care and treatment of residents, will be exchanged between the institutions; and

(iii) The transferring facility must provide any other information which could assist in determining whether the resident can be adequately cared for in a less expensive setting than either the facility or the hospital.

(b) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

15. Quality assessment and assurance.

(a) A facility must maintain a quality assessment and assurance committee consisting of—

(i) The chief administrative nurse;

(ii) A physician designated by the facility; and

(iii) At least 3 other members of the facility's staff.

(b) The quality assessment and assurance committee—

(i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and

(ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.

(c) The bureau may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with requirements of this section.

(d) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

16. Personnel.

(a) A facility must have written policies concerning the qualifications, responsibilities and conditions of employment for each type of personnel, including licensure or certification when required by law.

(b) The written policies must be reviewed as needed and made available to members of the staff.

(c) Personnel policies must provide for:

(i) The orientation of all health personnel to the policies and objectives of the facility training while on the job and continuing education;

(ii) The maintenance of current employee records, which confirm those personnel policies are followed.

(d) All personnel employed by the facility, or working under contract with the facility, who are required by law to be licensed or certified must have evidence of a current license or certification on file at the facility.

(e) The facility must ensure that employee health records contain documented evidence of surveillance and testing of employees for tuberculosis pursuant to NAC 441A.375.

(f) The facility must have proof that the facility did not find any evidence that the employee has been convicted of a crime listed in NRS 449.188.

(g) The facility must make the personnel files available for inspection by the bureau upon request.

INFORMATIONAL STATEMENT PER NRS 233B.066

1. DESCRIPTION OF HOW PUBLIC COMMENT WAS SOLICITED, SUMMARY OF PUBLIC RESPONSE, AND AN EXPLANATION OF HOW OTHER INTERESTED PERSONS MAY OBTAIN A COPY OF THE SUMMARY.

Notice of public workshops held on August 21, 1998, in Reno; August 24, 1998, in Winnemucca; and August 25, 1998, in Las Vegas was published in the Las Vegas Review Journal, Reno Gazette Journal, and Elko Daily Free Press on or before August 7, 1998. Notices of public workshops and proposed regulations were mailed to all county libraries in Nevada, skilled nursing facilities, and interested parties.

Notice of public hearing regarding the Board's intent to adopt amendments was published in the Las Vegas Review Journal, Reno Gazette Journal, and Elko Daily Free Press on or before November 11, 1998. Notices of public hearing and proposed regulations were mailed to all county libraries in Nevada, skilled nursing facilities, and interested parties on November 5, 1998.

Notice of public workshops held on August 19, 1999, in Las Vegas was published in the Las Vegas Review Journal, Reno Gazette Journal, and Elko Daily Free Press on or before August 2, 1999. Notices of public workshops and proposed regulations were mailed to all county libraries in Nevada, skilled nursing facilities, and interested parties.

Notice of public hearing regarding the Board's intent to adopt amendments was published in the Las Vegas Review Journal, Reno Gazette Journal, and Elko Daily Free Press on or before August 11, 1999. Notices of public hearing and proposed regulations were mailed to all county libraries in Nevada, skilled nursing facilities, and interested parties on July 30, 1999.

In addition, copies of the proposed regulations were available during normal office hours at:

Bureau of Licensure and Certification - Carson City
Bureau of Licensure and Certification - Las Vegas
Bureau of Licensure and Certification - Reno
Nevada State Library
Emergency Medical Services - Elko
Emergency Medical Services - Tonopah

For public response copies of the minutes of the Board of Health meetings may be obtained by calling the Health Division at 684-4200.

2. THE NUMBER OF PERSONS WHO:

(A) ATTENDED THE HEARING;

Approximately 85 people attended the December 11, 1998, Board of Health hearing.
Approximately 37 people attended the September 10, 1999, Board of Health hearing.

(B) TESTIFIED AT EACH HEARING; AND

Seven people testified at the December 11, 1998, Board of Health hearing.
No people testified at the September 10, 1999, Board of Health hearing.

(C) SUBMITTED TO THE AGENCY WRITTEN STATEMENTS.

There were no written statements submitted to the agency outside of the hearing before the State Board of Health.

3. A DESCRIPTION OF HOW COMMENT WAS SOLICITED FROM AFFECTED BUSINESSES, A SUMMARY OF THEIR RESPONSE, AND AN EXPLANATION HOW OTHER INTERESTED PERSONS MAY OBTAIN A COPY OF THE SUMMARY

Comment was solicited from affected or potentially affected businesses by mailing skilled nursing facilities and all interested parties the proposed regulations and notice for the workshops and Board of Health hearing. Copies the workshop minutes and Board of Health hearing minutes may be obtained by calling the Bureau of Licensure and Certification at (775) 687-4475.

4. IF THE REGULATION WAS ADOPTED WITHOUT CHANGING ANY PART OF THE PROPOSED REGULATION, A SUMMARY OF THE REASONS FOR ADOPTING THE REGULATION WITHOUT CHANGE.

None.

5. THE ESTIMATED ECONOMIC EFFECT OF THE REGULATION ON THE BUSINESS WHICH IT IS TO REGULATE AND ON THE PUBLIC. THESE MUST BE STATED SEPARATELY, AND IN EACH CASE MUST INCLUDE:
(A) BOTH ADVERSE AND BENEFICIAL EFFECTS; AND
(B) BOTH IMMEDIATE AND LONG TERM EFFECTS.

Effect on Industry: While these regulations are more stringent than previous licensure regulations they are expected to have a beneficial effect for the industry. These state licensure regulations correspond to current federal Medicare certification regulations. This is anticipated to be beneficial for industry by eliminating the need to meet two differing sets of standards. These effects should be evidenced immediately and continue for the long term.

Effect on the Public: More stringent licensure regulations offer more assurance to the public to safe-guard the well-being of residents in any skilled nursing facility licensed in Nevada. This will allow for the state to take licensure action and apply sanctions in facilities that fail to meet the requirements for nursing home residents. These effects should be evidenced immediately and

continue for the long term.

6. THE ESTIMATED COST TO THE AGENCY FOR ENFORCEMENT OF THE PROPOSED REGULATION.

There is no anticipated cost to the agency. The agency currently surveys for compliance with these requirements under the federal Medicare contract. This will not impact on time frames or survey staff.

7. A DESCRIPTION OF ANY REGULATIONS OF OTHER STATE OR GOVERNMENT AGENCIES WHICH THE PROPOSED REGULATION OVERLAPS OR DUPLICATES AND A STATEMENT EXPLAINING WHY THE DUPLICATION OR OVERLAPPING IS NECESSARY. IF THE REGULATION OVERLAPS OR DUPLICATES A FEDERAL REGULATION, NAME THE REGULATING FEDERAL AGENCY.

These state licensure regulations mirror the federal regulations for voluntary Medicare certification of nursing homes found at 42 C.F.R. 483.1 through 483.75, inclusive. The Medicare program is regulated by the Health Care Financing Administration. It is necessary to have mandatory state licensure regulations that protect the well being of nursing home residents.

8. IF THE REGULATION INCLUDES PROVISION WHICH ARE MORE STRINGENT THAN A FEDERAL REGULATION WHICH REGULATES THE SAME ACTIVITY, A SUMMARY OF SUCH PROVISION.

There are 3 areas in which the state licensure regulations are more stringent than the federal regulations governing skilled nursing facilities: 1) Tuberculosis testing is required pursuant to NAC 441A; 2) Criminal history background checks are required pursuant to NRS 449.179 through 449.188, inclusive; 3) Compliance with the American Institute of Architects Guidelines for Healthcare Facilities is required for construction features.

9. IF THE REGULATION PROVIDES A NEW FEE OR INCREASES AN EXISTING FEE, THE TOTAL ANNUAL AMOUNT THE AGENCY EXPECTS TO COLLECT AND THE MANNER IN WHICH THE MONEY WILL BE USED.

There are no additional or increased fees associated with the passage of these regulations.