DIVISION OF PUBLIC & BEHAVIORAL HEALTH

BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE

LCB File No. R048-22

Informational Statement per NRS 233B.066

1. A clear and concise explanation of the need for the adopted regulation;

The proposed regulations align Chapter 449 of NAC with the passage of several bills, including, Senate Bill 92 and Assembly Bills 131 and 232 of the 2019 Legislative Sessions and Senate Bill 69 and Assembly Bill 287 of the 2021 Legislative Session.

- Senate Bill 92 of the 2019 Legislative Session expanded provisions for the licensing and regulation of referral agencies that provide referrals to residential facilities for groups to also require the licensing and regulation of referral agencies that provide referrals to certain similar group housing arrangements. The proposed regulations expand provisions governing referral agencies to also include agencies that provide referrals to group housing arrangements as defined in Section 9 of the proposed regulations. In addition to the changes as a result of the passage of Senate Bill 92, Section 32 of this regulation authorizes a licensed nurse, public guardian, social worker, physician, physician assistant or hospital to provide a referral to a group housing arrangement through a licensed referral agency.
- Assembly Bill 131 of the 2019 Legislative Session removed a requirement that a provider of community-based living arrangement services must be Certified by the Division of Public and Behavioral Health and instead requires such a provider to be licensed by the Division as a facility for the dependent. The proposed regulations replace language referring to a certificate and instead uses the term license where applicable.
- Assembly Bill 232 of the 2019 Legislative Session abolished the classification of a general hospital; therefore, the proposed regulations remove the term general hospital from Nevada Administrative Code.
- Senate Bill 69 of the 2021 Legislative Session removed the provisions for licensure of a peer support recovery organization; therefore, the proposed regulations remove the associated fee.
- To conform with the passage of Assembly Bill 287 of the 2021 Legislative Session, the proposed regulations revise the term "obstetric center" to instead refer to a "freestanding birthing center."

In addition, the adopted regulations and errata make the following changes:

Section 1 to be omitted.

Section 3 adopts by reference certain guidelines concerning the use of personal protective equipment, and section 4 requires a medical facility, facility for the dependent or other licensed facility to follow those

guidelines and to take certain measures to ensure that the facility maintains an adequate supply of personal protective equipment.

Section 5 to be omitted.

Section 6 expands the requirement for a hospital to notify the Division if the hospital that is not required to be accredited and becomes accredited or loses accreditation to apply to any medical facility that acquires or loses accreditation. It also authorizes the Division to impose an administrative penalty for failure to report the acquisition or loss of accreditation; and prohibits the Bureau of Health Care Quality and Compliance from imposing any other administrative sanction for such a violation.

Section 7 requires a facility for the dependent to develop and carry out an infection control program and an emergency preparedness plan; and designate two employees to be responsible for infection control at the facility.

Section 8 requires a facility for hospice care that plans to commence new construction or certain remodeling to submit two copies of the building plans to that designated entity and the Division, requires the building plans to be approved before the construction or remodeling, as applicable, begins, and requires the Bureau to conduct a site survey before licensing a newly constructed facility for hospice care. (Modified by Errata)

Section 26 requires a facility for hospice care to comply with certain requirements for fire safety. (Modified by Errata)

Section 44 specifies that the administrator of an agency to provide personal care services in the home is required to ensure that employees are provided all training required by chapter 449 of NRS and chapter 449 of NAC. Section 10 provides that an agency to provide personal care services in the home may satisfy that requirement by providing or arranging for the provision of such training. It also requires such an agency to pay certain costs associated with such training; and the salary or hourly wage of an employee for time spent attending such training.

Section 13 prescribes different class designations for ambulatory surgical centers based on the type of surgical procedures performed at an ambulatory surgical center; and requires an ambulatory surgical center to have a certain amount of space in the operating room, depending on the class designation of the ambulatory surgical center. (Modified by Errata)

Section 19 requires an application for a license to operate an ambulatory surgical center to identify the class designation of the ambulatory surgical center.

Section 14 prescribes certain qualifications for a surgical technologist who is hired if, after conducting a thorough and diligent search, the facility is unable to employ a sufficient number of surgical technologists who possess the qualifications pursuant to NRS 449.24185, establishes the conditions under which an ambulatory surgical center will be deemed to have conducted a thorough and diligent search, and requires an ambulatory surgical center that employs a surgical technologist under such circumstances to maintain certain documentation.

Section 15 prescribes certain required training for a natural person responsible for the operation of a provider of community-based living arrangement services; an employee of a provider of community-based living

arrangement services who supervises or provides support to recipients of services; and a caregiver who assists a recipient of community-based living arrangement services in the administration of medication.

Section 16 requires a provider of community-based living arrangement services who operates a facility that provides assistance to residents in the administration of medications to maintain certain records concerning those medications; and prescribes requirements governing the administration of over-the-counter medications or dietary supplements to such residents. Section 62 requires an applicant for a provisional license to post a surety bond in a certain amount, place that amount in escrow or take other action prescribed by the Division to ensure the continuation of services if the applicant becomes insolvent. Section 63 requires a provider of community-based living arrangement services to maintain a staff sufficient to meet the needs of each person receiving services from the provider.

If there is an immediate and serious threat to the health and safety of residents or patients at a facility, section 17 requires the Bureau of Health Care Quality and Compliance to notify the facility as soon as possible and authorizes the Bureau to require the facility to establish a plan of abatement to end the threat.

Sections 18 and 67 update the titles and prices of and certain other information concerning certain publications adopted by reference.

Section 20 extends the requirement to investigate and survey a facility and receive a satisfactory report of inspection of the facility from the State Fire Marshal or local fire department before issuing a license to the facility to additionally apply to intermediary service organizations, which are certified by the Division; and (2) exempts from the requirement to receive a fire inspection certain entities that are required to obtain a license or certificate from the Division but do not always operate in a physical facility.

The proposed regulations remove references to the term “subunit agency” of a home health agency as there will no longer be a separate licensure category for subunits.

Section 24 removes the requirement that a complaint must be submitted by a consumer, thereby authorizing the Division to charge a licensee for the investigation of any complaint against the licensee.

Section 28 authorizes a residential facility for groups to retain a resident with a serious infection during an epidemic or pandemic if the resident does not have symptoms that require a higher level of care than the residential facility is capable of providing.

Section 27 revises requirements governing the size of the windows in a bedroom of a residential facility for groups.

Sections 41, 47 and 80 require a hospital or independent center for emergency medical care to provide training to each employee who provides care to victims of sexual assault or attempted sexual assault concerning appropriate care for such persons within 60 days after the date on which the employee commenced employment or, if the employee is employed on the effective date of this regulation, within 60 days after the effective date of this regulation; and maintain evidence of such training in the personnel file of each such employee. (Modified by Errata)

If there is reasonable cause to believe that a resident of a psychiatric residential treatment facility has been abused or neglected, section 45 requires an employee or independent contractor having knowledge of the abuse or neglect to report the abuse or neglect as required by law; and the facility to take certain measures to

stop the abuse or neglect, notify the family of or other person legally responsible for the alleged victim and ensure that the alleged victim receives proper care.

Sections 46, 52 and 70 revise provisions governing facilities for the treatment of irreversible renal disease, facilities for skilled nursing and recovery centers to clarify that a dietitian, physician, physician assistant, dentist, advanced practice registered nurse or podiatric physician is authorized to order or prescribe, as appropriate, a therapeutic diet for a patient at any of those facilities.

Section 50 revises the required dimensions of doors to certain rooms that permit access for wheelchairs at an intermediate care facility.

Section 60 brings home health agency regulations in line with existing law by authorizing a physician assistant or advanced practice registered nurse to order home health care for a patient.

The proposed regulations also omit a large portion of the state home health agency regulations and instead align them more closely with the federal CMS home health agency regulations by adopting those by reference and requiring they be followed by licensed home health agencies.

Section 68 removes the requirement that each ambulatory surgical center must maintain a written agreement with a hospital concerning the transfer of patients.

Section 71 requires a pharmacy conducted by a recovery center to be licensed; and a recovery center to comply with the requirement concerning the signing of chart orders.

Sections 73 and 74 establish requirements concerning the confidentiality of a statement of deficiencies and plan of correction.

2. A description of how public comment was solicited, a summary of public response, and an explanation how other interested persons may obtain a copy of the summary;

An email was sent through the Division's medical and non-medical facility List Servs which are open to both providers and members of the public with information on how small businesses could provide input on the proposed regulations and how to access the small business impact questionnaire and proposed regulations through a link to the Division's webpage with links to the questionnaire and proposed regulations.

The public workshop notice, proposed regulations and small business impact questionnaire was posted in all the locations listed on the notice of public workshop, including on the Division of Public and Behavioral Health's website and the Nevada Legislature's Administrative Regulation Notices, Meetings and Workshops web page.

Public Workshop -September 28, 2022

A summary of the public workshop testimony, including written comments not presented during the public workshop, includes:

Oral Testimony Summary

Sections 41, 47, 80 Concern was expressed that the regulations refer back to statutes, but the statutes indicate regulations will be adopted to create training; therefore, not giving real guidance to be able to ensure compliance with the proposed regulations. The proposed regulations are self-referential as drafted.

Section 68 Concerns were expressed regarding omitting the provision in NAC 449.996 requiring an ambulatory surgical center to maintain a written patient transfer agreement with a hospital. Concern was expressed that without a written transfer agreement a hospital may receive a patient that is not appropriate for a hospital. It was expressed that this was a significant concern because it puts patients at risk. Transfer agreements are very important and should something happen in an ambulatory surgical center that there is a facility ready to go.

Support of the proposed regulations was expressed with one large exception. Cannot support the draft regulations until Section 44 is modified. The concern expressed is that Section 44 requires personnel receive all trainings required by NRS Chapter 449, including family member caregivers providing care to their family taking the entire cultural competency training. A request was made to modify the proposed regulations to provide a waiver or exemption to family members that care for family from having to take the cultural competency training. Once this issue was resolved, there would be support for the proposed regulations.

Written Testimony Summary

1. Definition of Monitoring. Assuming that the audio or video monitoring provisions in section 5 do not apply to security cameras in public entryways and communal areas of a facility, but only pertain to equipment found in a resident's room.
2. Clarify Language. Recommendation to simplify language pertaining to consent by using the term "occupant" instead of "a patient, a resident, or a roommate".
3. Identification of Surrogates. Recommendation to identify only individuals with legitimate legal rights to make decisions on behalf of an individual.
4. Identifying a Surrogate in Subsection 7.

Concerns were expressed about:

- The potential for exposure (civil and regulatory) for the facilities and staff should the facility incorrectly accept an individual as surrogate when someone of a higher "tier" is available but not identified.
- The administrative burden to contact and obtain consent from "all reasonably available" members of a tier. It would become difficult and time consuming for facilities with limited resources, especially where a facility not only needs to contact, but identify and locate family members who may live outside of Nevada.

Two potential methods of addressing the issues relating to the identification of a "surrogate" were proposed. First, and most desirable, would be for the draft rule to revise subsection 7 to include only "spouse or other individual identified as having medical or legal decision-making authority, pursuant to the policies of the facility" which would eliminate the "tier" system as well as the need to identify and consult with all members of a tier. It was noted that while this may lead to circumstances where a decision maker cannot immediately be located and the facility may not use audio or video monitoring, this also is the most protective of an individual's privacy rights. The facility is not without the ability to frequently monitor that individual through traditional means, and there is limited risk of the individual being subject to unwanted surveillance and invasions of privacy.

A second, but less desirable option, would be to limit the amount of time that a "surrogate" could consent to video monitoring to give time for a legal representative to be identified through guardianship proceedings or other similar proceeding. There should also be language which would indicate that a "surrogate's" consent may be immediately overruled should a legal representative be identified.

Public Hearing – December 2, 2022

A summary of the public hearing testimony includes:
Concerns regarding cultural competency training were expressed as well as concerns that the infection control training requirements in subsection 4, section 7 are too prescriptive because they require the training be provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention, and the World Health Organization for the Society for Healthcare Epidemiology of America. It was noted this did not allow for training by accredited programs. A request was made to amend the proposed regulations to allow for other trainings. A Board of Health member explained that a facility could submit a variance for adding another infection control program (training) which could be used to track the additions to see if regulations need to be adjusted at a future date. The Division's Deputy Attorney General explained the variance process.

Sections 10 and 44: Licensed care agencies must meet the standards in NRS. There are 16 required topics. A request was made to have caregivers be excluded from requirement to have additional training. A Division representative noted that Sections 10 and 44 did not add any additional training requirements, but instead required that agencies pay employees, including payment of wages, to take the trainings required in NAC and NRS Chapters 449.

Additional comments on Section 10 are noted below:
An individual testified that the Home Care Employment Standards Board made an unanimous decision to make the training recommendations in the proposed regulations. This was to remove ambiguity. She strongly recommends approval of the proposed regulations.

Another individual indicated they were a member of the Home Care Employment Standards Board. The individual noted the demand on home care is increasing, that there is a severe worker shortage, and that inflation is also having an impact. The individual recommended approval of the amendment.

Another individual testified that there are 16 training subjects, and that labor law requires employees be paid for receiving training.

A DPBH representative noted that although covered by labor law, the proposed regulations were needed to authorize the Bureau of Health Care Quality and Compliance (HCQC) to monitor this. That HCQC would be able to assist with the review of these requirements.

A Board of Health member had concerns related to the cost of Section 10 and noted he did not see it addressed in the Small Business Impact Statement.

A DPBH representative noted that this was addressed in the Small Business Impact Statement (please refer to #3 – economic effect on small business, adverse economic effects section). In addition, it was noted that on page 5 in the summary of responses, one entity noted the financial impact in dollar amounts, for example, one portion notes: "Section 44 of the proposed regulation specifies that the administrator of a personal care agency is required to ensure that employees are provided training required by 449 which would cost approximately $45,000." It was also explained that the fiscal impact may be different for different agencies, as some may already be paying for the required trainings while others may not.

Note: #3, adverse economic effects section on small business noted: Section 10: One response to the small

business impact questionnaire noted that it estimates the costs of the proposed regulations to be $85,200 annually. In the end, the comments were provided by a similar provider type to a personal care agency, but since the provider is not a personal care agency, the provisions noted as having the negative impact did not apply to the provider; therefore, he confirmed his concerns were alleviated. For sections 10 and 44, no one else provided a fiscal impact in dollar amounts. As noted previously, one individual did testify that labor law already requires employees be paid for receiving training.

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

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

3. A statement indicating the number of persons who attended each hearing, testified at each hearing, and submitted written statements regarding the proposed regulation. This statement should include for each person identified pursuant to this section that testified and/or provided written statements at each hearing regarding the proposed regulation, the following information, if provided to the agency conducting the hearing:

(a) Name

(b) Telephone Number

(c) Business Address

(d) Business telephone number

(e) Electronic mail address; and

(f) Name of entity or organization represented

Public Workshop -September 28, 2022

Sixteen (16) individuals, not including Division of Public and Behavioral Health (DPBH) and DPBH deputy attorney general, attended the public workshop. Of those individuals, three individuals provided oral testimony and one individual provided written testimony. The individuals that provided oral and/or written testimony are noted below.

Brett Salmon
Nevada Health Care Association/Nevada Center for Assisted Living
2990 Sunridge Heights Pkwy, Suite 140|Henderson, NV 89052
bsalmon@nvhca.org

Jesse Wadhams
jessewadhams@blackwadhams.law

Joan Hall
Nevada Rural Hospital Partners
4600 Kietzke Ln, Suite I-209
Reno, NV 89502
joan@nrhp.org

Eddie Ableser
Tri-Strategies
59 Damonte Ranch Pkwy, Ste. B - 552
Reno, NV 89521
eddie@tri-strategies.com

Public Hearing – December 2, 2022

Ninety-one (91) individuals attended the public hearing, either virtually or in person. As there were several agenda items, not all attendees may have been in attendance for the hearing on these proposed regulations. Of those individuals, 6 individuals provided oral testimony. The individuals that provided oral testimony are noted below:

Connie McMullen
Personal Care Association of Nevada (PCAN)

Jeanne Bishop-Parise
775-232-3379

Marlene Lockard

Farren Epstein

Allan Ward – Home Instead

Cody Phinney – Deputy Administrator, Division of Public and Behavioral Health
4150 Technology Way, Suite 300, Carson City, NV 89706
775-684-4041
c.phinney@health.nv.gov

Leticia Metherell, RN – Health Program Manager, Division of Public and Behavioral Health, Bureau of

Health Care Quality and Compliance
727 Fairview Drive, Suite E, Carson City, NV
lmetherell@health.nv.gov
775-684-1045

4. A description of how comment was solicited (i.e., notices) from affected businesses, a summary of their response, and an explanation how other interested persons may obtain a copy of the summary.

Pursuant to NRS 233B.0608 (2)(a), the Division of Public and Behavioral Health has requested input from licensed health care facilities.

An email was sent to emergency service providers licensed/certified in accordance with NRS and NAC Chapters 450B on 6/23/2022 and to licensed health care facilities and the Division's medical and non-medical facility List Servs which are open to both providers and members of the public on 7/7/2022 with information on how small businesses could provide input on the proposed regulations and how to access the small business impact questionnaire and proposed regulations through a link to the Division's webpage with links to the questionnaire and proposed regulations. A second email, with the above information, was emailed to licensed health care facilities and through the medical and non-medical facility List Servs on 7/20/2022 reminding them to provide input on the proposed regulation changes by 5 pm on July 22, 2022.

The following is a count of the first email that went out. The majority of the reminder emails that went out are duplicates of the first one, so those are not counted.

- Licensed/certified emergency medical service providers: 7,488
- Licensed health care facilities: 1,733
- Non-medical list serv: 340
- Medical facility List Serv: 410
- Total Emails: 9,971

The questions on the questionnaire were:

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

Summary of Response

Summary Of Comments Received (Seven (7) responses were received out of 9,971* small business impact questionnaires distributed)			
Will a specific regulation have an adverse economic effect upon your business?	**Will the regulation (s) have any beneficial effect upon your business?**	**Do you anticipate any indirect adverse effects upon your business?**	**Do you anticipate any indirect beneficial effects upon your business?**

Yes = 4 No = 2 No response: 1	Yes = 1 No = 5 No response: 1	Yes = 4 No = 2 No response: 1	Yes = 0 No = 6 No Response: 1
449. we are a pca agency, this is not workable for us, we dont have a facility, we dont control clients residency and there is no way we can. If we do not receive funding to provide the personal protective equipment we can not properly comply with any new requirements. (A quick point of clarification for a previous inaccurate questionnaire submission... Freedom Care is a fiscal Intermediary with less than 50 direct employees administering services within state. However, we administer self directed Personal Care Services for approximately 450 Medicaid patients and their caregivers.) Section 44 of the proposed regulation specifies that the administrator of a personal care agency is required to ensure that employees are provided training required by 449 which would cost approximately $45,000. Additionally, Section 10 requires the agency to pay certain costs associated with this training including the salary or hourly wage of an employee for the time spent attending such training. These costs would result in $40,000 of additional wages to be paid annually. In total Freedom Care would estimate the costs of the proposed regulation to be $85,200 annually. In 2021 Freedom Care had a total of 450 consumers put on care, which would equate to a minimum of 450 caregivers. Providing each caregiver training using a state approved online course will cost an estimated $100 per caregiver or $45,000 annually. The use of self-paced an online course is preferred to ensure maximum flexibility for the caregiver, to avoid losing any direct personal care service hours or having to incur additional travel costs. To provide employees, or in our case the caregivers, their regular $11 hourly wage for 8 hours of training would cost $88 per employee/caregiver in additional wages, or approximately	yes as long as we are provided with equipment and funding, it will provide a safe environment for everyone.	another unlogical regulation for pca agencies, we dont belong in same category as facilities Ensuring that healthcare providers in all facilities and service environments receive adequate and comprehensive cultural competency training is essential to reducing health disparities. However, the level of training should be relative to the setting in which the care is provided and mindful of the individual providing the care or services. Patients who receive personal care services (PCS) in their own homes are self-directing and responsible for hiring and supervising their own caregivers. These caregivers are friends and family members who often only work with one patient with whom they have a pre-existing personal relationship. Requiring these caregivers to receive the same eight-hour training that a physician, physician assistant, Nurse Practitioner, nurse, and other licensed professional who interacts with multiple patients from diverse backgrounds daily is not warranted or appropriate. PCS caregivers are often of the same cultural background as their patients and often encounter the same cultural biases as the patients they are assisting. Using the same courses for these individuals that are developed for other healthcare professionals who are traditionally educated and trained will not result in the same understanding or desired outcome. Requiring this level of training will only exacerbate the recruitment and retention of PCS caregivers by imposing additional barriers to providing care. Establishing and providing	

$40,000 annually. As the fiscal intermediary we would incur all trainings related expenses to prevent the patient from losing 8 hours of personal care services related to their caregiver receiving the required training as dictated by this proposed regulation. Currently for every new patient enrolled to receive PCS services we invest over $1000 per patient prior to any care being provided that can result in a reimbursement for services. This initial investment includes costs associated with obtaining health assessments, TB testing, fingerprinting and background checks, and other basic requirements. When considering the average, a patient is approved for only 13 hours of care per week with a reimbursement rate of $17.65/hour, less the $11 hourly wage it takes over three months of a patient receiving PCS services to cover the initial costs required to on board new patients. This investment doesn't factor in the in-payroll taxes, overhead or new training requirements as required in this proposed regulation. Controlling the initial expenses related to providing PCS services will be essential to ensure that providers can and will continue to provide these services to patient consumers throughout the state. Section 5 Videoing patients. We notify patients they will be on camera but don't require written consent and sometimes the patient may refuse written consent, it is necessary for two main reasons. 1. Employee safety, if the patient is known to be violent or combative having a camera so others can keep an eye on the patient and employee is a safety feature. If the patient knows they will be combative they may refuse to sign so they can hurt an employee without being on video. This is dangerous and expensive for workers comp and liability. 2. Patients can be unsafe to be left alone without eyes on the patient. If a patient in this category		a tailored training that ensures PCS caregivers are educated and aware of the cultural competency concepts, with a greater focus on being an advocate for their patients within the health system, would be more appropriate and beneficial. Empowering PCS caregivers to recognize disparities for their patients and themselves would build a stronger understanding and provide the tools needed to navigate the healthcare system and address health disparities encountered on behalf of patients and for themselves. Section 5 on patient monitoring. By requiring written consent on patients, we will give more opportunities for patients to deny monitoring. This includes behavioral health patients that may be borderline a danger to themselves but not be L2K which means they could deny it and do something to cause self harm. We are risking patients and employees health with this added requirement, and by not having it we don't have any issues. Not sure why adding more administrative work and more steps to a process that works is necessary. Just another example of added cost to healthcare settings which results in more staffing and higher charges to offset costs.	

refuses to sign consent for recording they would require a 1 on 1 staffing situation which costs 1 FTE for each patient in this situation. This could add up to multiple employees not being able to work efficiently and thus cost the facility considerable, especially given all the staffing issues. When a patient is asleep a staff member can keep an eye on the monitor while doing work, if this isn't an option we will lose that ability and incur significant cost. Getting written consent is much more complicated in this patient population and this environment.			

*Based on first emailing as the majority of the second reminder email were duplicates

A summary of the public workshop testimony, including written comments not presented during the public workshop, includes:

Oral Testimony Summary

Sections 41, 47, 80 Concern was expressed that the regulations refer back to statutes, but the statutes indicate regulations will be adopted to create training; therefore, not giving real guidance to be able to ensure compliance with the proposed regulations. The proposed regulations are self-referential as drafted.

Section 68 Concerns were expressed regarding omitting the provision in NAC 449.996 requiring an ambulatory surgical center to maintain a written patient transfer agreement with a hospital. Concern was expressed that without a written transfer agreement a hospital may receive a patient that is not appropriate for a hospital. It was expressed that this was a significant concern because it puts patients at risk. Transfer agreements are very important and should something happen in an ambulatory surgical center that there is a facility ready to go.

Support of the proposed regulations was expressed with one large exception. Cannot support the draft regulations until Section 44 is modified. The concern expressed is that Section 44 requires personnel receive all trainings required by NRS Chapter 449, including family member caregivers providing care to their family taking the entire cultural competency training. A request was made to modify the proposed regulations to provide a waiver or exemption to family members that care for family from having to take the cultural competency training. Once this issue was resolved, there would be support for the proposed regulations.

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2. Clarify Language. Recommendation to simplify language pertaining to consent by using the term "occupant" instead of "a patient, a resident, or a roommate".
3. Identification of Surrogates. Recommendation to identify only individuals with legitimate legal rights to make decisions on behalf of an individual.
4. Identifying a Surrogate in Subsection 7.
Concerns were expressed about:

- The potential for exposure (civil and regulatory) for the facilities and staff should the facility incorrectly accept an individual as surrogate when someone of a higher "tier" is available but not identified.
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Two potential methods of addressing the issues relating to the identification of a "surrogate" were proposed. First, and most desirable, would be for the draft rule to revise subsection 7 to include only "spouse or other individual identified as having medical or legal decision-making authority, pursuant to the policies of the facility" which would eliminate the "tier" system as well as the need to identify and consult with all members of a tier. It was noted that while this may lead to circumstances where a decision maker cannot immediately be located and the facility may not use audio or video monitoring, this also is the most protective of an individual's privacy rights. The facility is not without the ability to frequently monitor that individual through traditional means, and there is limited risk of the individual being subject to unwanted surveillance and invasions of privacy.

A second, but less desirable option, would be to limit the amount of time that a "surrogate" could consent to video monitoring to give time for a legal representative to be identified through guardianship proceedings or other similar proceeding. There should also be language which would indicate that a "surrogate's" consent may be immediately overruled should a legal representative be identified.

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Sections 10 and 44: Licensed care agencies must meet the standards in NRS. There are 16 required topics. A request was made to have caregivers be excluded from requirement to have additional training. A Division representative noted that Sections 10 and 44 did not add any additional training requirements, but instead required that agencies pay employees, including payment of wages, to take the trainings required in NAC and NRS Chapters 449.

Additional comments on Section 10 are noted below:

An individual testified that the Home Care Employment Standards Board made a unanimous decision to make the training recommendations in the proposed regulations. This was to remove ambiguity. She strongly recommends approval of the proposed regulations.

Another individual indicated they were a member of the Home Care Employment Standards Board. The individual noted the demand on home care is increasing, that there is a severe worker shortage, and that inflation is also having an impact. The individual recommended approval of the amendment.

Another individual testified that there are 16 training subjects, and that labor law requires employees be paid for receiving training.

A DPBH representative noted that although covered by labor law, the proposed regulations were needed to authorize the Bureau of Health Care Quality and Compliance (HCQC) to monitor this. That HCQC would be able to assist with the review of these requirements.

A Board of Health member had concerns related to the cost of Section 10 and noted he did not see it addressed in the Small Business Impact Statement.

A DPBH representative noted that this was addressed in the Small Business Impact Statement (please refer to #3 – economic effect on small business, adverse economic effects section). In addition, it was noted that on page 5 in the summary of responses, one entity noted the financial impact in dollar amounts, for example, one portion notes: "Section 44 of the proposed regulation specifies that the administrator of a personal care agency is required to ensure that employees are provided training required by 449 which would cost approximately $45,000." It was also explained that the fiscal impact may be different for different agencies, as some may already be paying for the required trainings while others may not.

Note: #3, adverse economic effects section on small business noted: Section 10: One response to the small business impact questionnaire noted that it estimates the costs of the proposed regulations to be $85,200 annually. In the end, the comments were provided by a similar provider type to a personal care agency, but since the provider is not a personal care agency, the provisions noted as having the negative impact did not apply to the provider; therefore, he confirmed his concerns were alleviated. For sections 10 and 44, no one else provided a fiscal impact in dollar amounts. As noted previously, one individual did testify that labor law already requires employees be paid for receiving training.

Other interested persons may obtain a copy of the summary by calling, writing or emailing:

Nevada Division of Public and Behavioral Health
Bureau of Health Care Quality and Compliance
Attention: Leticia Metherell
727 Fairview Drive, Suite E
Carson City, NV 89701
Phone: 775-684-1030
Email: lmetherell@health.nv.gov

5. If, after consideration of public comment, the regulation was adopted without changing any part of the proposed regulation, a summary of the reasons for adopting the regulation without change. The statement should also explain the reasons for making any changes to the regulation as proposed.

After consideration of public comment, the changes to the proposed regulations and reasons for the changes are noted below.

Removal of Section 1. The proposed regulations were heard at the Joint Interim Standing Committee on Health and Human Services and concerns were expressed regarding Section 1 related to the power to require any person or entity in Nevada to report in accordance with section 1. As NRS 233B.039(5)(a) gives the State Board of Health the authority to order reporting in response to a pandemic or epidemic, it was determined this section was not necessary and that it should be omitted.

Removal of Section 5. Written testimony expressing several concerns with section 5 relating to the use of audio or video monitoring equipment to monitor a patient or resident was submitted to the Division. In addition to the written testimony, other stakeholders also expressed concerns through the regulatory development process. Based on these concerns, it was determined that the best course of action would be to remove Section 5. This would allow time to better vet the provisions of this section by stakeholders, to see if this issue is addressed in the 2023 legislative session and to determine if this should be addressed in regulations at a future date.

Changes to Section 8 to correct a drafting error in Section 8 (1) (b) which starts off as "The Division. " followed by an unrelated sentence, by omitting the text "The Division."

Changes to Section 13 by changing the word "may' to "must" to require ambulatory surgical centers to have operating rooms that meet minimum area and space requirements based on the complexity of surgery, instead of being permissive. The original intent was to make this a "must" statement to ensure sufficient space in an operating room to accommodate the equipment and resources need to perform surgeries safely, instead of making it a permissive statement.

Changes to Section 26 by changing the requirement for a facility for hospice care to comply with federal fire protection regulations instead of the standard adopted by reference in NAC 449.0105. The reason to aligning state standards with federal fire protection standards is to help ensure that state licensed facilities for hospice applying for Centers for Medicare and Medicaid Services (CMS) certification are able to obtain CMS certification as a hospice.

Revises sections 41 and 47 by adding provisions detailing the sexual assault or attempted sexual assault training components needed to comply with the training required pursuant to paragraph (f) of subsection 1 of NRS 449.0302; and modifies Section 80 to refer to the modifications made to subsection 6 of section 41 and subsection 6 of section 47. These changes were made to address concerns that the proposed regulations refer back to statutes, but the statutes indicate regulations will be adopted to create training; therefore, not giving real guidance to be able to ensure compliance with the proposed regulations.

The following changes were not made:

1) Concerns related to omitting the provision in NAC 449.996 requiring an ambulatory surgical center to maintain a written patient transfer agreement with a hospital in section 68. Reasons for not making this recommended change include:

- Surgical centers are required to establish written guidelines for transferring a patient to a licensed hospital and the proposed regulations clarify the hospital must have medical and surgical capabilities.
- All medical and administrative information relating to the patient are to be transferred with the patient or be promptly available to the licensed center or agency responsible for the patient's continuing care.
- In 2019 the Centers for Medicare and Medicaid (CMS) removed the requirement for an ambulatory surgical center to have a written transfer agreement with a local hospital. One article noted that according to CMS, this was meant, in part, "to address the competition barriers that currently exist in some situations where hospitals providing outpatient surgical services refuse to sign written transfer agreements…" The article also noted that at the time the rule was finalized, 14 states, including California, did not have written transfer agreement requirements.
- The Emergency Medical Treatment & Labor Act (EMTALA) emergency response regulations would continue to address emergency transfer of a patient from an ambulatory surgical center to a nearby hospital.
- Emergency medical services will implement their procedures to ensure a patient is transferred to a higher level of care based on the patient's condition.

2) Concerns related to requiring personnel receive all trainings required by NRS Chapter 449, including family member caregivers providing care to their family taking the entire cultural competency training in Section 44. The recommendation to modify the proposed regulations to provide a waiver or exemption to family members that care for family from having to take the cultural competency training was not included. Cultural competency training is a statutory requirement; therefore, the Board of Health does not have the authority to waive or exempt these requirements.

6. 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.

<u>Anticipated effects of Chapter 449 of the Nevada Administrative Code (LCB File No. R048-22) on the businesses which it regulates</u>:

A*. Adverse effects*:

It is anticipated that the following sections may or will result in adverse economic effects on small businesses:

Section 4 which requires a medical facility, facility for the dependent or other facility required by the regulations adopted by the Board pursuant to NRS 449.0303 to be licensed maintain not less than a 30-day supply of personal protective equipment (PPE) at all times. The cost of keeping, at a minimum, a 30-day supply of PPE at all times, may result in an adverse economic effect on some facilities. One of the responses to the small business impact questionnaire noted that as long as they were provided with equipment and funding, the proposed regulations would provide a safe environment for everyone. Another noted: *If we do*

not receive funding to provide the personal protective equipment we cannot properly comply with any new requirements.

Section 6 – If a medical facility complies with the provisions in section 6 regarding submitting a copy of their accreditation notice from a national accrediting organization to the Division or losing its accreditation then there would be no fiscal impact. If a medical facility does not maintain compliance with the provisions of Section 6, the Division may impose an administrative penalty which may result in a financial hardship to certain facilities.

Section 10 – Requiring a personal care agency to pay the cost of employee training, including the cost of the training, the costs for travelling to and from the location where the training is provided and paying an employee for attending such training his or her salary or hourly wage, may result in a significant adverse economic effect on certain small businesses that don't have the capability to provide such trainings themselves to their employees. One response to the small business impact questionnaire noted that it estimates the costs of the proposed regulations to be $85,200 annually.

Section 13 – The fiscal impact to build surgical centers depends on the class of surgery center the center chooses to build. For example, the cost to build a Class A surgical center, that only performs minor surgical procedures, is expected to be less than building a Class C surgical center that may perform more complex surgeries that require general anesthesia. The exact costs cannot be determined as many factors including the size of the surgery center, the location of the surgery center, the construction costs at the time the center is built, and other factors may play a role in the costs to build a surgical center.

Section 24 – Removing the requirement that a complaint must be submitted by a consumer, thereby authorizing the Division to charge a licensee for the investigation of any complaint against the licensee, may result in an increase in complaint billing fees for facilities that have substantiated complaints in accordance with NAC 449.01685.

Section 26 - Requires a facility for hospice care to comply with certain life safety code standards. This requirement is currently absent for facilities for hospice in the administrative code. This causes a problem for facilities who obtain a license as a facility for hospice that have a desire to then apply for CMS certification, because in order to meet the CMS certification requirements, a facility for hospice must comply with the federal life safety code standards. The modifications in Section 26, allow for better alignment of state regulations and CMS certification standards, making it easier to design facilities that meet CMS certification standards. This may result in increased cost to initial licensure applicants for hospice facilities, but it appears all of these applicants desire CMS certification. Whereas there would be significant savings for facilities when they chose to obtain CMS certification, as they will already meet the CMS life safety code standards. In the past, facilities have applied for licensure and/or obtained a license, then have withdrawn or closed because they are unable to meet CMS life safety code standards.

Indirect Adverse Economic Effects

Section 5 - Feedback received from the small-business impact questionnaire included concerns that requiring residents to provide written consent to be monitored via audio or video equipment, would result in an adverse economic effect. Comments included:

If a patient in this category refuses to sign consent for recording they would require a 1 on 1 staffing situation which costs 1 FTE for each patient in this situation. This could add up to multiple employees not being able to work efficiently and thus cost the facility considerable, especially given all the staffing issues.

Just another example of added cost to healthcare settings which results in more staffing and higher charges to offset costs.

By omitting Section 5 from the adopted regulations, this indirect adverse economic effect would no longer be applicable.

B*. Beneficial:*

Section 20 exempts certain entities that are required to obtain a license or certificate from the Division but do not always operate in a physical facility, from the requirement to receive a fire inspection that requires a sprinkler system in order to become licensed or certified, therefore; it may reduce the cost to open such a business. This may encourage the growth of small businesses in these facility types, as it reduces the cost associated with opening a new business.

Indirect Beneficial Effects

Section 7 of the proposed regulations requires a facility for the dependent to develop and carry out an infection control program to prevent and control infections within the facility. The prevention of infections may have a beneficial financial effect by saving money on resources used to care for residents with infections, including, but not limited to COVID-19.

Omitting the majority of the state home health agency regulations and instead adopting the federal home health agency regulations may have an indirect beneficial economic effect, by having home health agencies, for the most part, having to follow only one set of regulations instead of two.

Section 26 - Having facilities for hospice meet life safety code standards will better prepare a facility in the case of a fire. This may result in a cost savings as it may reduce structural damage due to a fire, and better protect staff and patients in the case of a fire, potentially saving lives.

C. *Immediate*: Upon the proposed regulations becoming effective, the Division would implement the necessary procedures to implement the regulations and enforce them as necessary. This may result in an immediate adverse or beneficial effect, as noted in the above adverse and beneficial effects sections, although some may take longer to realize. Please refer to long-term section below.

D. *Long-term*: Although there may be an initial adverse financial impact to licensed facilities for hospice to meet federal life safety code requirements, it is anticipated there will be a positive financial impact in the long term as it would be easier to become CMS certified and be able to bill CMS for services. In addition, if there was a fire, the increased fire protection may result in less structural damage and better protect patients housed in these facilities. Increased costs, as noted, in the adverse section may have long-term negative consequences as some of the costs, such as those to train PCA employees, would be continuing costs. Other long-term impacts would be unknown, for example, if a facility remains in compliance with reporting the national accrediting organization status to the Division, there would be no fiscal impact, but non-compliance may result in a fiscal impact.

<u>Anticipated effects on the public</u>:

A. *Adverse:* The proposed regulations may have an adverse financial impact on members of the public that utilize the services of certain providers licensed by the Division. For example, covering the costs of training and paying the wages of personal care agency (PCA) employees may result in additional operating costs to PCA's that are not currently covering these costs, although labor law does require employers to pay employees for training. These costs may be passed on to consumers who rely on PCA services. For facilities that do not currently have a 30-day supply of PPE, the additional costs to maintain a 30 day may be passed on to consumers.

B. *Beneficial:* Certain provisions of the proposed regulations are anticipated to have a positive impact on the public, for example, the removal of fire inspections that require a sprinkler system for entities that do not always operate in a physical facility to become licensed or certified may reduce the cost to open such a business. This may encourage the growth of small businesses in these facility types, as it reduces the cost associated with opening a new business. This may result in more facilities opening and expanding access of care to the public. In addition, it may result in lower costs which may be passed down to consumers. Reduced infections through the use of evidence-based standards for infection control and prevention may result in both quality-of-life improvement as well as cost savings, by potentially avoiding the cost to treat an infection.

C. *Immediate:* It is anticipated that there would be no immediate impacts on the public because upon the regulations becoming effective it may take time before any adverse or beneficial effects are realized by the general public.

D. *Long-term*: There may be long-term effects including increased costs to the public to use certain services offered by certain licensed health care facilities, for example, if the costs to PCA agencies to train their employees, is passed on to consumers. There may also be long term benefits to the public, for example, if improved infection control and prevention measures reduce the number of infections suffered by members of the public utilizing the services of licensed health care facilities, there may be a cost benefit through avoidance of medical costs to treat such infections as well as improvement in quality of care and life.

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

There is no cost to the agency anticipated for the enforcement of the proposed regulations.

8. 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.

The adopted regulations require a facility for hospice to comply with Centers for Medicare and Medicaid Services (CMS) fire protection standards. The reason to aligning state standards with federal fire protection standards is to help ensure that state licensed facilities for hospice applying for CMS certification are able to obtain CMS certification as a hospice. This also helps to ensure the safety of patients and staff in facilities for hospice.

The proposed regulations help to bring home health agency regulations in line with federal home health agency regulations, for the most part, to help reduce duplication.

Sections 10 and 44 are adding a new requirement for the licensure of these operators, which does not otherwise exist in state or federal law. Thus, it is not duplicative or overlapping of existing requirements.

9. If the regulation includes provisions which are more stringent than a federal regulation which regulates the same activity, a summary of such provisions;

Centers for Medicare and Medicaid Services (CMS) certification of certain health care facilities is optional; therefore, state regulations are needed in addition to the federal regulations, for regulatory oversight of health care facilities that are licensed but not certified. For state licensed only facilities, such as residential facilities for groups, there would be no federal regulations which regulate the same activity. The requirement to maintain not less than a 30-day supply of personal protective equipment (PPE) at all times may be more stringent than federal regulations requiring general maintenance of supplies. The reason for adding this requirement was that during the early stages of the COVID-19 pandemic there was a severe shortage of PPE leaving many facilities without sufficient PPE for their staff. The American Healthcare Association, Care for Our Seniors Act, proposed a solution to require each nursing home to have a minimum 30-day supply of PPE for average conventional use.

Sections 10 and 44 are not more stringent than any federal law. The Fair Labor Standards Act does govern compensation for working time including training, however R048-22 is not more stringent than the federal provisions. Under The Fair Labor Standards Act (29 C.F.R. § 785.27), time spent attending training or educational programs is not working time if:

- attendance occurs outside the employee's regular working hours;
- attendance is voluntary;
- the employee does no productive work while in attendance; and
- the program, lecture, or meeting is not directly related to the employee's job.

When state law requires employers to provide training as a condition of the employer's license to remain open for business, it would not be voluntary, and this criterion would not be met.

Sections 10 and 44 require the agency, as a requirement of an agency's license, to provide the training. Therefore, Sections 10 and 44 are in line with the Fair Labor Standards Act and are not more stringent.

10. If the regulation establishes a new fee or increases an existing fee, a statement indicating the total annual amount the agency expects to collect and the manner in which the money will be used.

Section 6 does provide the Division the ability to impose an administrative penalty in an amount not to exceed $1,000 for failure to comply with the requirements of this section. It is unknown what the total annual amount the Division expects to collect. If there are no violations of Section 6 no monetary penalties would be collected. If there are violations, the amount would depend on the number of violations and if the Division chose to impose a monetary penalty or not. The monies would be used to support the Division's Bureau of Health Care Quality and Compliance operating costs.

Section 24 removes the requirement that a complaint must be submitted by a consumer, thereby authorizing the Division to charge a licensee for the investigation of any complaint against the licensee, which may result in an increase in complaint billing fees for facilities that have substantiated complaints in accordance with NAC 449.01685. The total annual amount DPBH expects to collect is unknown, as it depends on the number of complaints received and of those, the number that are substantiated. The monies would be used to support the Division's Bureau of Health Care Quality and Compliance operating costs.