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

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

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

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

Sec. 16 NAC 449.99899 and Sec. 17 NAC 449.999

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

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

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

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

Regulations 449.99899 and 449.999 monetary penalties:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Description of vitals able to now perform should include weights.

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

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

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

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

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

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

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

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

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

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

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

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

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

Increasing fines will not help financially.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Increased cost could mean closing the business due to unaffordable.

I would have to close my business against government goals.

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

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

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

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

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

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

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

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

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

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

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

This could potentially increase vulnerability to litigation from consumers.

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

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

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

A poor rating could cause adverse effects.

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

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

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

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

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

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

How can the thousands of low-income be displaced?

No benefits as regulations are written!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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