COMMISSION ON BEHAVIORAL HEALTH
MINUTES
NOVEMBER 18, 2016

VIDEO CONFERENCE MEETING LOCATIONS:

Northern Nevada Adult Mental Health Services (NNAMHS)
480 Galletti Way, Bldg. 22, Sparks, NV

6161 W. Charleston Blvd., Bldg. 1, Las Vegas, NV

COMMISSIONERS PRESENT:
Valerie Kinnikin, Chair- Las Vegas, Pamela Johnson, RN- Sparks, Noelle Lefforge, Ph.D.- Las Vegas, Tabitha Johnson- Las Vegas, Thomas Hunt, M.D.- Las Vegas, Asma Tahir- Las Vegas, Lisa Ruiz-Lee- Las Vegas, Barbara Jackson- on phone

Sparks:
Cody L. Phinney, Administrator, DPBH, Julian Montoya, SRC, Tom Durante, LCC, Lisa Sherych, NNAMHS, Kyle Devine, Bureau Chief, John DiMuro Chief Medical Officer, Robin Williams, RRC, Tina Gerber-Winn, Rural Clinics

Las Vegas:
Joanne Malay, SNAMHS, Ellen Richardson-Adams, SNAMHS, Leon Ravin, Psychiatric Medical Doctor, Leslie Brown, DRC, Rose Park, Dan Musgrove, CCCBHC, Julie Slabaugh, DAG, Susanne Sliwa, DAG

On the phone:
Amy Roukie, Deputy Administrator Clinical Services, Barry Lovgren, private citizen, Eddie Ableser, Administrator ADSD, Kate Mc Closkey, ADSD, Jon Kirwan, Rural Clinics

Chair Kinnikin called the meeting to order at 8:40 am. Roll call is reflected above. It was determined that a quorum was present. Introductions were made at both locations.

PUBLIC COMMENT:

Mr. Lovgren provided a written statement which is attached to these minutes as Exhibit "A". Mr. Lovgren is concerned with the insufficient substance abuse treatment being provided to pregnant women and how it is to SAPTA not meeting Substance Abuse Block Grant requirements. He is requesting that SAPTA report how they met requirements to be eligible for funding.

Dr. Hunt commented how it was discussed in the last meeting that SAPTA would be on the agenda. Chair Kinnikin stated that as agenda item #5 is addressed, comment can be provided to address Mr. Lovgren's concerns and it would be more specific in the next agenda.

CONSENT AGENDA:

Approval of the Minutes September 16, 2016

A motion was made by Dr. Hunt, seconded by Ms. T. Johnson and passed to accept the minutes of September 16, 2016.

Agency Directors' Reports

Lake's Crossing Center: Mr. Durante provided a written and verbal report. Mr. Durante reported that the caseloads are increasing, there are difficulties in filling positions, a Pet Therapy group has been added, and they will be starting an ADA (American Disabilities Act) project towards the middle of November.

NNAMHS: Ms. Sherych provided a written and verbal report. Ms. Sherych reported that effective November 1st, she will be responsible for both inpatient and outpatient services. They are currently in process of getting the assisted outpatient treatment program up and running to start January 2017. They continue to work on waitlist for inpatient services by collaborating with community hospitals.

Rural Clinics: Ms. Gerber-Winn provided a handout, Exhibit "B", and verbal report. Ms. Gerber-Winn reported that the agency continues to develop the sequential intercept model which would be assisting crisis intervention training through law enforcement agencies. The Rural Mobile Crisis Response Team is up and running.

Chair Kinnikin advised all agency managers that each agency is welcome to submit information to the Commission to be included in the Governor's letter. She stated to keep in mind some highlights and successes, as well as needs that would like addressed and can be included in the letter.

RRC: Ms. Williams provided a written and verbal report. She reported that they continue to experience difficulty to recruit and fill professional positions due to shortage of professionals and higher salaries that private and county agencies can offer. They are currently opening three new supported living arrangements.

SRC: Mr. Montoya provided a written and verbal report. Currently they are still going forward with the AB 307 pilot home project with Chrysalis. However, they are struggling with rental increases. AB 307 is a pilot program they are operating where they have a home for youth with co-occurring disorders. They are staffed in a 24-hour home with BCBA's and RBT's. The behavior plan is to control their behavior and get them on path with a re-unification plan.

DRC: Ms. Brown provided a written and verbal report. Challenges that DRC is facing with jobs and day training is the assessment requirement through vocational rehabilitation and providers being at capacity

for the individuals that are ready for placement. It was suggested that a follow up on these issues be provided in the next meeting. It was also requested that average wait time to service be added on the reports for the waitlists.

SNAMHS: Ms. Richardson-Adams and Ms. Malay provided a written and verbal report. Ms. Richardson-Adams stated that there is no new programming to add since last meeting. They continue to build and strengthen what is currently in place. Ms. Malay reported that Token Economy, which is a positive behavior program, along with active therapies and treatments has greatly reduced incidents with seclusion and restraint numbers.

Ms. Roukie informed that they are currently working on a collaborative partnership with the Division of Public Safety, Parole and Probation meeting with Welfare and Developmental Services in assisting with pre-release and post release eligibility for individuals coming out of incarceration. It is currently being piloted and working on developing it statewide.

Agenda item #14 taken out of order and moved to #5.

Review of Organizational Charts

Ms. Phinney provided handouts listing the structure of the Division of Public and Behavioral Health and organizational charts with recent incumbents. Since the merging of divisions, there are multiple boards such as this one and the continued goal is to find the best integration between behavioral and public health aspects. With the merging of divisions, Ms. Phinney informed the commission, if there are concerns on process or safety of seclusion and restraint reports, they could be referred to another part of the organization such as the Bureau of Health Care Quality and Compliance. After further discussion, it was determined that increased relation with the Bureau of Health Care Quality and Compliance would be beneficial going forward.

Action: Follow up, establishing a process with having a member present from the Bureau of Health Care Quality and Compliance at the meeting when reviewing seclusion and restraint reports.

Agenda item #8 taken out of order and moved to #6.

Aging and Disability Services

Dr. Ableser reported that they are currently in negotiation working towards securing agency's request in the budget to clear the waitlist. Ms. Ruiz-Lee inquired on changes to Early Childhood Services. Dr. Ableser provided an overview of the changes relating to Early Intervention.

Behavioral Health Wellness and Prevention - Kyle Devine, Chief

Mr. Devine reported that they are looking at improving the efficiency and efficacy of the sub-grant process. Changes have been made to the process, which includes involving supervisors. Currently, they are moving forward with developing a comprehensive State plan, as required by statute, that will start in December. The State plan will look at gaps and create priorities to drive the sub-granting process. Mr.

Devine is proposing to develop a grants management unit that will monitor sub-agreements to reduce errors.

Action: Mr. Devine will provide an update on what's being implemented in the next meeting.

Seclusion and Restraint Report

Ms. Roukie provided an overview of the seclusion and restraint data that was provided as a handout.

Dr. Lefforge suggested that the time on the waitlist in the reports would be more helpful. Dr. Lefforge also inquired on seclusion and restraint international data to compare to.

Action: Ms. Roukie will attempt to provide waitlist times on the next report in March and will look into international data.

Local Governing Body Reports

Ms. P. Johnson reported on LGB's for Lake's Crossing and Northern Nevada Adult Mental Health Services. Ms. P. Johnson stated that a meeting was held in November and the agency directors' reports summarized all of the activities that the agencies are participating in.

Ms. Malay reported for SNAMHS. A tour was given to new commissioners. A detailed account of the intent and history around the data that is collected in governing body was provided. In the next meeting, they will be discussing what the plan is on compliance and how they will improve compliance rates.

Overview of denial of rights statutes

Ms. Slabaugh provided a handout with NRS 433.534 and Use of Restraints and Interventions, which is attached to these minutes as Exhibit "B". NRS 433.534 is the statute that involves the commission and why commission members receive denial of rights reports. The statute requires when a denial of rights occur, such as seclusion or restraint, a report must be done and received by the Agency Administrator. The Agency Administrator must submit the report to the Division Administrator and a copy sent to the commission.

Agenda item #10 was discussed in conjunction with agenda item #9.

Establish Bylaws Committee

Committee was not established due to members not having a copy of bylaws.

Action: A copy of bylaws, for review, was requested by commission members for next agenda.

Governor's Letter Committee Appointment

Chair Kinnikin, Dr. Hunt, Ms. P. Johnson, Ms. T. Johnson, and Ms. Ruiz-Lee have agreed to be on the committee. A meeting for the committee will be arranged through email.

Housing Regulations

Ms. Richardson-Adams provided an update on the housing regulation. A public workshop was conducted on October 31st. The next step, will be for it to be heard through the Board of Health on December 9th.

Policies

Policy review was tabled.

Future Agenda Items

- Inviting an HCQC member to meeting
- DRC Agency Manager to provide update on schools and referrals
- Behavioral Health Wellness and Prevention to provide an update on improvements
- Length of wait and international models data
- Copy of Bylaws
- Policies

There was no public comment.

The DPBH Commission on Behavioral Health meeting was adjourned at 11:16 am.

Exhibit "A"

Barry W. Lovgren
PO Box 6744
Gardnerville, NV 89460

Testimony before the Nevada Commission on Behavioral Health November 18, 2016

My name's Barry Lovgren, and I'm a retired behavioral health professional.

It's now precisely seven years since I first brought to this Commission's attention the problem of insufficient substance abuse treatment being provided to pregnant women and how I ascribed much of this problem to SAPTA not meeting Substance Abuse Block Grant requirements designed to maximize substance abuse treatment of pregnant women and of injection drug users. That was back in 2009 when the number of pregnant women receiving substance abuse treatment had fallen to half what it had been. It's stayed down there since, with no corresponding decrease in the number of pregnancies and no evidence that the rate of substance abuse among pregnant women has diminished.

At your last meeting I spoke with you about how the Division had attained compliance with the requirement to publicize the availability of substance abuse treatment and admission priority for pregnant women, but had been failing to meet Block Grant requirements for a waiting list and capacity management system for pregnant women and injection drug users, for a substance abuse services needs assessment, and for funded treatment programs to conduct outreach to injection drug users. I spoke to how the Division Administrator had given signed assurance to the Substance Abuse and Mental Health Services Administration that these requirements would be met. That funding began on October 1st, and I asked that your agenda for today's meeting include a report from SAPTA on how those requirements now have been met.

While the agenda doesn't call for that, it does provide for SAPTA to report on simplification of the sub-grant process by which SAPTA distributes that Block Grant funding. I'm hoping that the report will include letting us know how SAPTA met the requirements for Nevada to be eligible for the funding. What I'm hoping for most is that you'll care about this. In 2007 SAPTA became an orphan agency not accountable to any public body and it may or may not be a coincidence that that's when the number of pregnant women receiving substance abuse treatment began to collapse. In 2013 you became the public body with statutory authority to provide citizen overview of SAPTA.

When the Division was considering consolidation of behavioral health with public health back in 2013 it commissioned a gaps analysis to identify the challenges to be met. One that was identified was the longstanding and continuing lack of sufficient public overview of behavioral health services. SAPTA needs you to help keep an eye on the shop. Whether we're going to have healthy babies or whether we're going to have addicted and disabled ones depends on whether we're doing all we should be doing to make treatment available to pregnant women who have problems with alcohol and other drugs.

Exhibit "B"

NRS 433.534 Denial of rights prohibited; exceptions; report; investigation and action by Commission; closure of meeting in certain circumstances.

1. The rights of a consumer enumerated in this chapter must not be denied except to protect the consumer's health and safety or to protect the health and safety of others, or both. Any denial of those rights in any facility must be entered in the consumer's record of treatment, and notice of the denial must be forwarded to the administrative officer of the facility. Failure to report denial of rights by an employee may be grounds for dismissal.

2. If the administrative officer of a facility receives notice of a denial of rights as provided in subsection 1, the officer shall cause a full report to be prepared which must set forth in detail the factual circumstances surrounding the denial. Except as otherwise provided in NRS 239.0115, such a report is confidential and must not be disclosed. A copy of the report must be sent to the Commission.

3. The Commission:

(a) Shall receive reports of and may investigate apparent violations of the rights guaranteed by this chapter;

(b) May act to resolve disputes relating to apparent violations;

(c) May act on behalf of consumers to obtain remedies for any apparent violations; and

(d) Shall otherwise endeavor to safeguard the rights guaranteed by this chapter.

4. Pursuant to NRS 241.030, the Commission may close any portion of a meeting in which it considers the character, alleged misconduct or professional competence of a person in relation to:

(a) The denial of the rights of a consumer; or

(b) The care and treatment of a consumer.

➥ The provisions of this subsection do not require a meeting of the Commission to be closed to the public.

(Added to NRS by 1975, 1598; A 1979, 812; 1985, 2268; 1989, 1757; 1993, 2112, 2719; 1995, 676, 1735; 2007, 2106; 2011, 417)

USE OF RESTRAINTS AND INTERVENTIONS

NRS 433.545 Definitions. As used in NRS 433.545 to 433.551, inclusive, unless the context otherwise requires, the words and terms defined in NRS 433.5453 to 433.548, inclusive, have the meanings ascribed to them in those sections.

(Added to NRS by 1999, 3229; A 2001, 2744)

NRS 433.5453 "Aversive intervention" defined. "Aversive intervention" means any of the following actions if the action is used to punish a person with a disability or to eliminate, reduce or discourage maladaptive behavior of a person with a disability:

1. The use of noxious odors and tastes;
2. The use of water and other mists or sprays;
3. The use of blasts of air;
4. The use of corporal punishment;
5. The use of verbal and mental abuse;
6. The use of electric shock;
7. Requiring a person to perform exercise under forced conditions if the:

(a) Person is required to perform the exercise because the person exhibited a behavior that is related to his or her disability;

(b) Exercise is harmful to the health of the person because of his or her disability; or

(c) Nature of the person's disability prevents the person from engaging in the exercise;

8. Any intervention, technique or procedure that deprives a person of the use of one or more of his or her senses, regardless of the length of the deprivation, including, without limitation, the use of sensory screens; or

9. The deprivation of necessities needed to sustain the health of a person, regardless of the length of the deprivation, including, without limitation, the denial or unreasonable delay in the provision of:

(a) Food or liquid at a time when it is customarily served; or

(b) Medication.

(Added to NRS by 1999, 3229)

NRS 433.5456 "Chemical restraint" defined. "Chemical restraint" means the administration of drugs for the specific and exclusive purpose of controlling an acute or episodic aggressive behavior when alternative intervention techniques have failed to limit or control the behavior. The term does not include the administration of drugs on a regular basis, as prescribed by a physician, to treat the symptoms of mental, physical, emotional or behavioral disorders and for assisting a person in gaining self-control over his or her impulses.

(Added to NRS by 1999, 3230)

NRS 433.546 "Corporal punishment" defined. "Corporal punishment" means the intentional infliction of physical pain, including, without limitation, hitting, pinching or striking.

(Added to NRS by 1999, 3230)

NRS 433.5463 "Electric shock" defined. "Electric shock" means the application of electric current to a person's skin or body. The term does not include electroconvulsive therapy.

(Added to NRS by 1999, 3230)

NRS 433.5466 "Emergency" defined. "Emergency" means a situation in which immediate intervention is necessary to protect the physical safety of a person or others from an immediate threat of physical injury or to protect against an immediate threat of severe property damage.

(Added to NRS by 1999, 3230)

NRS 433.547 "Mechanical restraint" defined. "Mechanical restraint" means the use of devices, including, without limitation, mittens, straps, restraint chairs, handcuffs, belly chains and four-point restraints to limit a person's movement or hold a person immobile.

(Added to NRS by 1999, 3230; A 2001, 2744)

NRS 433.5473 "Person with a disability" defined. "Person with a disability" means a person who:

1. Has a physical or mental impairment that substantially limits one or more of the major life activities of the person;
2. Has a record of such an impairment; or
3. Is regarded as having such an impairment.

(Added to NRS by 1999, 3230)

NRS 433.5476 "Physical restraint" defined. "Physical restraint" means the use of physical contact to limit a person's movement or hold a person immobile.

(Added to NRS by 1999, 3230)

NRS 433.548 "Verbal and mental abuse" defined. "Verbal and mental abuse" means verbal intimidation or coercion of a person without a redeeming purpose.

(Added to NRS by 1999, 3230)

NRS 433.5483 Use of aversive intervention on consumer prohibited. A person employed by a facility or any other person shall not use any aversive intervention on a person with a disability who is a consumer.

(Added to NRS by 1999, 3230; A 2011, 420)

NRS 433.5486 Use of physical, mechanical or chemical restraint on consumer by facility authorized in certain circumstances. Notwithstanding the provisions of NRS 433.549 to 433.5503, inclusive, to the contrary, a facility may use or authorize the use of physical restraint, mechanical restraint or chemical restraint on a person with a disability who is a consumer if the facility is:

1. Accredited by a nationally recognized accreditation association or agency; or
2. Certified for participation in the Medicaid or Medicare Program,

↪ only to the extent that the accreditation or certification allows the use of such restraint.

(Added to NRS by 1999, 3230; A 2011, 420)

NRS 433.549 Use of physical, mechanical or chemical restraint on consumer by person employed by facility prohibited; exceptions. A person employed by a facility or any other person shall not:

1. Except as otherwise provided in NRS 433.5493, use physical restraint on a person with a disability who is a consumer.
2. Except as otherwise provided in NRS 433.5496 and 433.5499, use mechanical restraint on a person with a disability who is a consumer.
3. Except as otherwise provided in NRS 433.5503, use chemical restraint on a person with a disability who is a consumer.

(Added to NRS by 1999, 3231; A 2001, 2744; 2011, 420)

NRS 433.5493 Use of physical restraint on consumer; requirements; exceptions; report as denial of rights.

1. Except as otherwise provided in subsection 2, physical restraint may be used on a person with a disability who is a consumer only if:

(a) An emergency exists that necessitates the use of physical restraint;

(b) The physical restraint is used only for the period that is necessary to contain the behavior of the consumer so that the consumer is no longer an immediate threat of causing physical injury to himself or herself or others or causing severe property damage; and

(c) The use of force in the application of physical restraint does not exceed the force that is reasonable and necessary under the circumstances precipitating the use of physical restraint.

2. Physical restraint may be used on a person with a disability who is a consumer and the provisions of subsection 1 do not apply if the physical restraint is used to:

(a) Assist the consumer in completing a task or response if the consumer does not resist the application of physical restraint or if the consumer's resistance is minimal in intensity and duration;

(b) Escort or carry a consumer to safety if the consumer is in danger in his or her present location; or

(c) Conduct medical examinations or treatments on the consumer that are necessary.

3. If physical restraint is used on a person with a disability who is a consumer in an emergency, the use of the procedure must be reported as a denial of rights pursuant to NRS 433.534 or 435.610, as applicable, regardless of whether the use of the procedure is authorized by statute. The report must be made not later than 1 working day after the procedure is used.

(Added to NRS by 1999, 3231; A 2011, 420; 2013, 3011)

NRS 433.5496 Use of mechanical restraint on consumer other than consumer of forensic facility; requirements; exceptions; report as denial of rights.

1. Except as otherwise provided in subsections 2 and 4, mechanical restraint may be used on a person with a disability who is a consumer only if:

(a) An emergency exists that necessitates the use of mechanical restraint;

(b) A medical order authorizing the use of mechanical restraint is obtained from the consumer's treating physician before the application of the mechanical restraint or not later than 15 minutes after the application of the mechanical restraint;

(c) The physician who signed the order required pursuant to paragraph (b) or the attending physician examines the consumer not later than 1 working day immediately after the application of the mechanical restraint;

(d) The mechanical restraint is applied by a member of the staff of the facility who is trained and qualified to apply mechanical restraint;

(e) The consumer is given the opportunity to move and exercise the parts of his or her body that are restrained at least 10 minutes per every 60 minutes of restraint;

(f) A member of the staff of the facility lessens or discontinues the restraint every 15 minutes to determine whether the consumer will stop or control his or her inappropriate behavior without the use of the restraint;

(g) The record of the consumer contains a notation that includes the time of day that the restraint was lessened or discontinued pursuant to paragraph (f), the response of the consumer and the response of the member of the staff of the facility who applied the mechanical restraint;

(h) A member of the staff of the facility continuously monitors the consumer during the time that mechanical restraint is used on the consumer; and

(i) The mechanical restraint is used only for the period that is necessary to contain the behavior of the consumer so that the consumer is no longer an immediate threat of causing physical injury to himself or herself or others or causing severe property damage.

2. Mechanical restraint may be used on a person with a disability who is a consumer and the provisions of subsection 1 do not apply if the mechanical restraint is used to:

(a) Treat the medical needs of a consumer;

(b) Protect a consumer who is known to be at risk of injury to himself or herself because the consumer lacks coordination or suffers from frequent loss of consciousness;

(c) Provide proper body alignment to a consumer; or

(d) Position a consumer who has physical disabilities in a manner prescribed in the consumer's plan of services.

3. If mechanical restraint is used on a person with a disability who is a consumer in an emergency, the use of the procedure must be reported as a denial of rights pursuant to NRS 433.534 or 435.610, as applicable, regardless of whether the use of the procedure is authorized by statute. The report must be made not later than 1 working day after the procedure is used.

4. The provisions of this section do not apply to a forensic facility, as that term is defined in subsection 5 of NRS 433.5499.

(Added to NRS by 1999, 3231; A 2001, 2744; 2011, 421; 2013, 3011)

NRS 433.5499 Use of mechanical restraint on consumer of forensic facility; requirements; exceptions; report as denial of rights.

1. Except as otherwise provided in subsection 3, mechanical restraint may be used on a person with a disability who is a consumer of a forensic facility only if:

(a) An emergency exists that necessitates the use of the mechanical restraint;

(b) The consumer's behavior presents an imminent threat of causing physical injury to himself or herself or to others or causing severe property damage and less restrictive measures have failed to modify the consumer's behavior;

(c) The consumer is in the care of the facility but not on the premises of the facility and mechanical restraint is necessary to ensure security; or

(d) The consumer is in the process of being transported to another location and mechanical restraint is necessary to ensure security.

2. If mechanical restraint is used pursuant to subsection 1, the forensic facility shall ensure that:

(a) The mechanical restraint is applied by a member of the staff of the facility who is trained and qualified to apply mechanical restraint;

(b) A member of the staff of the facility continuously monitors the consumer during the time that mechanical restraint is used on the consumer;

(c) The record of the consumer contains a notation that indicates the time period during which the restraint was used and the circumstances warranting the restraint; and

(d) The mechanical restraint is used only for the period that is necessary.

3. Mechanical restraint may be used on a person with a disability who is a consumer of a forensic facility, and the provisions of subsections 1 and 2 do not apply if the mechanical restraint is used to:

(a) Treat the medical needs of a consumer;

(b) Protect a consumer who is known to be at risk of injury to himself or herself because the consumer lacks coordination or suffers from frequent loss of consciousness;

(c) Provide proper body alignment to a consumer; or

(d) Position a consumer who has physical disabilities in a manner prescribed in the consumer's plan of services.

4. If mechanical restraint is used in an emergency on a person with a disability who is a consumer of a forensic facility, the use of the procedure must be reported as a denial of rights pursuant to NRS 433.534 or 435.610, as applicable, regardless of whether the use of the procedure is authorized by statute. The report must be made not later than 1 working day after the procedure is used.

5. As used in this section, "forensic facility" means a secure facility of the Division for offenders and defendants with a mental disorder who are ordered to the facility pursuant to chapter 178 of NRS.

(Added to NRS by 2001, 2743; A 2011, 422; 2013, 3012)

NRS 433.5503 Use of chemical restraint on consumer; requirements; report as denial of rights.

1. Chemical restraint may only be used on a person with a disability who is a consumer if:

(a) The consumer has been diagnosed as mentally ill, as defined in NRS 433A.115, and is receiving mental health services from a facility;

(b) The chemical restraint is administered to the consumer while he or she is under the care of the facility;

(c) An emergency exists that necessitates the use of chemical restraint;

(d) A medical order authorizing the use of chemical restraint is obtained from the consumer's attending physician or psychiatrist;

(e) The physician or psychiatrist who signed the order required pursuant to paragraph (d) examines the consumer not later than 1 working day immediately after the administration of the chemical restraint; and

(f) The chemical restraint is administered by a person licensed to administer medication.

2. If chemical restraint is used on a person with a disability who is a consumer, the use of the procedure must be reported as a denial of rights pursuant to NRS 433.534 or 435.610, as applicable, regardless of whether the use of the procedure is authorized by statute. The report must be made not later than 1 working day after the procedure is used.

(Added to NRS by 1999, 3232; A 2011, 422; 2013, 3013)

NRS 433.5506 Facility required to develop program of education in positive behavioral interventions and supports; facility required to train certain members of staff to use physical, mechanical and chemical restraint.

1. Each facility shall develop a program of education for the members of the staff of the facility to provide instruction in positive behavioral interventions and positive behavioral supports that:

(a) Includes positive methods to modify the environment of consumers to promote adaptive behavior and reduce the occurrence of inappropriate behavior;

(b) Includes methods to teach skills to consumers so that consumers can replace inappropriate behavior with adaptive behavior;

(c) Includes methods to enhance a consumer's independence and quality of life;

(d) Includes the use of the least intrusive methods to respond to and reinforce the behavior of consumers; and

(e) Offers a process for designing interventions based upon the consumer that are focused on promoting appropriate changes in behavior as well as enhancing the overall quality of life for the consumer.

2. Each facility shall provide appropriate training for the members of the staff of the facility who are authorized to carry out and monitor physical restraint, mechanical restraint and chemical restraint to ensure that those members of the staff are competent and qualified to carry out the procedures in accordance with NRS 433.545 to 433.551, inclusive.

(Added to NRS by 1999, 3233; A 2011, 423)

NRS 433.551 Facility required to report violations to Division and to develop corrective plan; Division required to forward corrective plan to Director of Department; power of Department to withhold funding.

1. A facility where a violation of the provisions of NRS 433.545 to 433.551, inclusive, occurs shall:

(a) Not later than 24 hours after a violation occurs, or as soon thereafter as the violation is discovered, report the violation to the Division; and

(b) Develop, in cooperation with the Division, a corrective plan to ensure that within 30 calendar days after the violation occurred, appropriate action is taken by the facility to prevent future violations.

2. The Division shall forward the plan to the Director of the Department. The Director or the Director's designee shall review the plan to ensure that it complies with applicable federal law and the statutes and regulations of this state. The Director or the designee may require appropriate revision of the plan to ensure compliance.

3. If the facility where the violation occurred does not meet the requirements of the plan to the satisfaction of the Director or the designee, the Department may withhold funding for the facility until the facility meets the requirements of the plan.

(Added to NRS by 1999, 3233)