NOTICE OF INTENT TO ACT UPON A REGULATION

Notice of Hearing for the Amendment of Regulations of the Board of Health

LCB File No. R048-22 - Proposed regulation amendment(s) to Nevada Administrative Code (NAC) 449, "Medical Facilities and Other Related Entities."

NOTICE IS HEREBY GIVEN that the State Board of Health will hold a public hearing to consider amendments to Chapter 449 of Nevada Administrative Code (NAC). This public hearing is to be held in conjunction with the State Board of Health meeting on December 2, 2022, at 9:00 AM at the following virtual and physical locations.

Virtual Meeting Locations:

- Click here to join the meeting; or
- Call in (audio only): 775-321-6111 (Phone Conference ID: 153 453 179#)

Physical Meeting Locations:

- Southern Nevada Health District (SNHD)
  Red Rock Trail Rooms A and B
  280 S. Decatur Boulevard
  Las Vegas, Nevada 89107

- Nevada Division of Public and Behavioral Health (DPBH)
  Hearing Room No. 303, 3rd Floor
  4150 Technology Way
  Carson City, Nevada 89706

1. The need for and the purpose of the proposed regulation or amendment.

The proposed regulations are needed to 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 use 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 proposed regulations address:

- Issues identified during the COVID-19 pandemic related to infection control and prevention.
- The use of audio or video monitoring equipment to monitor patients/residents as this equipment is currently being used by facilities with no clear state regulatory guidelines on the use of this equipment. The proposed regulations help protect a patient's/resident's right to privacy and confidentiality.
- The allowance of a monetary penalty for facilities that don't notify the Division of a change in its national accreditation status.
- Construction and life safety code state regulations for facilities of hospice care. Currently construction and life safety codes standards are not addressed in state regulations, but federal Centers for Medicare and Medicaid Services (CMS) regulations do address life safety code requirements. The errata modifies the proposed regulations so that facilities must meet CMS federal life safety code standards in order to obtain a state facility for hospice license which may help newly licensed facilities obtain CMS hospice certification.
- Increased alignment of state home health agency regulations with federal CMS home health agency regulations.
- Ambulatory surgical center operating room size minimum requirements based on the complexity of the surgeries being performed.
- Existing law (NRS 449.24185 (3)) has a provision which allows a health care facility to employ a person who does not possess the qualification listed in NRS 449.24185 (1) to engage in the practice of surgical technology if certain criteria are met and allows the facility to continue to employ such a person. The proposed regulations establish a minimum experience requirement of not less than 1 year of experience within the immediately preceding 3 years practicing surgical technology or completion of an evidence-based training and passing a written competency evaluation before engaging in the practice of surgical technology.
- Community-based living arrangement services (CBLA) training requirements and requirements for providers who operates a CBLA that provides assistance to residents in the administration of medications to help ensure the safety of CBLA clients.
- Outlines procedures to be followed if the Bureau of Health Care Quality and Compliance determines that there is an immediate and serious threat to the health and safety of recipients

served by a facility to help ensure appropriate actions are taken to end the immediate and serious threat.

- Requires personal care agencies to pay the costs for personal care employees to attend all training required by NAC and NRS Chapter 449 in accordance with section 10 of the proposed regulations.
- Removes the requirement that the Division receives a satisfactory Fire Marshal or local fire department inspection report for agency/service-based facilities.
- The Division incurs costs related to investigating substantiated complaints regardless of who submits a complaint; therefore, the words "by a consumer" are being omitted from Section 24 of the proposed regulations.

A summary of the major provisions of the proposed regulations and proposed errata include:

Section 1 authorizes the Chief Medical Officer to impose reporting requirements, in addition to those currently prescribed in NRS Chapter 441A, concerning a disease for which a pandemic or epidemic is ongoing without adopting additional regulations.

Section 3 adopts by reference certain guidelines concerning the use of personal protective equipment, and section 4 of this regulation 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 imposes certain requirements relating to the use of audio and video monitoring equipment to monitor a patient or resident at a medical facility, facility for the dependent or other licensed facility.

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.

Section 26 requires a facility for hospice care to comply with certain requirements for fire safety.

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.

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, prices of and certain other information concerning certain publications adopted by reference.

Section 20 extends the requirement concerning the investigation and survey by the Division to additionally apply to intermediary service organizations, which are certified by the Division; and 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 physically house patients/residents/clients.

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.

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.

The errata being moved forward:
Section 1 removes Section 1 of the proposed regulations.
Section 13 changes the word “may’ to “must” in Section 13 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.
Section 26 changes 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.

Based on feedback received during the public workshop process, the following is a summary of modifications to the proposed regulations added to the errata:

Section 5

- References to a patient, resident or roommate of a patient or resident was changed to an occupant.

- Clarification was provided that audio or video monitoring equipment does not include the use of security cameras in public entryways or communal areas of the facility outside of the patient or resident rooms.
- Clarification was added that an occupant does not include temporary occupants of a room, such as visitors, including but not limited to, other residents or patients visiting an occupant.
- Clarification was provided that a court-appointed guardian or attorney-in-fact has priority over a surrogate that is not a court-appointed guardian or an attorney-in-fact.
- Subsection 7 was modified so a surrogate means the following persons, in order of priority: the spouse, adult child, the parents, or an adult sibling of an occupant. The other provisions in subsection 7 are being proposed to be omitted.

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

Sections 41 and 47 were revised by adding provisions detailing the training components needed to comply with the training required pursuant to paragraph (f) of subsection 1 of NRS 449.0302.

Section 80 was also modified to refer to the modifications made to subsection 6 of section 41 and subsection 6 of section 47.

2. A statement explaining how to obtain the approved or revised text of the proposed regulation.
Any persons interested in obtaining a copy of the approved or revised text of the proposed regulations 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. The estimated economic effect of the regulation on the business which it is to regulate and on the public. Anticipated effects of Chapter 449 of the Nevada Administrative Code (LCB File No. R048-22) on the businesses which it regulates:

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.

B. *Beneficial:*

Section 20 exempts certain facilities, such as agencies that provide services in a patient's home but do not provide direct patient care in their physical facility, from the requirement to receive a fire inspection and therefore; any associated costs, such as the costs of a sprinkler system, to come into compliance with the findings of a fire inspection. 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. 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 and associated requirements from agency/service type providers, that provide services in a patient's home, 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.

4. The methods used by the agency in determining the impact on a small business.

The methods used by the agency in determining the impact of the proposed changes to Chapter 449 of the Nevada Administrative Code (LCB File No. R048-22) on a small business are as follows:

Emails with a link to the proposed regulations and a small business impact questionnaire with the following questions were distributed.

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?

The above information included distribution to:

- 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

Summary of Responses

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 don't have a facility, we don't control clients residency and there is no way we can. If we do not receive funding to provide the personal protective equipment we cannot 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	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 don't 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	

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 $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 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		imposing additional barriers to providing care. Establishing and providing 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.	

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 public workshop was also held on September 28, 2022, to gain further information on the proposed regulations on business, including small businesses. 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.

An analysis of industry input collected was conducted by a health program manager. The analysis involved analyzing feedback obtained from the small business impact questionnaire and general industry feedback, the public workshop, and review of statutes in determining the impact to small business.

5. The estimated cost for the Division of Public and Behavioral Health for enforcement of the proposed changes to Chapter 449 of the Nevada Administrative Code (LCB File No. R048-22) are as follows:
There is no cost to the agency anticipated for the enforcement of the proposed regulations.

6. A description of and citation to any regulations of other state or local governmental agencies which the proposed regulation overlaps or duplicates and a statement explaining why the duplication or overlapping is necessary. If the proposed regulation overlaps or duplicates a federal regulation, the notice must include the name of the regulating federal agency.

The Centers for Medicare and Medicaid Services (CMS) certifies certain medical facilities, including but not limited to ambulatory surgical centers, home health agencies, hospitals, facilities for hospice, skilled nursing facilities, and others. CMS certification is optional for licensed health care facilities, but in general health care facilities that have the option to become CMS certified, apply for and receive CMS certification. There are facilities that choose not to become CMS certified, even when the option is open to them, and remain only state licensed.

Current home health agencies state regulations do overlap with federal home health agency regulations. The proposed regulations minimize the duplication by omitting many of the current state regulations and instead adopting the federal home health agency regulations. There are components of the current state home health agency regulations that have not been omitted by the proposed regulations. In these cases, it was determined that there was not a corresponding federal regulation, and it was still necessary to protect the public's health.

Current facilities for hospice regulations do not have state life safety code standards; therefore, the proposed

regulations as modified by the errata require facilities for hospice to comply with CMS federal fire protection regulations to avoid two separate sets of standards and to facilitate state licensed hospice facilities to obtain their hospice CMS hospice certification.

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.

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

Section 4 Although in general CMS federal regulations address infection control and use of personal protective equipment, the federal regulations do not require a facility to maintain not less than a 30-day supply of personal protective equipment (PPE) at all times, unless a shortage prohibits them from complying with this requirement. It also does not require a facility to enter into a contract with a supplier of personal protective equipment to ensure a facility has a sufficient PPE supply to comply with the requirements of the proposed regulations.

8. Whether the proposed regulation establishes a new fee or increases an existing fee.

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.

Persons wishing to comment upon the proposed action of Board of Health may appear at the scheduled public hearing or may address their comments, data, views or arguments, in written form, to the Board's Secretary, Lisa Sherych, to be received no later than November 17, 2022, at the following address:

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

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

Members of the public who are disabled and require special accommodations or assistance at the hearing are requested to notify Leticia Metherell, in writing, no later than five (5) working days before the hearing via email at: lmetherell@health.nv.gov or by mailing a request to:

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

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

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

Nevada Division of Public and Behavioral Health
4150 Technology Way
Carson City, NV 89706

Nevada State Library
100 Stewart Street
Carson City, NV 89701

Washoe County Administration Complex
1001 E 9th St.
Reno, NV 89512

Southern Nevada Health District (SNHD)
280 S. Decatur Boulevard
Las Vegas, Nevada 89107

Nevada Division of Public and Behavioral Health
4220 S. Maryland Parkway, Suite 100, Building A
Las Vegas, NV 89119

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

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

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

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

Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Helping people. It's who we are and what we do.

Lisa Sherych
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

October 1, 2022

MEMORANDUM

To: Jon Pennell, DVM, Chair
State Board of Health

From: Lisa Sherych, Secretary
State Board of Health

Re: Consideration and adoption of proposed regulation amendment(s) to Nevada Administrative Code (NAC) 449, "Medical Facilities and Other Related Entities", LCB File No. R048-22.

PURPOSE OF AMENDMENT

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 proposed regulations address:

- Issues identified during the COVID-19 pandemic related to infection control and prevention.
- The use of audio or video monitoring equipment to monitor patients/residents as this equipment is currently being used by facilities with no clear state regulatory guidelines on the use of this equipment. The proposed regulations help protect a patient's/resident's right to privacy and confidentiality.
- The allowance of a monetary penalty for facilities that don't notify the Division of a change in its national accreditation status. The Division needs to know when facilities are deemed to meet CMS standards or not in order to determine whether the Division is responsible for conducting certain inspections and complaints. Failure for facilities to update the Division on its deeming status results in inefficiencies and higher enforcement costs to the agency. For example, a facility does not notify the Division it is deemed so the Division schedules and travels to conduct a federal survey, but the survey team must return without conducting a survey. In addition, if a facility loses its deemed status it then becomes the responsibility of the Division to conduct inspections in accordance with CMS federal guidelines. If the Division is not aware that it is now responsible for conducting the federal surveys, this may result in survey omissions or delayed surveys, which may impact meeting the Division's federal grant obligations which in turn may result in loss of federal CMS funds to conduct inspections.
- Construction and life safety code state regulations for facilities of hospice care. Currently construction and life safety codes standards are not addressed in state regulations, but federal CMS regulations do address life safety code requirements. This results in certain facilities for hospices committing resources, including associated costs, of getting a state license but not being able to get CMS certified because they cannot meet the CMS federal life safety code standards. The errata modifies the proposed regulations so that facilities must meet CMS federal life safety code standards in order to obtain a state facility for hospice license which may help newly licensed facilities obtain CMS hospice certification.
- Increased alignment of state home health agency regulations with federal home health agency regulations. The goal of the Bureau of Health Care Quality and Compliance is to move towards the direction of adopting federal regulations, for the most part, as state regulations. This has several advantages, including less confusion with one set of standards to follow, reduced duplications, elimination of possible conflicts, increased efficiencies, and keeps current state regulations up to date anytime the federal CMS standards are updated. In most cases, there will also be state regulations that are not addressed by the federal standards, such as construction standards, that will still need to be addressed in state regulations.
- Ambulatory surgical center operating room size minimum requirements based on the complexity of the surgeries being performed.
- Existing law (NRS 449.24185 (3)) has a provision which allows a health care facility that does not possess the qualification listed in NRS 449.24185 (3) to engage in the practice of surgical technology if certain criteria are met and allows the facility to continue to employ such a person. The proposed regulations establish a minimum experience requirement of not less than 1 year of experience within the immediately preceding 3 years practicing surgical technology or completion of an evidence-based training and passing a written competency evaluation before engaging in the practice of surgical technology. This is to help ensure the competent and safe practice of surgical technology in Nevada's licensed health care facilities.
- Community-based living arrangement services (CBLA) training requirements and requirements for providers who operates a CBLA that provides assistance to residents in the administration of medications to help ensure the safety of CBLA clients.

- Outlines procedures to be followed if the Bureau determines that there is an immediate and serious threat to the health and safety of recipients served by a facility to help ensure appropriate actions are taken to end the immediate and serious threat.
- Requires personal care agencies to pay the costs for personal care employees to attend the training required pursuant to paragraph (a) of subsection 2 of NAC 449.3973. The recommendation for personal care agencies to pay for employee training costs was recommended by the Home Care Employment Standards Board, established pursuant to NRS 608.610, to address the training costs of low wage caregivers.
- Removes the requirement that the Division receives a satisfactory Fire Marshal or local fire department inspection report for agency/service-based facilities. For example, a personal care agency provides care in a client's home and not at the agency itself; therefore, only requiring the fire inspection for facility types that actually house patients/clients/residents. This continues to protect the vulnerable populations housed in licensed health care facilities, while reducing the financial and regulatory burden on agency/serviced based offices that do not house vulnerable populations. This may encourage more agencies/services to open and provide greater access to care.
- The Division incurs costs related to investigating substantiated complaints regardless of who submits a complaint; therefore, the words "by a consumer" are being omitted form Section 24 of the proposed regulations. This alleviates confusion as to who a consumer is and helps ensure the collection of fees to cover the costs of investigating such complaints.

SUMMARY OF CHANGES TO NEVADA ADMINISTRATIVE CODE (NAC) 449.

Section 1 authorizes the Chief Medical Officer to impose reporting requirements, in addition to those currently prescribed in chapter 441A of NRS, concerning a disease for which a pandemic or epidemic is ongoing without adopting additional regulations.

Section 3 adopts by reference certain guidelines concerning the use of personal protective equipment, and section 4 of this regulation 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 imposes certain requirements relating to the use of audio and video monitoring equipment to monitor a patient or resident at a medical facility, facility for the dependent or other licensed facility.

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.

Section 26 requires a facility for hospice care to comply with certain requirements for fire safety.

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.

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 concerning the investigation and survey by the Division to additionally apply to intermediary service organizations, which are certified by the Division; and 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 physically house patients/residents/clients.

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.

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.

The errata modifies the following sections of the proposed regulations.

Section 1 Removes Section 1 of the proposed regulations.

Section 5 Removes Section 5 of the proposed regulations.

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

Section 13 Changes the word "may' to "must" in Section 13 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.

Section 26 Changes 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.

Sections 41 and 47 were revised by adding provisions detailing the training components needed to comply with the training required pursuant to paragraph (f) of subsection 1 of NRS 449.0302.

Section 80 was also modified to refer to the modifications made to subsection 6 of section 41 and subsection 6 of section 47.

POSSIBLE OUTCOME IF PROPOSED AMENDMENT IS NOT APPROVED

If the proposed amendments are not approved by the Board of Health, applicable current regulations will not align with statutes that passed as a result of the passage of the bills listed in the purpose of amendment section.

In addition, for provisions not being moved forward as a direct result of passage of statutes, the issues the proposed regulations and errata address, as noted in the purpose of amendment and summary of changes to NAC 449, would not be realized.

APPLICABILITY OF PROPOSED AMENDMENT

The proposed regulations will apply statewide.

PUBLIC COMMENT RECEIVED

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 don't have a facility, we don't control clients residency and there is no way we can. If we do not receive funding to provide the personal protective equipment we cannot 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	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 don't 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	

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 $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		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 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	

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 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.		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.	

In addition, written comments were received expressing concerns that the existing statutes and the proposed regulations violate federal and state anti-competitive laws. NRS 449.24185 notes *1. A health care facility may not employ or otherwise allow a person to engage in the practice of surgical technology at the health care facility unless the person has:*

(a) Successfully completed a program for surgical technologists that is accredited by a national accrediting organization and is certified as a Certified Surgical Technologist by the National Board of Surgical Technology and Surgical Assisting or a successor organization;

(b) Successfully completed a training program for surgical technologists administered by the United States Public Health Service, Army, Navy, Air Force, Marine Corps or Coast Guard; or

(c) Engaged in the practice of surgical technology in a health care facility before January 1, 2018.

Although it is true that the statutes above require surgical technologists to only be certified by the National Board of Surgical Technology and Surgical Assisting when applicable, the proposed regulations do not. The

Board of Health does not have the authority to remedy this situation via regulations. To remedy this issue a legislative change would be required.

Public Workshop – September 28, 2022

A public workshop was also held on September 28, 2022, to gain further information on the proposed regulations on business, including small businesses. 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.

An analysis of industry input collected was conducted by a health program manager. The analysis involved analyzing feedback obtained from the small business impact questionnaire and general industry feedback, the public workshop, and review of statutes in determining the impact to small business.

Several modifications to the proposed regulations are included in the errata based on feedback received during the public workshop and regulatory development process including modification to the following sections:

Section 1 Removes Section 1 of the proposed regulations. 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.

Section 5 Removes Section 5 of the proposed regulations. After feedback from several stakeholders and concerns related to patient safety, it was determined that the best course of action would be to remove Section 5 of the proposed regulations. 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.

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

Section 13 Changes the word "may' to "must" in Section 13 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.

Section 26 Changes 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.

Sections 41 and 47 were revised by adding provisions detailing the training components needed to comply with the training required pursuant to paragraph (f) of subsection 1 of NRS 449.0302.

Section 80 was also modified to refer to the modifications made to subsection 6 of section 41 and subsection 6 of section 47.

Recommendations made by industry that were not incorporated into the proposed regulations

The recommended change to not omit from current regulations the requirement that ambulatory surgical centers obtain a written patient transfer agreement was not made. Concerns regarding the provisions of section 68 included 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.

Although the proposed regulations remove the requirement for an ambulatory surgical center to have a written patient transfer agreement with a hospital, the proposed regulations continue to require an ambulatory surgical center to establish written guidelines for transferring a patient to a licensed hospital. The proposed regulations also require the established written guidelines for transferring patients to a licensed hospital, be to a hospital that has medical and surgical capabilities. It also provides for continuity of care by requiring the ambulatory surgical center to either transfer with the patient or make promptly available to the hospital all of the patient's medical information. It also does not prohibit an ambulatory surgical center from keeping their current written transfer agreements in place or entering into a transfer agreement with a hospital.

There was an instance that occurred several years ago in which the only rural hospital in an area refused to have a written transfer agreement with the local surgical center, so the surgical center came into a written agreement with a hospital in another location which was much further away just to be in compliance with the regulations.

In addition, emergency medical services have protocols for transferring patients based on their condition and needs.

The Centers for Medicare and Medicaid Services federal ambulatory surgical center regulations no longer require a transfer agreement between an ambulatory surgical center and a hospital. This brings the state ambulatory surgical center regulations in line with the federal regulations.

In addition, a recommendation 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.

This recommendation was not made because cultural competency training is a statutory requirement and the statutes do not exempt family members who are employees of a personal care agency who care for their family members from taking the cultural competency training. The Board of Health does not have the authority to waive or exempt these individuals from taking the cultural competency training required by statutes. In addition, the individual's concerns were alleviated when he was made aware that the facility type he represented was not required to have its employees take the cultural competency training required in statutes.

STAFF RECOMMENDATION

Staff recommends the State Board of Health adopt the proposed regulation amendments and the proposed errata to Nevada Administrative Code (NAC) 449, “Medical Facilities and Other Related Entities”, LCB File No. R048-22.

PRESENTER

Leticia Metherell, RN, Health Program Manager III

Enclosures

REVISED PROPOSED REGULATION OF THE

STATE BOARD OF HEALTH

LCB File No. R048-22

June 23, 2022

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

AUTHORITY: § 1, NRS 233B.039, 439.200 and 441A.120; §§ 2-5, 7, 8, 10-13, 15-18, 20, 21, 25-28, 36-44, 47-51, 53-57, 59-68, 72, 80 and 81, NRS 439.200 and 449.0302; §§ 6, 73 and 74, NRS 439.200, 449.0302 and 449.165; §§ 9 and 29-35, NRS 439.200, 449.0302 and 449.0305; § 14, NRS 439.200, 449.0302 and 449.24185; § 19, NRS 439.200, 449.0302 and 449.040; §§ 22 and 23, NRS 439.150, 439.200, 449.0302 and 449.050; § 24, NRS 439.150, 439.200 and 449.0302; §§ 45 and 69-71, NRS 439.200, 449.0302 and 449.0303; §§ 46 and 52, NRS 439.200, 449.0302 and 449.1915; § 58, NRS 439.200, 449.0302 and 629.051; §§ 75-79, NRS 439.200, 450B.120 and 450B.237.

A REGULATION relating to health care; authorizing the Chief Medical Officer to impose certain reporting requirements during a pandemic or epidemic; adopting certain publications by reference; prescribing certain requirements concerning the operation of a medical facility, facility for the dependent or certain other licensed facilities; requiring a medical facility to report the acquisition or loss of certain accreditation; providing for the licensure and regulation of certain referral agencies; revising requirements concerning the training of employees at certain facilities; requiring a home health agency to comply with certain federal requirements concerning the reporting of data; prescribing class designations for ambulatory surgical centers; establishing requirements concerning the employment of a surgical technologist by an ambulatory surgical center; establishing requirements relating to the licensure and operation of providers of community-based living arrangement services; prescribing certain actions in response to an immediate and serious threat to the health and safety of recipients of services from certain facilities; revising certain publications adopted by reference; removing the requirement that certain facilities must be inspected by the State Fire Marshal or a local fire department before the issuance of a license or certificate; revising certain requirements governing the licensure and operation of a home health agency; authorizing the Division of Public and Behavioral Health of the Department of Health and Human Services to recover the costs of certain investigations; authorizing certain persons to make referrals through a referral agency; removing the term “general hospital” from the Nevada Administrative Code; imposing certain requirements concerning the abuse or neglect of a resident at a psychiatric residential treatment facility; clarifying that certain professionals are authorized to order or prescribe a therapeutic diet or home health care; revising certain requirements

concerning intermediate care facilities; imposing certain requirements concerning the operation of a pharmacy at a recovery center; revising provisions concerning the imposition of administrative sanctions upon certain facilities; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the State Board of Health to adopt regulations governing the control of communicable diseases in this State. (NRS 441A.120) Existing law also authorizes the Board to take immediate action for the preservation of human health without going through the prescribed process for the adoption of regulations. (NRS 233B.039) **Section 1** of this regulation authorizes the Chief Medical Officer to impose reporting requirements, in addition to those currently prescribed in chapter 441A of NRS, concerning a disease for which a pandemic or epidemic is ongoing without adopting additional regulations.

Existing law requires the Board to adopt regulations governing the licensing and operation of medical facilities and facilities for the dependent. (NRS 449.0302) Existing law also authorizes the Board to require the licensing of other facilities that provide medical care or treatment. (NRS 449.0303) **Section 3** of this regulation adopts by reference certain guidelines concerning the use of personal protective equipment, and **section 4** of this regulation 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** of this regulation imposes certain requirements relating to the use of audio and video monitoring equipment to monitor a patient or resident at a medical facility, facility for the dependent or other licensed facility. **Section 7** of this regulation requires a facility for the dependent to: (1) develop and carry out an infection control program and an emergency preparedness plan; and (2) designate two employees to be responsible for infection control at the facility.

Existing regulations require certain hospitals to be accredited by a national accrediting organization. Existing regulations also require a hospital to notify the Division of Public and Behavioral Health of the Department of Health and Human Services if the hospital: (1) is not required to be accredited and becomes accredited; or (2) loses accreditation. (NAC 449.318) **Section 6** of this regulation makes this requirement applicable to any medical facility that acquires or loses accreditation, and **section 39** of this regulation removes duplicative requirements concerning hospitals. **Section 6** also: (1) authorizes the Division to impose an administrative penalty for failure to report the acquisition or loss of accreditation; and (2) prohibits the Bureau of Health Care Quality and Compliance of the Division from imposing any other administrative sanction for such a violation.

Existing regulations require an applicant for the issuance or renewal of a license to operate a medical facility or facility for the dependent who wishes or is required to have building plans for new construction or remodeling reviewed by the Division to submit two complete sets of building plans for new construction or remodeling to the entity designated to review such plans by the Division. (NAC 449.0115) **Section 8** of this regulation 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, regardless of whether the facility is applying for the issuance or renewal of a license. **Section 8** requires the building plans to be approved before the construction or remodeling, as applicable, begins. **Section 8** additionally requires the Bureau to conduct a site survey before licensing a newly constructed facility for

hospice care. **Section 25** of this regulation makes a conforming change to indicate the proper placement of **section 8** in the Nevada Administrative Code. **Section 26** of this regulation requires a facility for hospice care to comply with certain requirements for fire safety.

Senate Bill No. 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. (Chapter 75, Statutes of Nevada 2019, at page 405) **Sections 9 and 29-35** of this regulation expand provisions governing referral agencies to also include agencies that provide referrals to the group housing arrangements added by Senate Bill No. 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.

Existing regulations require the administrator of an agency to provide personal care services in the home to arrange for the training of employees. (NAC 449.3973) **Section 44** of this regulation specifies that the administrator is required to ensure that employees are provided all training required by chapter 449 of NRS and chapter 449 of NAC. **Section 10** of this regulation 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. **Section 10** also requires such an agency to pay: (1) certain costs associated with such training; and (2) the salary or hourly wage of an employee for time spent attending such training. **Section 43** of this regulation makes a conforming change to indicate the proper placement of **section 10** in the Nevada Administrative Code.

Sections 11 and 12 of this regulation require a home health agency to comply with certain federal requirements concerning the collection and reporting of data, and **section 54** of this regulation makes a conforming change to indicate the proper placement of **sections 11 and 12** in the Nevada Administrative Code.

Section 13 of this regulation: (1) prescribes different class designations for ambulatory surgical centers based on the type of surgical procedures performed at an ambulatory surgical center; and (2) 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. **Section 19** of this regulation requires an application for a license to operate an ambulatory surgical center to identify the class designation of the ambulatory surgical center.

Existing law, in general, prohibits a hospital, independent center for emergency medical care, psychiatric hospital or ambulatory surgical center from employing a surgical technologist unless the surgical technologist has: (1) successfully completed an accredited training program for surgical technologists and obtained certification as a Certified Surgical Technologist by the National Board of Surgical Technology and Surgical Assisting or a successor organization; (2) successfully completed a training program for surgical technologists administered by certain federal entities; or (3) engaged in the practice of surgical technology at such a facility before January 1, 2018. Existing law authorizes such a facility to employ a surgical technologist who does not meet those requirements if, after conducting a thorough and diligent search, the facility is unable to employ a sufficient number of surgical technologists who possess such qualifications. (NRS 449.24185) **Section 14** of this regulation prescribes certain qualifications for a surgical technologist who is hired under such circumstances. **Section 14** also establishes the conditions under which an ambulatory surgical center will be deemed to have conducted a thorough and diligent search. Finally, **section 14** requires an ambulatory surgical center that

employs a surgical technologist under such circumstances to maintain certain documentation. **Section 65** of this regulation makes a conforming change to indicate the proper placement of **sections 13 and 14** in the Nevada Administrative Code.

Section 15 of this regulation prescribes certain required training for: (1) a natural person responsible for the operation of a provider of community-based living arrangement services; (2) an employee of a provider of community-based living arrangement services who supervises or provides support to recipients of services; and (3) a caregiver who assists a recipient of community-based living arrangement services in the administration of medication. **Section 16** of this regulation: (1) 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 (2) prescribes requirements governing the administration of over-the-counter medications or dietary supplements to such residents. **Section 61** of this regulation makes a conforming change to indicate the proper placement of **sections 15 and 16** in the Nevada Administrative Code.

Assembly Bill No. 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 of the Department of Health and Human Services and instead required such a provider to be licensed by the Division as a facility for the dependent. (Chapter 51, Statutes of Nevada 2019, at page 246) **Section 62** of this regulation makes a conforming change to replace language referring to a provisional certificate to language referring to a provisional license. **Section 62** also 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** of this regulation 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** of this regulation: (1) requires the Bureau of Health Care Quality and Compliance of the Division to notify the facility as soon as possible; and (2) authorizes the Bureau to require the facility to establish a plan of abatement to end the threat. **Section 72** of this regulation makes a conforming change to indicate the proper placement of **section 17** in the Nevada Administrative Code.

Existing regulations adopt by reference certain publications concerning the design, construction and operation of health care facilities and require certain health care facilities in this State to comply with the requirements prescribed by those publications. (NAC 449.0105, 449.3154, 449.3156, 449.685, 449.74413, 449.74543, 449.97026, 449.9843, 449.9935, 449.99718) **Sections 18 and 67** of this regulation update the titles and prices of and certain other information concerning those publications, and **sections 37, 38, 49, 51, 53, 64, 66, 67 and 69** of this regulation make conforming changes.

Existing regulations require the Division to perform an investigation and survey of 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. (NAC 449.0112) **Section 20** of this regulation: (1) extends the requirement concerning the investigation and survey by the Division 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.

Existing regulations: (1) define the term "subunit agency" to mean a home health agency owned and controlled by a central organization, corporate entity or home office, but operated and directed by governing and administrative bodies separate from the central organization or any other unit owned and controlled by the central organization; and (2) require a subunit agency to obtain a license separate from that of the parent agency. (NAC 449.749, 449.758) **Section 55** of this regulation removes the requirement that a subunit agency obtain a separate license. **Sections 22, 23, 54, 57, 58 and 81** of this regulation remove other requirements governing subunit agencies and references to the term "subunit agency." **Section 21** of this regulation makes a conforming change to remove a reference to a repealed section. **Sections 56-59 and 81** of this regulation revise certain other requirements concerning the administration and operation of a home health agency. **Section 22** of this regulation also: (1) revises the term "obstetric center" to "freestanding birthing center" to conform with changes made by Assembly Bill No. 287 of the 2021 Legislative Session; and (2) removes the fee for licensure of a peer support recovery organization to conform with the removal of provisions for the licensure of peer support recovery organizations by Senate Bill No. 69 of the 2021 Legislative Session. (Assembly Bill No. 287, chapter 517, Statutes of Nevada 2021, at page 3427; Senate Bill No. 69, chapter 444, Statutes of Nevada 2021, at page 2807)

Existing regulations provide that the Division may charge a licensee for the cost of investigating a complaint against the licensee submitted by a consumer. (NAC 449.01685) **Section 24** of this regulation removes the requirement that the complaint must be submitted by a consumer, thereby authorizing the Division to charge a licensee for the investigation of any complaint against the licensee.

Existing regulations prohibit a residential facility for groups from accepting or retaining a resident who is suffering from a serious infection. (NAC 449.271) **Section 28** of this regulation authorizes a residential facility for groups to retain such a resident 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** of this regulation revises requirements governing the size of the windows in a bedroom of a residential facility for groups.

Assembly Bill No. 232 of the 2019 Legislative Session abolished the classification of general hospital. (Section 9 of Assembly Bill No. 232, chapter 424, Statutes of Nevada 2019, at page 2644) **Sections 40, 42, 68, 75-79 and 81** of this regulation make conforming changes to remove the term "general hospital" from the Nevada Administrative Code. **Section 36** of this regulation makes a conforming change to remove a reference to a repealed section.

Existing law requires the Board to adopt regulations requiring 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. (NRS 449.0302) **Sections 41, 47 and 80** of this regulation require a hospital or independent center for emergency medical care to: (1) provide such training to each employee who provides care to victims of sexual assault or attempted sexual assault 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 (2) maintain evidence of such training in the personnel file of each such employee.

Existing law requires certain health care providers and other personnel at a medical facility to report the abuse or neglect of an older or vulnerable person or a child. (NRS 200.5093, 432B.220) If there is reasonable cause to believe that a resident of a psychiatric residential treatment facility has been abused or neglected, **section 45** of this regulation requires: (1) an

employee or independent contractor having knowledge of the abuse or neglect to report the abuse or neglect as required by law; and (2) 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.

Existing law requires a medical facility to ensure that the facility provides a special diet for each patient for whom such a diet has been ordered by a licensed dietitian or prescribed by a physician, physician assistant, dentist, advanced practice registered nurse or podiatric physician. (NRS 449.1915) **Sections 46, 52 and 70** of this regulation 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.

Existing regulations require an employee at a medical facility, a facility for the dependent, a home for individual residential care or an outpatient facility to undergo certain screening for communicable diseases. (NAC 441A.375) **Section 48** of this regulation removes duplicative requirements concerning employees of intermediate care facilities. **Section 50** of this regulation revises the required dimensions of doors to certain rooms that permit access for wheelchairs at an intermediate care facility.

Existing law authorizes a physician assistant or advanced practice registered nurse to order home health care for a patient. (NRS 630.271, 632.237, 633.432) **Section 60** of this regulation makes conforming changes to existing regulations governing home health agencies.

Existing regulations prescribe certain requirements concerning the transfer of a patient from an ambulatory surgical center to a hospital, including a requirement that each ambulatory surgical center must maintain a written agreement with a hospital concerning the transfer of patients. (NAC 449.996) **Section 68** of this regulation removes the requirement for an ambulatory surgical center to maintain such an agreement.

Existing law authorizes the State Board of Pharmacy to issue a license to a recovery center to conduct a pharmacy. (NRS 639.2177) If an order for entry on a chart is given by a prescribing practitioner, existing law requires the practitioner who authorized the administration of the drug to sign the chart order within 48 hours after giving the order. (NRS 639.23275) **Section 71** of this regulation requires: (1) a pharmacy conducted by a recovery center to be licensed; and (2) a recovery center to comply with the requirement concerning the signing of chart orders.

Existing law authorizes the Division to impose administrative sanctions against a medical facility, facility for the dependent or certain other facilities that: (1) are not in compliance with statutes or regulations governing such facilities; or (2) have engaged in certain other conduct. (NRS 449.160, 449.163) If the Bureau discovers a deficiency at a such a facility, existing regulations require: (1) the Bureau to notify the facility of the deficiency; and (2) the facility to develop a plan of correction for the deficiency. (NAC 449.99856, 449.9987) **Sections 73 and 74** of this regulation establish requirements concerning the confidentiality of a statement of deficiencies and plan of correction.

Section 1. Chapter 441A of NAC is hereby amended by adding thereto a new section to read as follows:

If the Chief Medical Officer determines that a pandemic exists or an epidemic exists within this State, the Chief Medical Officer may require any person or entity in this State to report to the Chief Medical Officer information prescribed by the Chief Medical Officer concerning the disease for which the pandemic or epidemic has been determined to exist.

Sec. 2. Chapter 449 of NAC is hereby amended by adding thereto the provisions set forth as sections 3 to 17, inclusive, of this regulation.

Sec. 3. ***1. The following publications are hereby adopted by reference:***

(a) "Part II.E.: Personal Protective Equipment (PPE) for Healthcare Personnel" of 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, as updated in May 2022, published by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services and available at no cost on the Internet at http://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf, or, if that Internet website ceases to exist, from the Division.

(b) "Optimizing Personal Protective Equipment (PPE) Supplies," available at no cost on the Internet website of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html, or, if that Internet website ceases to exist, from the Division.

(c) "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," available at no cost on the Internet website of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services at http://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, or, if that Internet website ceases to exist, from the Division.

2. If any publication adopted by reference in subsection 1 is revised, the Division shall review the revision to determine its suitability for this State. If the Division determines that the revision is not suitable for this State, the Division shall hold a public hearing to review its determination and give notice of that hearing within 90 days after the date of the publication of the revision. If, after the hearing, the Division does not revise its determination, the Division shall give notice that the revision is not suitable for this State within 90 days after the hearing. If the Division does not give such notice, the revision becomes part of the publication adopted by reference pursuant to subsection 1.

Sec. 4. *1. 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 shall ensure that each person on the premises of the facility uses personal protective equipment in accordance with the publications adopted by reference in section 3 of this regulation. The facility shall maintain:*

(a) Not less than a 30-day supply of personal protective equipment at all times; or

(b) If the facility is unable to comply with the requirements of paragraph (a) due to a shortage in personal protective equipment, documentation of attempts by and the inability of the facility to obtain personal protective equipment.

2. Except as otherwise provided in subsection 3, 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 shall:

(a) Enter into a contract with a supplier of personal protective equipment which ensures that the facility has a supply of personal protective equipment sufficient to comply with the requirements of subsection 1; and

(b) Track the amount of personal protective equipment that the facility has available, the rate at which personal protective equipment is used in the facility and orders for personal protective equipment in a manner sufficient to ensure compliance with the requirements of subsection 1.

3. The requirements of subsection 2 do not apply to a nursing pool that receives sufficient personal protective equipment from its clients to meet the requirements of subsection 1. Such a nursing pool shall maintain documentation demonstrating that it meets the requirements of this subsection.

Sec. 5. *1. Except as authorized by this section, 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 shall not use audio or video monitoring equipment to monitor a patient or resident.*

2. 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 may use audio or video monitoring equipment to monitor a patient or resident only if:

(a) The patient or resident or a person authorized by subsection 5 or 6 to serve as the representative of the patient or resident has requested or consented to the monitoring and agreed in writing to a specific duration for the monitoring;

(b) The monitoring is only used in the room in which the patient or resident sleeps;

(c) The monitoring does not violate any state or federal law, regulation or rule;

(d) The monitoring is conducted to protect the health, safety or personal property of the patient or resident; and

(e) If the patient or resident has a roommate, the roommate of the patient or resident or a person authorized by subsection 5 or 6 to serve as the representative of the roommate has also consented to the monitoring.

3. 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 must immediately stop using audio or video monitoring equipment to monitor a patient or resident if the patient or resident, a person authorized by subsection 5 or 6 to serve as the representative of the patient or resident, a roommate of the patient or resident or a person authorized by subsection 5 or 6 to serve as the representative of a roommate withdraws consent or becomes unable to consent.

4. At least quarterly, 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 that uses audio or video monitoring equipment to monitor a patient or resident shall, in consultation with the patient or resident or a person authorized by subsection 5 or 6 to serve as the representative of the patient or resident, reevaluate in writing the need for continued monitoring. The reevaluation must be:

(a) Signed and dated by the patient or resident or a person authorized by subsection 5 or 6 to serve as the representative of the patient or resident; and

(b) Maintained in the file of the patient or resident.

5. A court-appointed guardian or attorney-in-fact for a patient, a resident or the roommate of a patient or resident may serve as the representative of the patient, resident or roommate, as applicable, for the purposes of this section if:

(a) The patient, resident or roommate, as applicable, is unable to provide or withdraw consent; and

(b) A court order specifically authorizes the court-appointed guardian or attorney-in-fact to consent to the use of audio or video monitoring equipment to monitor the patient, resident or roommate, as applicable. The facility shall maintain a copy of the court order in the record of the patient, resident or roommate, as applicable.

6. A surrogate of a patient, a resident or the roommate of a patient or resident may serve as the representative of the patient, resident or roommate, as applicable, for the purpose of providing or withdrawing consent pursuant to this section only to the use of video monitoring equipment without audio capabilities to monitor the patient or resident if the patient, resident or roommate, as applicable, is unable to provide or withdraw consent.

7. As used in this section, "surrogate" means the following persons, in order of priority:

(a) The spouse of a patient or resident or of the roommate of a patient or resident;

(b) An adult child of a patient or resident or of the roommate of a patient or resident or, if there is more than one adult child, a majority of the adult children who are reasonably available for consultation;

(c) The parents of a patient or resident or of the roommate of a patient or resident;

(d) An adult sibling of a patient or resident or of the roommate of a patient or resident or, if there is more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation;

(e) The nearest other adult relative of a patient or resident or of the roommate of a patient or resident by blood or adoption who is reasonably available for consultation; or

(f) An adult who has exhibited special care or concern for a patient or resident or for the roommate of a patient or resident, is familiar with the values of the patient, resident or roommate, as applicable, and is willing and able to make health care decisions for the patient, resident or roommate, as applicable.

Sec. 6. *1. If a medical facility receives notice from a national accrediting organization that the national accrediting organization has accredited the medical facility, the medical facility shall submit to the Division in the manner prescribed by the Division a copy of the notice not later than 7 calendar days after receiving the notice.*

2. If a medical facility loses the accreditation of a national accrediting organization, the medical facility shall notify the Division not later than 7 calendar days after receiving notice of the loss of accreditation.

3. The Division may impose an administrative penalty in an amount not to exceed $1,000 for a failure to comply with the requirements of this section. The Bureau shall not impose any administrative sanction pursuant to NAC 449.9982 to 449.99939, inclusive, for such a deficiency.

4. As used in this section, "national accrediting organization" has the meaning ascribed to it in 42 C.F.R. § 488.1.

Sec. 7. *1. A facility for the dependent shall:*

(a) Develop and carry out an infection control program to prevent and control infections within the facility;

(b) Review the infection control program, including, without limitation, the infection control policy adopted pursuant to subsection 2, at least annually to ensure that the program

meets current evidence-based standards for infection control plans and the safety needs of residents, staff and visitors; and

(c) Develop and carry out a comprehensive plan for emergency preparedness.

2. To carry out the infection control program developed pursuant to paragraph (a) of subsection 1, the facility shall adopt an infection control policy. The policy must include, without limitation, current infection control guidelines developed by a nationally recognized infection control organization that are appropriate for the scope of service of the facility. Such nationally recognized organizations include, without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations.

3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of:

(a) A primary person who is responsible for infection control; and

(b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times.

4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for

Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter.

5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training.

6. The plan for emergency preparedness developed pursuant to paragraph (c) of subsection 1 must address internal and external emergencies and local and widespread emergencies. Such emergencies must include, without limitation, emerging infectious diseases.

Sec. 8. *1. Except as otherwise provided in subsection 2, before any construction of a new facility for hospice care or remodeling of an existing facility for hospice care commences, the facility must submit two complete sets of the building plans for the construction or remodeling, as applicable, to:*

(a) The entity designated by the Division to review such plans in the manner prescribed by NAC 449.0115, regardless of whether the facility is applying for a license or the renewal of a license. The review by that entity is only advisory, and approval by that entity does not constitute the approval of the construction or remodeling by the Bureau.

(b) The Division. The facility shall not commence the construction or remodeling, as applicable, until the plans have been approved by the Division.

2. The provisions of subsection 1 do not apply to the remodeling of an existing facility for hospice care if the remodeling is limited to refurbishing an area within the facility including,

without limitation, painting the area, replacing flooring in the area, repairing windows in the area or replacing window and wall coverings in the area.

3. The Division shall not issue a license to operate a newly constructed facility for hospice care until the Bureau has approved the construction. The Bureau shall not approve the construction without conducting a survey at the site of the facility. Such a survey must occur after the construction has been completed.

Sec. 9. *"Group housing arrangement" means a residential facility for groups or any other group housing arrangement that provides assistance, food, shelter or limited supervision to a person with a mental illness, intellectual disability, developmental disability or physical disability or who is aged or infirm.*

Sec. 10. *1. To comply with the requirements of paragraph (a) of subsection 2 of NAC 449.3973 concerning the training of employees, an agency shall:*

(a) Provide or arrange for the provision of the training required by that paragraph;

(b) Except as otherwise provided in subsection 4, pay any costs associated with attending such training, including, without limitation:

(1) The cost of the training; and

(2) If the training is not provided at the agency, the costs of travelling to and from the location where the training is provided; and

(c) Pay an employee attending such training his or her salary or hourly wage as if the employee were working for:

(1) Time spent attending the training; and

(2) The time that would ordinarily be required to travel from the agency to the location of the training and back to the agency.

2. An agency that provides training pursuant to paragraph (a) of subsection 2 of NAC 449.3973 on the premises of the agency is not required to arrange or pay the costs of training provided at another location if:

(a) The training provided on the premises of the agency meets the applicable requirements of state law and regulations; and

(b) The agency pays all costs associated with the training provided on the premises of the agency.

3. An agency may require an employee attending training pursuant to paragraph (a) of subsection 2 of NAC 449.3973 to provide any documentation necessary to verify expenses or time described in paragraph (b) or (c) of subsection 1. Such documentation may include, without limitation, receipts and proof of mileage.

4. An agency is not required to pay the costs described in paragraph (b) of subsection 1 for an employee who attends, but fails to complete, the training described in paragraph (a) of subsection 2 of NAC 449.3973.

5. An agency shall:

(a) Require an employee who completes training pursuant to paragraph (a) of subsection 2 of NAC 449.3973 to provide to the agency documentation of the completion of the training; and

(b) Maintain such documentation in the personnel file of the employee.

Sec. 11. *1. "Appendix B - Guidance to Surveyors: Home Health Agencies" of the State Operations Manual, issued February 21, 2020, published by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, is hereby adopted by reference. The publication is available at no cost on the Internet at*

https://www.hhs.gov/guidance/document/state-operations-manual-appendix-b-guidance-surveyors-home-health-agencies, or, if that Internet website ceases to exist, from the Division.

2. If the publication adopted by reference in subsection 1 is revised, the Division shall review the revision to determine its suitability for this State. If the Division determines that the revision is not suitable for this State, the Division shall hold a public hearing to review its determination and give notice of that hearing within 90 days after the date of the publication of the revision. If, after the hearing, the Division does not revise its determination, the Division shall give notice that the revision is not suitable for this State within 90 days after the hearing. If the Division does not give such notice, the revision becomes part of the publication adopted by reference in subsection 1.

Sec. 12. *1. Except as otherwise provided in this subsection, a home health agency shall comply with the provisions of 42 C.F.R. §§ 484.1 to 484.115, inclusive, and the publication adopted by reference in section 11 of this regulation. A home health agency that is not certified by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services is not required to comply with:*

(a) 42 C.F.R. § 484.45 and any associated guidance prescribed by the publication adopted by reference in section 11 of this regulation, except that the home health agency shall:

(1) Collect the data prescribed by 42 C.F.R. § 484.55(c)(8); and

(2) Update and revise that data at the frequency required by 42 C.F.R. § 484.55(d);

(b) 42 C.F.R. § 484.50(c)(7)(i) and (ii) and any associated guidance prescribed by the publication adopted by reference in section 11 of this regulation; or

(c) The requirement prescribed by 42 C.F.R. § 484.50(c)(8) that a home health agency must comply with the requirements of 42 C.F.R. §§ 405.1200 to 405.1204, inclusive, and any

associated guidance prescribed by the publication adopted by reference in section 11 of this regulation.

2. A home health agency shall provide the data described in 42 C.F.R. § 484.55(c)(8) to the Division upon the request of the Division. Such data must accurately reflect the status of the patient at the time that the relevant assessment is conducted.

3. For the purposes of this section, any provision of 42 C.F.R. §§ 484.1 to 484.115, inclusive, or the publication adopted by reference in section 11 of this regulation that refers to a physician shall be deemed to apply equally to a physician assistant licensed pursuant to chapter 630 or 633 of NRS or an advanced practice registered nurse.

Sec. 13. *1. An ambulatory surgical center may be designated as Class A, Class B, Class C, Class E or Endoscopy Only.*

2. An ambulatory surgical center that is designated as Class A may provide minor surgical procedures performed under local or topical anesthesia. An operating room in an ambulatory surgical center that is designated as Class A must have a minimum clear area of 130 square feet (12.077 square meters) and a minimum clear dimension of 10 feet (3.05 meters).

3. An ambulatory surgical center that is designated as Class B may provide any surgical procedure authorized for an ambulatory surgical center that is designated as Class A and any surgical procedure performed under conscious or deep sedation. An operating room in an ambulatory surgical center that is designated as Class B must have a minimum clear area of 250 square feet (23.23 square meters) and a minimum clear dimension of 15 feet (4.57 meters).

4. An ambulatory surgical center that is designated as Class C may provide any surgical procedure authorized for an ambulatory surgical center that is designated as Class A or B and any surgical procedure that requires general anesthesia. An operating room in an ambulatory surgical center that is designated as Class C must have a minimum clear area of 400 square feet (37.16 square meters) and a minimum clear dimension of 18 feet (5.49 meters).

5. An ambulatory surgical center that is designated as Class E must have been licensed before August 5, 2004.

6. An ambulatory surgical center that is designated as Endoscopy Only may only provide endoscopy procedures. An operating room in an ambulatory surgical center that is designated as Endoscopy Only must have a minimum clear area of 180 square feet (16.7225 square meters).

7. As used in this section:

(a) "Clear area" means the open area of an operating room, excluding fixed cabinets and built-in shelves.

(b) "Clear dimension" means the open space between the operating room and another area of the building.

Sec. 14. *1. A person employed to engage in the practice of surgical technology in an ambulatory surgical center pursuant to subsection 3 of NRS 449.24185 must have passed a written competency evaluation demonstrating that he or she is competent to practice surgical technology and have:*

(a) Not less than 1 year of experience within the immediately preceding 3 years practicing surgical technology in a hospital or surgical center for ambulatory patients that is licensed in

a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico or a territory or insular possession subject to the jurisdiction of the United States; or

(b) Completed evidence-based training concerning:

(1) Proper surgical attire;

(2) Identification of patients;

(3) Proper positioning of a patient on an operating table;

(4) Consent of a patient to surgery;

(5) Time-out before surgery;

(6) The proper use of instruments and equipment, including, without limitation, identifying dangers associated with equipment;

(7) Asepsis and sterile technique, including, without limitation, identifying a break in the sterile field;

(8) Washing hands before surgery;

(9) Counting surgical instruments, surgical sponges and any other items used during surgery that may be left in the body of a patient;

(10) Preparing medications in the sterile field;

(11) The use of gowns and gloves;

(12) Draping of the patient;

(13) Proper care for specimens;

(14) Procedures for disinfecting and sterilizing equipment and supplies;

(15) Procedures for determining whether equipment and supplies have been properly sterilized and measures to be taken if a break in the sterile field is identified;

(16) Storage of sterile equipment and supplies; and

(17) Environmental cleaning and disinfecting the operating room.

2. An ambulatory surgical center shall be deemed to have conducted a thorough and diligent search for the purposes of subsection 3 of NRS 449.24185 if the ambulatory surgical center advertises for a surgical technologist who meets the requirements of subsection 1 or 2 of NRS 449.24185 for not less than 30 days:

(a) In a newspaper of general circulation within 50 miles of the ambulatory surgical center; or

(b) On an Internet website on which jobs in health care are regularly posted.

3. The administrator of an ambulatory surgical center that employs a person to engage in the practice of surgical technology in the ambulatory surgical center pursuant to subsection 3 of NRS 449.24185 shall maintain in the personnel file of the person documentation demonstrating:

(a) Compliance with subsection 1 of this section;

(b) Evidence of the advertising conducted pursuant to subsection 2 of this section; and

(c) The reasons the ambulatory surgical center was unable to employ a sufficient number of surgical technologists who meet the requirements prescribed by subsection 1 or 2 of NRS 449.24185.

4. As used in this section, "time-out" means pausing immediately before surgery to confirm the identity of the patient, the surgical procedure that will be performed and the site of the surgery.

Sec. 15. *1. Except as otherwise provided in subsection 2, a natural person responsible for the operation of a provider of community-based living arrangement services and each*

employee of a provider of community-based living arrangement services who supervises or provides support to recipients of community-based living arrangement services shall:

(a) Complete not less than 16 hours of training concerning the provision of community-based living arrangement services to persons with mental illness within 30 days after the date of hire or before providing services to a patient, whichever is later; and

(b) Annually complete not less than 8 hours of continuing education approved by the Division concerning the particular population served by the provider.

2. If the Board determines that a person described in subsection 1 is required to receive training or continuing education substantially equivalent to that prescribed in that subsection as a condition of licensure or certification under title 54 of NRS, the person is not required to complete the training or continuing education, as applicable, required by subsection 1.

3. If a caregiver assists a recipient of community-based living arrangement services in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must:

(a) Before assisting a resident in the administration of a medication, receive not less than 16 hours of training in the management of medication approved by the Division, which must consist of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate attesting to the completion of such training;

(b) Receive annually not less than 8 hours of training in the management of medication and provide the provider of community-based living arrangement services with satisfactory evidence of the content of the training and his or her attendance at the training; and

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

Sec. 16. *1. A provider who operates a facility that provides assistance to residents in the administration of medications shall maintain:*

(a) A log for each medication received by the facility for use by a resident of the facility. The log must include:

(1) The type and quantity of medication received by the facility;

(2) The date of its delivery;

(3) The name of the person who accepted the delivery;

(4) The name of the resident for whom the medication is prescribed; and

(5) The date on which any unused medication is removed from the facility or destroyed.

(b) A record of the medication administered to each resident, including, without limitation, any over-the-counter medication or dietary supplement. The record must include:

(1) The type of medication administered;

(2) The date and time that the medication was administered;

(3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and

(4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse.

2. A provider or an employee of a provider may provide or administer an over-the-counter medication or dietary supplement only if the physician, physician assistant or advanced practice registered nurse of the resident has approved the medication or dietary supplement in writing or the provider or employee is ordered by a physician, physician assistant or advanced practice registered nurse to provide or administer the medication to the resident. The over-the-

counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse.

Sec. 17. ***1. If the Bureau determines that there is an immediate and serious threat to the health and safety of recipients served by a facility, the Bureau:***

(a) Shall notify the facility as soon as possible; and

(b) May require the facility to submit a plan of abatement.

2. If the Bureau requires a facility to submit a plan of abatement, the facility shall submit the plan within the time specified by the Bureau, which must not exceed 48 hours after the Bureau notifies the facility of the requirement to submit the plan.

3. A plan of abatement:

(a) Must include, without limitation, a description of the immediate action that the facility has taken or will take to end the immediate and serious threat and the date by which the immediate and serious threat will cease to exist.

(b) Must ensure that serious harm does not occur or recur but is not required to include measures to correct all items of noncompliance associated with the immediate and serious threat.

Sec. 18. NAC 449.0105 is hereby amended to read as follows:

449.0105 1. The State Board of Health hereby adopts by reference:

(a) *NFPA 101: Life Safety Code*, in the form most recently published by the National Fire Protection Association, unless the Board gives notice that the most recent revision is not suitable for this State pursuant to subsection 2. A copy of the code may be obtained from the National Fire Protection Association at 11 Tracy Drive, Avon, Massachusetts 02322, at the Internet address **http://www.nfpa.org** or by telephone at (800) 344-3555, for the price of ~~[~~$88.20~~]~~

$113.85 for members or ~~[$98.00]~~ ***$126.50*** for nonmembers ***.*** ~~[, plus, for a printed copy, $9.95 for handling.]~~

(b) *NFPA 99: Health Care Facilities Code*, in the form most recently published by the National Fire Protection Association, unless the Board gives notice that the most recent revision is not suitable for this State pursuant to subsection 2. A copy of the standard may be obtained from the National Fire Protection Association at 11 Tracy Drive, Avon, Massachusetts 02322, at the Internet address **http://www.nfpa.org** or by telephone at (800) 344-3555, for the price of ~~[$65.25]~~ ***$83.25*** for members or ~~[$72.50]~~ ***$92.50*** for nonmembers ***.*** ~~[, plus, for a printed copy, $9.95 for handling.]~~

(c) *Guidelines for Design and Construction of Hospitals* ***,*** ~~[and Outpatient Facilities,]~~ in the form most recently published by the Facility Guidelines Institute, unless the Board gives notice that the most recent revision is not suitable for this State pursuant to subsection 2. A copy of the guidelines may be obtained from the Facility Guidelines Institute ~~[at AHA Services, Inc., P.O. Box 933283, Atlanta, Georgia 31193-3283,]~~ at the Internet address ~~[http://www.fgiguidelines.org/]~~ ***https://shop.fgiguidelines.org*** or by telephone at ~~[(800) 242-2626,]~~ ***(800) 798-9296,*** for the price of ~~[$200.]~~ ***$235.***

(d) *Guidelines for Design and Construction of Residential Health, Care, and Support Facilities*, in the form most recently published by the Facility Guidelines Institute, unless the Board gives notice that the most recent revision is not suitable for this State pursuant to subsection 2. A copy of the guidelines may be obtained from the Facility Guidelines Institute ~~[at AHA Services, Inc., P.O. Box 933283, Atlanta, Georgia 31193-3283,]~~ at the Internet address ~~[http://www.fgiguidelines.org/]~~ ***https://shop.fgiguidelines.org*** or by telephone at ~~[(800) 242-2626,]~~ ***(800) 798-9296,*** for the price of ~~[$200.]~~ ***$235.***

(e) Guidelines for Design and Construction of Outpatient Facilities, in the form most recently published by the Facility Guidelines Institute, unless the Board gives notice that the most recent revision is not suitable for this State pursuant to subsection 2. A copy of the guidelines may be obtained from the Facility Guidelines Institute at the Internet address https://shop.fgiguidelines.org or by telephone at (800) 798-9296, for the price of $235.

2. The State Board of Health will review each revision of the publications adopted by reference pursuant to subsection 1 to ensure its suitability for this State. If the Board determines that a revision is not suitable for this State, the Board will hold a public hearing to review its determination within 12 months after the date of the publication of the revision and give notice of that hearing. If, after the hearing, the Board does not revise its determination, the Board will give notice within 30 days after the hearing that the revision is not suitable for this State. If the Board does not give such notice, the revision becomes part of the publication adopted by reference pursuant to subsection 1.

Sec. 19. NAC 449.011 is hereby amended to read as follows:

449.011 An application for a license that is filed with the Division pursuant to NRS 449.040:

1. Must be complete and include proof of the identity of the applicant that is acceptable to the Division.

2. In accordance with NRS 449.050, must be accompanied by the appropriate application fee specified in NAC 449.002 to 449.99939, inclusive.

3. In establishing that the applicant is of reputable and responsible character as required by NRS 449.040, must include personal references and information concerning the applicant's financial status and business activities and associations in and out of this State during the

immediately preceding 3-year period. If the applicant is a firm, association, organization, partnership, business trust, corporation or company, such references and information must be provided with respect to the members thereof and the person in charge of the facility or program for which application is made.

4. In addition to the information required by NRS 449.040 and any other information specifically required for a particular license, must include:

(a) Full, complete and accurate information regarding the ownership of the facility or program and all changes to that ownership that occur while the application is pending. The information must include the name of:

(1) Each natural person who is an owner of the facility or program;

(2) Each person who has a direct or indirect ownership interest in the facility or program of 10 percent or more and who is the owner, in whole or in part, of any mortgage, deed of trust, note or other obligation secured in whole or in part by the facility or program or any of the property or assets of the facility or program;

(3) If the applicant is a corporation, each officer and director; and

(4) If the applicant is a partnership, each partner.

(b) The address of the applicant's principal office.

(c) Evidence satisfactory to the Division that the facility or program meets all applicable federal, state and local laws and complies with all safety, health, building and fire codes. If there are any differences between the state and local codes, the more restrictive standards apply.

(d) If required by NRS 439A.100, a copy of a letter of approval issued by the Director of the Department of Health and Human Services.

(e) A copy of the certificate of occupancy, a copy of the applicant's business license and a copy of any special use permits obtained in connection with the operation of the facility or program.

(f) A copy of any property lease or rental agreements concerning the facility or program.

(g) If the applicant is a corporation, a copy of its bylaws and articles of incorporation.

5. If the application is for a facility for the care of adults during the day, must include the maximum number of clients allowed to occupy the facility at one time.

6. If the application is for an ambulatory surgical center, must identify the class designation for the ambulatory surgical center designated pursuant to section 13 of this regulation. As used in this subsection, "ambulatory surgical center" has the meaning ascribed to it in NAC 449.972.

Sec. 20. NAC 449.0112 is hereby amended to read as follows:

449.0112 1. Upon receipt of a properly completed application, proof of the identity of the applicant that is acceptable to the Division and the appropriate fee, the Division shall conduct an investigation concerning the premises, facilities, qualifications of personnel, methods of operation and policies of the applicant and perform a prelicensure ***survey or precertification*** survey ***, as applicable,*** of:

(a) The applicant; and

(b) The facility, program plan and management plan, as appropriate.

2. ~~[Before]~~ ***Except as otherwise provided in this subsection, before*** issuing a license ~~[,]~~ ***or certificate, as applicable,*** the Division must receive a satisfactory report of inspection of the facility from the State Fire Marshal or the local fire department. ***The Division is not required to receive such a report before issuing a license or certificate, as applicable, to:***

(a) A provider of community-based living arrangement services;

(b) An agency to provide personal care services in the home;

(c) An intermediary service organization;

(d) An agency to provide nursing in the home;

(e) A nursing pool;

(f) A business described in NRS 449.0305;

(g) An employment agency described in NRS 449.03005; or

(h) A program of hospice care.

Sec. 21. NAC 449.012 is hereby amended to read as follows:

449.012 As used in NAC 449.012 to 449.0169, inclusive, unless the context otherwise requires, the words and terms defined in NAC 449.01205 to ~~[449.0127,]~~ ***449.01265,*** inclusive, have the meanings ascribed to them in those sections.

Sec. 22. NAC 449.013 is hereby amended to read as follows:

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

(a) An ambulatory surgical center $9,784

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

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

(d) A rural clinic 4,058

(e) ~~[An obstetric]~~ ***A freestanding birthing*** center 1,564

(f) A program of hospice care 7,054

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

(h) A nursing pool 4,602

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

(j) A medication unit 1,200

(k) A referral agency 2,708

(l) A facility for refractive surgery 6,700

(m) A mobile unit 2,090

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

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

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

~~[(q) A peer support recovery organization ..... 1,000~~

~~(r)]~~ ***(q)*** A community health worker pool 1,000

~~[(s)]~~ ***(r)*** An employment agency to provide nonmedical services 1,400

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

(a) An ambulatory surgical center $4,892

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

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

(d) A rural clinic 2,029

(e) ~~[An obstetric]~~ ***A freestanding birthing*** center 782

(f) A program of hospice care 3,527

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

(h) A nursing pool 2,301

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

(j) A medication unit 600

(k) A referral agency 1,354

(l) A facility for refractive surgery 3,350

(m) A mobile unit 1,045

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

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

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

~~[(q) A peer support recovery organization ..... 500~~

~~(r)]~~ ***(q)*** A community health worker pool 500

~~[(s)]~~ ***(r)*** An employment agency to provide nonmedical services 700

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

Sec. 23. NAC 449.0168 is hereby amended to read as follows:

449.0168 1. Except as otherwise provided in subsection 2, a holder of a license to operate a medical facility, facility for the dependent, program of hospice care or referral agency who

wishes or is required pursuant to NAC 449.190, 449.307, 449.7473 or 449.758 to modify his or her license to reflect:

(a) A change in the name of the facility, program or agency;

(b) A change of the administrator of the facility, program or agency;

(c) A change in the number of beds in the facility;

(d) A change in the type of facility licensed or the addition of another type of facility to be licensed;

(e) A change in the category of residents who may reside at the facility;

(f) A change in the designation of a staging area for a mobile unit or, if the mobile unit is operated by an independent facility, a change in the address of the independent facility; or

(g) A change in any of the services provided by an agency to provide nursing in the home,

➥ must submit an application for a new license to the Division and pay to the Division a fee of $250.

2. An applicant who applies for a license pursuant to paragraph (c) of subsection 1 because of an increase in the number of beds in the facility must pay to the Division:

(a) A fee of $250; and

(b) A fee for each additional bed as follows:

(1) If the facility is an intermediate care facility for persons with an intellectual disability or persons with a developmental disability $280

(2) If the facility is a residential facility for groups 184

(3) If the facility is a facility for the treatment of abuse of alcohol or drugs 190

(4) If the facility is a facility for hospice care 352

(5) If the facility is a home for individual residential care 266

(6) If the facility is a facility for modified medical detoxification..... 494

(7) If the facility is a hospital, other than a rural hospital 110

(8) If the facility is a rural hospital..... 62

(9) If the facility is a skilled nursing facility 108

(10) If the facility is an intermediate care facility, other than an intermediate care facility for persons with an intellectual disability or persons with a developmental disability 92

(11) If the facility is a facility for the treatment of irreversible renal disease..... 120

(12) If the facility is a halfway house for recovering alcohol and drug abusers 368

(13) If the facility is a facility for transitional living for released offenders..... 146

3. If the address of the home office of a home health agency has not changed, a holder of a license to operate a ~~[subunit agency or]~~ branch office of the home health agency who wishes or is required pursuant to NAC 449.758 to modify his or her license to reflect a change in the address of the ~~[subunit agency or]~~ branch office of the home health agency must:

(a) Submit an application for a new license to the Division; and

(b) Pay to the Division a fee of $250.

4. A fee paid pursuant to this section is nonrefundable.

5. As used in this section:

(a) "Administrator" means the person who is responsible for the daily management of a medical facility, facility for the dependent or program of hospice care.

(b) "Independent facility" has the meaning ascribed to it in NAC 449.9701.

(c) "Staging area" has the meaning ascribed to it in NAC 449.97018.

Sec. 24. NAC 449.01685 is hereby amended to read as follows:

449.01685 1. The Division may charge and collect a fee from any licensee who is involved in a complaint submitted to the Division ~~[by a consumer]~~ to recover the costs of investigating the complaint after the investigation is completed and the complaint is substantiated. The fee will be based upon the hourly rate established for each surveyor of health facilities as determined by the budget of the Division.

2. As used in this section, "substantiated" means supported or established by evidence or proof.

Sec. 25. NAC 449.017 is hereby amended to read as follows:

449.017 As used in NAC 449.017 to 449.0188, inclusive, ***and section 8 of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 449.0171 to 449.0178, inclusive, have the meanings ascribed to them in those sections.

Sec. 26. NAC 449.0187 is hereby amended to read as follows:

449.0187 A facility for hospice care must comply with the following requirements:

1. A program of hospice care must be provided for each inpatient pursuant to a written plan of care established pursuant to NAC 449.0186.

2. Nursing services must be provided 24 hours per day in accordance with the plan of care for each patient.

3. Medication must be dispensed to each patient according to the instructions of the patient's physician or the medical director.

4. Treatment must be administered to a patient pursuant to the instructions of the physician of the patient or the plan of care for the patient.

5. Each patient must be maintained in a clean and well-groomed manner.

6. Each patient must be protected from accidents, injuries and infections.

7. At least one registered nurse must be on duty for each work shift, providing direct care to patients.

8. A written plan of the procedures to be followed during a local disaster, a widespread disaster or a disaster which occurs within the facility for hospice care must be adopted. The plan must:

(a) Provide procedures designed to protect each patient and to care for any casualty which may arise from such a disaster;

(b) Be reviewed and the procedures set forth therein rehearsed by all members of the staff at least once in each quarter of the year; and

(c) Be approved by the Division.

9. A private room with an adjoining bath must be provided for each patient.

10. An anteroom, a room adjoining the room of each patient or a private area must be provided and furnished with a bed and chairs for use by the members of the patient's family.

11. A facility for hospice care must comply with the provisions of NFPA 101: Life Safety Code, adopted by reference in NAC 449.0105.

Sec. 27. NAC 449.218 is hereby amended to read as follows:

449.218 1. A bedroom in a residential facility that is shared by two or three residents must have at least 60 square feet of floor space for each resident who resides in the bedroom. A resident may not share a bedroom with more than two other residents. A bedroom that is occupied by only one resident must have at least 80 square feet of floor space.

2. Each bedroom in a residential facility must have one or more windows to the outside that can be opened from the inside of the room without the use of tools or a door to the outside which is at least 36 inches wide and can be opened from the inside.

3. The combined size of the panes of glass of the windows in a bedroom in a facility that was issued a license on or after January 14, 1997, must equal not less than ~~[10]~~ ***8*** percent of the floor space in the room.

4. The arrangement of the beds and other furniture in the bedroom must provide privacy for and promote the safety of the residents occupying the bedroom. Adjustable curtains, shades, blinds or similar devices must be provided for visual privacy.

5. Each resident must be provided:

(a) At least 10 square feet of space for storage in a bedroom for each bed in the bedroom; and

(b) At least 24 inches of space in a permanent or portable closet for hanging garments.

6. A separate bed with a comfortable and clean mattress must be made available for each resident. The bed must be at least 36 inches wide. Two clean sheets, a blanket, a pillow and a bedspread must be available for each bed. Linens must be changed at least once each week and more often if the linens become dirty. Additional bedding, including protective mattress covers, must be provided if necessary.

7. Upon the request of a resident, a residential facility may authorize the resident to use personal furniture and furnishings that comply with the requirements of subsection 6 if their use does not jeopardize the health and safety of any of the residents of the facility.

8. There must be a light outside the entrance to each bedroom to provide a resident with adequate lighting to reach safely a switch for turning on a light fixture inside the bedroom. Upon the request of a resident, bedside lighting must be provided.

Sec. 28. NAC 449.271 is hereby amended to read as follows:

449.271 ***1.*** Except as otherwise provided in ***subsection 2 and*** NAC 449.2736, a person must not be admitted to a residential facility or permitted to remain as a resident of a residential facility if he or she:

~~[1.]~~ ***(a)*** Requires gastrostomy care;

~~[2.]~~ ***(b)*** Suffers from a staphylococcus infection or other serious infection; or

~~[3.]~~ ***(c)*** Suffers from any other serious medical condition that is not described in NAC 449.2712 to 449.2734, inclusive.

2. If a governmental entity with jurisdiction, including, without limitation, a local board of health, a local health officer, the Division, the Chief Medical Officer or the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, declares the existence of an epidemic or pandemic, a residential facility located in the area in which the epidemic or pandemic is occurring may permit a resident suffering from a serious infection to remain a resident if the resident does not have symptoms that require a higher level of care than the residential facility is capable of providing.

Sec. 29. NAC 449.27811 is hereby amended to read as follows:

449.27811 As used in NAC 449.27811 to 449.27831, inclusive, ***and section 9 of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 449.27813 to ~~[449.27821,]~~ ***449.27819,*** inclusive, ***and section 9 of this regulation*** have the meanings ascribed to them in those sections.

Sec. 30. NAC 449.27813 is hereby amended to read as follows:

449.27813 "Client" means a person who is referred by a referral agency for compensation to a ~~[residential facility for groups.]~~ ***group housing arrangement.***

Sec. 31. NAC 449.27817 is hereby amended to read as follows:

449.27817 "Financial assessment" means an assessment to determine the intended source of payment by a client for services which will be provided by a ~~[residential facility for groups]~~ ***group housing arrangement*** for 6 months, including the eligibility status of the client for services as determined by Medicaid and Medicare.

Sec. 32. NAC 449.27823 is hereby amended to read as follows:

449.27823 1. A licensed nurse or social worker working in a medical facility or a facility for the dependent licensed by the Bureau may make a referral for a client of the facility or program to a ~~[residential facility for groups]~~ ***group housing arrangement*** without first obtaining a license to operate as a referral agency. A person employed by this State or the governing body of any county or city within this State, who is employed in a position in which the person's duties require him or her to make referrals for clients to ~~[residential facilities for groups,]~~ ***group housing arrangements,*** may make those referrals without first obtaining a license to operate as a referral agency.

2. An applicant for a license to operate as a referral agency must submit to the Division a completed application on a form provided by the Division. The application for the initial license must include, without limitation:

(a) Evidence that the applicant has obtained a contract of insurance for protection against liability to third persons which may be incurred while operating as a referral agency; and

(b) The physical address of the applicant where the records of the referral agency will be maintained.

3. A licensed nurse, public guardian, social worker, physician, physician assistant or hospital may provide a referral to a group housing arrangement through a licensed referral agency.

Sec. 33. NAC 449.27827 is hereby amended to read as follows:

449.27827 1. Employees of a referral agency must have a working knowledge of the provisions of NRS and NAC that govern the licensing of ~~[residential facilities for groups.]~~ ***group housing arrangements.***

2. An employee of a referral agency who is not licensed as a nurse, social worker, physician or physician assistant shall not gather any information needed to complete a needs assessment or financial assessment of a client, or engage in the process of referring a client to a ~~[residential facility for groups.]~~ ***group housing arrangement.***

Sec. 34. NAC 449.27829 is hereby amended to read as follows:

449.27829 1. A referral agency shall:

(a) Complete a needs assessment and financial assessment for each client and make referrals for the services that would best meet the physical, psychosocial and financial needs and wishes of the client; and

(b) Submit to the ~~[residential facility for groups]~~ ***group housing arrangement*** to which a client is referred a copy of the needs assessment completed by the referral agency for the client.

2. A referral agency shall not:

(a) Accept any fee, inducement or incentive, for any reason, from a ~~[residential facility for groups,]~~ ***group housing arrangement,*** or from any person or entity associated with a ~~[residential facility for groups;]~~ ***group housing arrangement;*** or

(b) Give a discharge planner, case manager, social worker or any other person who has the responsibility of discharge planning, a fee or incentive for prospective clients.

Sec. 35. NAC 449.27831 is hereby amended to read as follows:

449.27831 1. Before a referral agency may provide any services to a client, the referral agency must obtain a written contract from the client or his or her legal representative to provide the services. The contract must:

(a) Be signed by a representative of the referral agency and the person who is paying for the services or his or her representative; and

(b) Include, without limitation, a description of the services to be provided pursuant to the contract and all fees associated with the provision of those services.

2. If, within 30 days after a client is admitted to a ~~[residential facility for groups,]~~ ***group housing arrangement,*** the referral of the client to the ~~[residential facility for groups]~~ ***group housing arrangement*** is determined by the facility, the Bureau or a physician to be inappropriate, the referral agency shall:

(a) Refund the full amount of the fee paid by the client or his or her representative; or

(b) Assist the client with an acceptable referral to another ~~[residential facility for groups]~~ ***group housing arrangement*** for no additional fee.

3. A referral agency shall not receive more than one fee from a client within any 6-month period unless, during that period, the client or his or her representative requests another referral by the referral agency.

4. A referral agency shall maintain an organized file for each client that includes, without limitation:

(a) A copy of the needs assessment and financial assessment completed by the referral agency for the client;

(b) A copy of the completed contract to provide the services to the client; and

(c) Information outlining the process used by the referral agency for determining the appropriate referral of the client.

➥ A referral agency shall maintain its file of a client for at least 5 years at the place of business of the referral agency.

Sec. 36. NAC 449.279 is hereby amended to read as follows:

449.279 As used in NAC 449.279 to 449.394, inclusive, unless the context otherwise requires, the words and terms defined in NAC ~~[449.285]~~ ***449.286*** to 449.300, inclusive, have the meanings ascribed to them in those sections.

Sec. 37. NAC 449.3154 is hereby amended to read as follows:

449.3154 1. Except as otherwise provided in this section, a hospital shall comply with the provisions of *NFPA 101: Life Safety Code*, adopted by reference pursuant to NAC 449.0105.

2. Except as otherwise provided in this section, any new construction, remodeling or change in the use of a hospital must comply with the applicable provisions of the guidelines adopted by reference in paragraphs (c) **,** ~~[and]~~ (d) ***and (e)*** of subsection 1 of NAC 449.0105, unless the remodeling is limited to refurbishing an area of the hospital, including, without limitation, painting the area, replacing the flooring in the area, repairing windows in the area and replacing window or wall coverings in the area.

3. Except as otherwise provided in subsection 4, a hospital shall meet all applicable:

(a) Federal and state laws;

(b) Local ordinances, including, without limitation, zoning ordinances; and

(c) Life safety, environmental, health, fire and local building codes,

➥ related to the construction and maintenance of the hospital. If there are any differences between the state and local codes, the more restrictive standards apply.

4. A hospital which is inspected and approved by the State Public Works Division of the Department of Administration in accordance with the provisions set forth in chapter 341 of NRS and chapter 341 of NAC is not required to comply with any applicable local building codes related to the construction and maintenance of the hospital.

5. A complete copy of the building plans for new construction and remodeling of a hospital, drawn to scale, must be submitted to the entity designated to review such plans by the Division of Public and Behavioral Health pursuant to the provisions of NAC 449.0115. Before the construction or remodeling may begin, plans for the construction or remodeling must be approved by the Division of Public and Behavioral Health.

6. The Bureau shall not approve the licensure of a hospital until all construction has been completed and a survey is conducted at the site. The plan review is only advisory and does not constitute prelicensing approval.

7. Notwithstanding any provision of this section to the contrary, a hospital which was licensed on January 1, 1999, shall be deemed to be in compliance with this section if the use of the physical space in the hospital does not change and the existing construction of the hospital does not have any deficiencies which are likely to cause serious injury, serious harm or impairment to public health and welfare.

Sec. 38. NAC 449.3156 is hereby amended to read as follows:

449.3156 1. Notwithstanding any provision of NAC 449.3154 to the contrary, a hospital shall be deemed to be in compliance with the applicable provisions of the guidelines adopted by reference in paragraphs (c) ***,*** ~~[and]~~ (d) ***and (e)*** of subsection 1 of NAC 449.0105, if:

(a) The hospital submitted architectural plans to the Bureau on or before February 1, 1999;

(b) The hospital began construction on or before August 1, 1999;

(c) The plans were determined by the Bureau to be in compliance with the provisions of NAC 449.002 to 449.99939, inclusive, that were in effect on December 1, 1998;

(d) The hospital is built in accordance with those provisions;

(e) The use of the physical space in the hospital has not changed; and

(f) There are no deficiencies in the construction of the hospital which are likely to cause serious injury, serious harm or impairment to public health and welfare.

2. If there are deficiencies that are likely to cause serious injury, serious harm or impairment to public health and welfare, the hospital shall take immediate action to correct the deficiencies or the hospital will not be allowed to continue to operate.

Sec. 39. NAC 449.318 is hereby amended to read as follows:

449.318 1. A hospital must be accredited by an approved national accrediting organization unless the hospital:

(a) Is a psychiatric hospital or rural hospital;

(b) Has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e);

(c) Contains a distinct part skilled nursing facility or a nursing facility, as defined in 42 C.F.R. § 483.5;

(d) Is a hospital described in 42 U.S.C. § 1395ww(d)(1)(B)(iv) and accepts payment through Medicare;

(e) Is owned by this State or a political subdivision thereof;

(f) Is licensed only for rehabilitation beds; or

(g) Was initially licensed before December 19, 2018, and has been licensed continually after that date.

2. A hospital that is required to comply with the requirements of subsection 1 shall submit to the Division proof of such compliance:

(a) Not later than 12 months after obtaining an initial license; ~~[and]~~

(b) With each application for renewal submitted pursuant to NAC 449.0116 ~~[~~.

~~3. A hospital that is not required to comply with the requirements of subsection 1 but is accredited by an approved national accrediting organization shall submit to the Division proof of such accreditation with each application for renewal.~~

~~4. If a hospital that is accredited by an approved national accrediting organization ceases to be so accredited, the hospital must immediately notify the Division.~~

~~5.]~~ ***; and***

(c) As required by section 6 of this regulation.

3. As used in this section, "approved national accrediting organization" means a national accrediting organization, as defined in 42 C.F.R. § 488.1, that has been approved by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services pursuant to 42 C.F.R. § 488.5.

Sec. 40. NAC 449.331 is hereby amended to read as follows:

449.331 1. A hospital shall develop and carry out policies and procedures to ensure that emergency services and medical care are provided in accordance with NRS 439B.410 and 450B.790 and 42 C.F.R. § 489.24 and to ensure compliance with the provisions of NRS 450B.795.

2. All ~~[general]~~ hospitals not having their own long-term facility shall have transfer agreements with long-term care facilities. Transfer agreements between facilities must be in writing and on file at each facility concerned. The agreements must provide for:

(a) The transfer of patients between facilities whenever the need for transfer is medically determined; and

(b) The exchange of appropriate medical and administrative information between facilities.

3. In addition to the application required by NAC 449.011 or 449.0116, as applicable, a hospital applying for initial licensure or the renewal of its license shall submit to the Division an attestation under penalty of perjury that the hospital is in compliance with the requirements of this section.

Sec. 41. NAC 449.363 is hereby amended to read as follows:

449.363 1. A hospital shall have written policies concerning the qualifications, responsibilities and conditions of employment for each type of hospital personnel, including the licensure and certification of each employee when required by law.

2. The written policies must be reviewed and updated as needed and must be made available to the members of the hospital staff.

3. Personnel policies must provide for:

(a) The orientation of all health personnel to the policies and objectives of the hospital; and

(b) The maintenance of records of current employees which confirm that the personnel policies are being followed.

4. The hospital shall have evidence of a current license or certification on file at the hospital for each person employed by the hospital, or under contract with the hospital, who is required to be licensed or certified by law to perform his or her job.

5. The hospital shall ensure that the health records of its employees contain documented evidence of surveillance and testing of those employees for tuberculosis in accordance with chapter 441A of NAC.

6. A hospital shall:

(a) Provide the training required by paragraph (f) of subsection 1 of NRS 449.0302 to each employee who provides care to victims of sexual assault or attempted sexual assault not later than 60 days after the date on which the employee commenced his or her employment and at least biennially thereafter; and

(b) Maintain evidence of compliance with the requirements of paragraph (a) in the personnel file for each employee who is subject to those requirements.

Sec. 42. NAC 449.394 is hereby amended to read as follows:

449.394 1. A ~~[general]~~ hospital which has a designated area set aside for use on a continuous basis for the treatment and care of psychiatric patients is deemed to operate a psychiatric service and shall comply with the requirements in this section.

2. A licensed physician may render psychiatric care in any licensed ~~[general]~~ hospital on a short term or emergency basis.

3. A hospital shall develop and carry out policies and procedures for the provision of psychiatric treatment and behavioral management services that are consistent with NRS 449A.200 to 449A.263, inclusive, to ensure that the treatment and services are safely and appropriately used. The hospital shall ensure that the policies and procedures protect the safety and rights of the patient.

4. The medical direction of the psychiatric unit and the psychiatric services provided by the hospital must be under the direct supervision of a qualified member of the medical staff.

5. All nursing services provided with regard to the provision of psychiatric care must be provided under the direction of a registered nurse.

6. A consulting medical staff composed of qualified persons in appropriate specialties must be available at all times to the patients in the psychiatric unit.

Sec. 43. NAC 449.396 is hereby amended to read as follows:

449.396 As used in NAC 449.396 to 449.3982, inclusive, ***and section 10 of this regulation,*** the words and terms defined in NAC 449.3961 to 449.3968, inclusive, have the meanings ascribed to them in those sections.

Sec. 44. NAC 449.3973 is hereby amended to read as follows:

449.3973 1. The administrator of an agency must:

(a) Be at least 18 years of age;

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

(c) Be responsible and mature and have the personal qualities which will enable the administrator to understand the problems of elderly persons and persons with disabilities;

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

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

2. The administrator of an agency shall represent the licensee in the daily operation of the agency and shall appoint a person to exercise his or her authority in the administrator's absence. The responsibilities of an administrator include, without limitation:

(a) Employing qualified personnel and ~~[arranging for their]~~ ***ensuring that such personnel receive all*** training ~~[;]~~ ***required by this chapter and chapter 449 of NRS in accordance with section 10 of this regulation;***

(b) Ensuring that only trained attendants are providing services to a client of the agency and that such services are provided in accordance with the functional assessment of the client, the service plan established for the client and the policies and procedures of the agency;

(c) Developing and implementing an accounting and reporting system that reflects the fiscal experience and current financial position of the agency;

(d) Negotiating for services provided by contract in accordance with legal requirements and established policies of the agency;

(e) Providing oversight and direction for attendants and other members of the staff of the agency as necessary to ensure that the clients of the agency receive needed services;

(f) Developing and implementing policies and procedures for the agency, including, without limitation, policies and procedures concerning terminating the personal care services provided to a client;

(g) Designating one or more employees of the agency to be in charge of the agency during those times when the administrator is absent; and

(h) Demonstrating to the Division upon request that the agency has sufficient resources and the capability to satisfy the requests of each client of the agency related to the provision of the personal care services described in the service plan to the client.

3. Except as otherwise provided in this subsection and subsection 4 of NAC 449.3976, an employee designated to be in charge of the agency when the administrator is absent must have access to all records kept at the agency. Confidential information may be removed from a file to which an employee designated to be in charge of the agency has access if the confidential information is maintained separately by the administrator.

4. The administrator of an agency shall ensure that:

(a) The clients of the agency are not abused, neglected or exploited by an attendant or another member of the staff of the agency, or by any person who is visiting the client when an attendant or another member of the staff of the agency is present; and

(b) Suspected cases of abuse, neglect or exploitation of a client are reported in the manner prescribed in NRS 200.5093 and 632.472.

Sec. 45. NAC 449.442 is hereby amended to read as follows:

449.442 ***1.*** A psychiatric residential treatment facility shall develop and carry out policies and procedures that protect and support the rights of residents in the same manner as set forth for medical facilities and facilities for the dependent in NRS 449A.100 to 449A.118, inclusive.

2. If an employee or independent contractor of a psychiatric residential treatment facility has reasonable cause to believe that another employee or independent contractor of the facility has abused or neglected a resident:

(a) The employee or independent contractor with knowledge of the abuse or neglect shall report the abuse or neglect as required by NRS 200.5093 or 432B.220, if applicable;

(b) The facility shall prevent the alleged perpetrator of the abuse or neglect from having further direct contact with any resident; and

(c) The facility shall notify the parent of or other person legally responsible for the alleged victim of the abuse or neglect and ensure that the alleged victim receives appropriate medical assessment and treatment.

Sec. 46. NAC 449.544 is hereby amended to read as follows:

449.544 1. Each facility shall provide nutrition services to each patient of the facility and the provider of care for that patient to maximize the nutritional status of the patient.

2. The licensed dietitian for a patient of a facility shall:

(a) Conduct an assessment of the nutrition of the patient;

(b) Participate in a team review of the progress of the patient in accordance with the provisions of NAC 449.541;

(c) After consulting with the physician of the patient, recommend ***or order*** a therapeutic diet for the patient based on:

(1) The cultural preferences of the patient;

(2) Changes in the treatment of the patient; and

(3) The nutritional requirements of the patient;

(d) Except as otherwise provided in subsection 7:

(1) Counsel the patient and the provider of care for that patient, if required, concerning any diet prescribed for the patient at the facility; and

(2) Monitor the patient's adherence and response to that diet;

(e) Refer the patient for assistance with any resources that are available to the patient, including, without limitation, financial assistance, community resources or assistance at the residence of the patient;

(f) Participate in activities conducted at the facility to ensure the quality of the facility; and

(g) Monitor the nutritional status of the patient to determine the need for intervention and follow-up by the facility. In making that determination, the licensed dietitian shall consider:

(1) Changes in the weight of the patient;

(2) The chemistry of the blood of the patient;

(3) The adequacy of the dialysis treatment provided to the patient; and

(4) Changes in the medication prescribed for the patient.

3. Each facility shall collect data to assess the nutritional status of a patient of the facility not later than 2 weeks after the patient is admitted to the facility or immediately after the patient receives seven treatments at the facility, whichever occurs later. A comprehensive assessment of the nutritional status of the patient must be completed within 30 days after the patient is admitted

to the facility or immediately after the patient receives 13 treatments at the facility, whichever occurs later. Such an assessment must include a determination by the dietitian of the degree to which the patient understands the diet prescribed for him or her by the facility.

4. Each facility shall, annually or more often if required by the circumstances concerning the treatment of the patient, revise the comprehensive assessment of the nutritional status of each patient specified in subsection 3.

5. Each facility shall employ or contract with a licensed dietitian to provide nutrition services for each patient of the facility. If a facility provides treatment for 100 or more patients, the facility shall ensure that one full-time equivalent licensed dietitian is available at the facility.

6. Nutrition services must be available at each facility during scheduled periods for treatment. The facility may require a patient to obtain an appointment with a licensed dietitian before receiving those services.

7. The provisions of paragraph (d) of subsection 2 do not apply to a correctional institution.

Sec. 47. NAC 449.6133 is hereby amended to read as follows:

449.6133 Except as otherwise provided in NAC 449.61322, the governing body of an independent center for emergency medical care shall appoint a person to administer the center. The administrator is responsible for:

1. The daily operation of the center;

2. Serving, along with any committee appointed for the purpose of serving, as a liaison between the governing body, the medical staff and all the departments of the center;

3. Reporting the pertinent activities of the center to the governing body at regular intervals;

4. Appointing a person responsible for the center in the absence of the administrator; ~~[and]~~

5. Planning for the services provided by the center and the operation of the center ~~[.]~~ ***; and***

6. Ensuring that:

(a) Each employee who provides care to victims of sexual assault or attempted sexual assault is provided the training required by paragraph (f) of subsection 1 of NRS 449.0302 not later than 60 days after the date on which the employee commenced his or her employment and at least biennially thereafter; and

(b) Evidence of compliance with the requirements of paragraph (a) is maintained in the personnel file for each employee who is subject to those requirements.

Sec. 48. NAC 449.680 is hereby amended to read as follows:

449.680 ~~[1.]~~ A facility must maintain evidence that ~~[members of the staff are free from health problems which would have a harmful effect on the residents or would interfere with the effective functioning of the program.~~

~~2. All persons employed in intermediate care facilities must have a preemployment physical examination or certification of a 3-year health record from a physician and a skin test or chest X-ray for tuberculosis.~~

~~3. An annual skin test or chest X-ray for tuberculosis is required after employment. If a positive skin test is found, then a chest X-ray is required.]~~ ***each employee or independent contractor of the facility has been screened for communicable diseases as required by NAC 441A.375.***

Sec. 49. NAC 449.685 is hereby amended to read as follows:

449.685 1. A facility must be designed, constructed, equipped and maintained in a manner that protects the health and safety of the patients and personnel of the facility and members of the general public.

2. Except as otherwise provided in this section and NAC 449.732 to 449.743, inclusive:

(a) A facility shall comply with the provisions of *NFPA 101: Life Safety Code*, adopted by reference pursuant to NAC 449.0105.

(b) Any new construction, remodeling or change in the use of a facility must comply with the applicable provisions of the guidelines adopted by reference in paragraphs (c) ***,*** ~~[and]~~ (d) ***and (e)*** of subsection 1 of NAC 449.0105, unless the remodeling is limited to refurbishing an area within the facility, including, without limitation, painting the area, replacing the flooring in the area, repairing windows in the area, and replacing window or wall coverings in the area.

3. A facility shall be deemed to be in compliance with the provisions of subsection 2 if the facility is licensed on February 1, 2004, the use of the physical space in the facility is not changed and there are no deficiencies in the construction of the facility that are likely to cause serious injury, harm or impairment to the public health and welfare.

4. Except as otherwise provided in subsection 5, a facility shall comply with all applicable:

(a) Federal and state laws;

(b) Local ordinances, including, without limitation, zoning ordinances; and

(c) Life safety, environmental, health, fire and local building codes,

➥ related to the construction and maintenance of the facility. If there is a difference between state and local requirements, the more stringent requirements apply.

5. A facility which is inspected and approved by the State Public Works Division of the Department of Administration in accordance with the provisions set forth in chapter 341 of NRS and chapter 341 of NAC is not required to comply with any applicable local building codes relating to the construction and maintenance of the facility.

6. A facility shall submit building plans for new construction or remodeling to the entity designated to review such plans by the Division of Public and Behavioral Health pursuant to

NAC 449.0115. The entity's review of those plans is advisory only and does not constitute approval for the licensing of the facility. Before the construction or remodeling may begin, the plans for the construction or remodeling must be approved by the Division of Public and Behavioral Health. The Bureau shall not approve a facility for licensure until all construction is completed and a survey is conducted at the site of the facility.

Sec. 50. NAC 449.7334 is hereby amended to read as follows:

449.7334 1. All rooms for occupancy by patients must be equipped with doors and hardware which permit access from the outside in any emergency.

2. The minimum width of all doors to those rooms must be 3.66 feet (111.7 centimeters). Doors to the toilet rooms of patients and other rooms needing access for wheelchairs must have a minimum width of ~~[2.83]~~ ***3*** feet ~~[(86.3]~~ ***(91.44*** centimeters). Doors opening onto corridors must not swing into the corridor unless they lead to spaces that are not occupied.

3. Windows and outer doors which may frequently be left open must be provided with screens for protection against insects.

4. Safety glass or plastic glazing materials must be used for shower doors, bath enclosures and in doors and windows of rooms for patients.

5. The height of a ceiling must be 8 feet (2.44 meters) in rooms which are occupied. Ceilings in storage rooms, corridors, toilet rooms and other minor rooms may have a height of 7.5 feet (2.29 meters) but may not have any projection lower than 7 feet (2.13 meters).

6. Flooring materials must be easily cleaned and maintained in good repair. Floors in areas subject to wet cleaning must not be physically affected by germicidal and cleaning solutions. Nonslip surfaces must be provided for areas subject to traffic while wet. Wall bases in kitchens and operating and delivery rooms must be integrated with the floor.

7. Wall finishes must be washable. Walls around plumbing fixtures must be resistant to moisture. Walls and floors must be free from cracks and holes.

8. Ceilings must be easily cleaned. Areas for preparing food must have ceilings which cover all overhead piping and ductwork. Acoustical ceilings must be provided in corridors in patient areas, nurses' stations, dayrooms, dining areas and waiting rooms. If acoustical ceilings cannot be provided, other methods of eliminating excessive noise and echoing must be used.

Sec. 51. NAC 449.74413 is hereby amended to read as follows:

449.74413 ~~[1.]~~ The owner of a facility for skilled nursing shall, at least 30 days before there is a change of ownership, change of use or change in the construction of the facility, notify the Bureau of that change. If the facility is not in compliance with the applicable provisions of the guidelines adopted by reference in paragraphs (c) ***,*** ~~[and]~~ (d) ***and (e)*** of subsection 1 of NAC 449.0105, the notice must identify those provisions of the guidelines with which the facility has failed to comply.

~~[2. Upon a change in use or change in the construction of a facility, the facility must comply with the applicable provisions of the guidelines adopted by reference in paragraphs (c) and (d) of subsection 1 of NAC 449.0105 before admitting patients to the area that is being changed or is under construction.]~~

Sec. 52. NAC 449.74525 is hereby amended to read as follows:

449.74525 1. A facility for skilled nursing shall employ full-time, part-time or as a consultant, a person who is a licensed dietitian. If a licensed dietitian is not employed full-time, the facility shall designate a person to serve as the director of food service who receives frequently scheduled consultations from a licensed dietitian.

2. A facility shall employ an adequate number of qualified and competent personnel to provide food service to the patients in the facility.

3. Menus must be planned in advance and followed to meet the nutritional needs of the patients in the facility in accordance with the recommended dietary allowances of the Food and Nutrition Board of the ~~[Institute of Medicine]~~ ***Health and Medicine Division*** of the National Academies ~~[.]~~ ***of Sciences, Engineering, and Medicine.***

4. A facility shall provide to each patient in the facility:

(a) Food that is prepared to conserve the nutritional value and flavor of the food.

(b) Food that is nourishing, palatable, attractive and served at the proper temperature.

(c) A well-balanced diet that meets the daily nutritional and special dietary needs of the patient.

(d) Who refuses the food that is regularly served by the facility, a substitute of similar nutritional value.

5. A therapeutic diet served to a patient by a facility must be prescribed by the attending physician ***, physician assistant, dentist, advanced practice registered nurse or podiatric physician*** of the patient ~~[.]~~ ***or ordered by a licensed dietitian.***

6. A facility shall serve to each patient in the facility at least three meals daily, at such times as are comparable to regular mealtimes within the community in which the facility is located. A snack must be offered to each patient daily at bedtime. Except as otherwise provided in this subsection, breakfast must be served not more than 14 hours after the previous evening meal. If a nourishing snack is served at bedtime, breakfast may be served not more than 16 hours after the previous evening meal if approved by a group of patients organized pursuant to NAC 449.74499.

7. A facility shall provide special eating equipment and utensils to each patient who requires them.

8. A facility shall:

(a) Comply with the applicable provisions of chapter 446 of NRS and the regulations adopted pursuant thereto and obtain such permits as are necessary from the Division for the preparation and service of food;

(b) Maintain a report of each inspection concerning the sanitation of the ~~[hospital]~~ ***facility*** for at least 1 year after the date of the inspection;

(c) Maintain a report of each corrective action taken to address a deficiency noted in a report described in paragraph (b) for at least 1 year after the date of the corrective action;

(d) Procure food from sources that are approved or considered satisfactory by federal, state and local authorities;

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

(f) Dispose of refuse and garbage properly.

Sec. 53. NAC 449.74543 is hereby amended to read as follows:

449.74543 1. A facility for skilled nursing must be designed, constructed, equipped and maintained in a manner that protects the health and safety of the patients and personnel of the facility and members of the general public.

2. Except as otherwise provided in this section:

(a) A facility for skilled nursing shall comply with the provisions of *NFPA 101: Life Safety Code*, adopted by reference pursuant to NAC 449.0105.

(b) Any new construction, remodeling or change in use of a facility for skilled nursing must comply with the applicable provisions of the guidelines adopted by reference in paragraphs (c) **,**

~~[and]~~ (d) ***and (e)*** of subsection 1 of NAC 449.0105, unless the remodeling is limited to refurbishing an area within the facility, including, without limitation, painting the area, replacing the flooring, repairing windows, or replacing window and wall coverings.

3. A facility for skilled nursing shall be deemed to be in compliance with the provisions of subsection 2 if:

(a) The facility is licensed on January 1, 1999, the use of the physical space in the facility is not changed and there are no deficiencies in the construction of the facility that are likely to cause serious injury, harm or impairment to the public health and welfare; or

(b) The facility has submitted building plans to the Bureau before February 1, 1999, and:

(1) The Bureau determines that the plans comply with standards for construction in effect before December 11, 1998;

(2) The facility is constructed in accordance with those standards;

(3) Construction of the facility is begun before August 1, 1999; and

(4) There are no deficiencies in the construction of the facility that are likely to cause serious injury, harm or impairment to the public health and welfare.

4. Except as otherwise provided in subsection 5, a facility for skilled nursing shall comply with all applicable:

(a) Federal and state laws;

(b) Local ordinances, including, without limitation, zoning ordinances; and

(c) Life safety, environmental, health, fire and local building codes,

➥ related to the construction and maintenance of the facility. If there is a difference between state and local requirements, the more stringent requirements apply.

5. A facility for skilled nursing which is inspected and approved by the State Public Works Division of the Department of Administration in accordance with the provisions set forth in chapter 341 of NRS and chapter 341 of NAC is not required to comply with any applicable local building codes related to the construction and maintenance of the facility.

6. A facility for skilled nursing shall submit building plans for new construction or remodeling to the entity designated to review such plans by the Division of Public and Behavioral Health pursuant to NAC 449.0115. The entity's review of those plans is advisory only and does not constitute approval for the licensing of the facility. Before the construction or remodeling may begin, the plans for the construction or remodeling must be approved by the Division of Public and Behavioral Health. The Bureau shall not approve a facility for licensure until all construction is completed and a survey is conducted at the site of the facility.

Sec. 54. NAC 449.749 is hereby amended to read as follows:

449.749 As used in NAC 449.749 to 449.800, inclusive, ***and sections 11 and 12 of this regulation,*** unless the context otherwise requires:

1. "Branch office" means an office, other than the home office, from which a home health agency provides services.

2. "Home health agency" means an agency to provide nursing in the home as defined in NRS 449.0015.

3. "Home health aide" means a nursing assistant as defined in NRS 632.0166.

4. "Home office" means the central administrative office of a home health agency.

~~[5. "Subunit agency" means an agency owned and controlled by a central organization, corporate entity or home office, but operated and directed by governing and administrative~~

~~bodies separate from the central organization or any other unit owned and controlled by the central organization.]~~

Sec. 55. NAC 449.758 is hereby amended to read as follows:

449.758 1. Each license is separate and is issued to a specific person to operate a home health agency at a specific location. The home health agency must be operated and conducted in the name designated on the license with the designated service area and the name of the person responsible for its operation also appearing on the face of the license. The license is not transferable.

2. ~~[A separate license is required for each subunit agency.~~

~~3.]~~ Copies of the original license must be issued for each agency or branch of an agency which is maintained on separate premises under the same management.

~~[4.]~~ ***3.*** Each home health agency must have proof that it is adequately covered against liabilities resulting from claims incurred in the course of operation.

Sec. 56. NAC 449.788 is hereby amended to read as follows:

449.788 1. ~~[If needed patient services are not available within the agency, the agency must assist in directing the patient to other community resources.~~

~~2. Services must be supplied only by qualified personnel and under the supervision of a physician licensed to practice in this State Qualifications include]~~ ***A person providing services on behalf of a home health agency must possess any*** licensure, registration, certification or their equivalent ~~[, as]~~ required by state or federal law ***.*** ~~[, for each of the following disciplines:~~

~~(a) The professional registered nurse must hold a state license.~~

~~(b) The practical nurse must hold a state license.~~

~~(c) The home health aide must hold a certificate as a nursing assistant issued by the State Board of Nursing.~~

~~(d) The physical therapist must be registered in this State.~~

~~(e) The occupational therapist must meet the requirements of the American Occupational Therapy Association or the equivalent thereof.~~

~~(f) The speech therapist must hold a certificate from the American Speech-Language-Hearing Association or the equivalent thereof.~~

~~(g) The social worker must be licensed pursuant to chapter 641B of NRS.~~

~~(h) The~~

2. A nutritionist ***providing services on behalf of a home health agency*** must ~~[have a bachelor of science degree in home economics in foods and nutrition or the equivalent thereof.~~

~~(i) The inhalation therapist must be registered by the American Association of Inhalation Therapists or the equivalent thereof.~~

~~3. The agency is responsible for bonding all personnel.]~~ ***be a dietitian licensed pursuant to chapter 640E of NRS.***

Sec. 57. NAC 449.793 is hereby amended to read as follows:

449.793 1. The governing body ~~[of an]~~ ***or other entity responsible for the operation of a home health*** agency ~~[is responsible for providing for an evaluation of the agency once a year. The purpose of the evaluation is to audit, review policies and procedures, recommend additions or changes and ensure that the policies and regulations are being met.~~

~~2. A committee shall review all contracts and charters held by the agency to ascertain that:~~

~~(a) Existing contracts are legal and up to date.~~

~~(b) The existing contracts meet the needs of all parties involved.~~

~~3. A committee shall review the management and office procedures of the agency to ascertain that:~~

~~(a) The agency is being operated in the most effective and economical means while still giving quality service.~~

~~(b) All office procedures are up to date, filing is correctly done and bookkeeping is meeting accepted accounting procedures and is current.~~

~~(c) Equipment is in good repair and adequately meets operational needs.~~

~~4. The committee shall submit a report to the governing body with any recommendations for changes and pertinent observations as it deems necessary.~~

~~5. A committee shall review the medical and personnel policies to ensure that the policies are being fulfilled and necessary changes or additions are effected.~~

~~6. The governing body]~~ shall ***appoint a committee to*** provide for a quarterly review of 10 percent of the records of patients who have received services ***from the agency*** during the preceding 3 months in each service area. The members of the committee must include an administrative representative, a physician, a registered nurse and a clerk or librarian who keeps records.

2. The clerk or librarian ***of the committee*** shall review the clinical records to ensure that they are complete, that all forms are properly filled out and that documentation complies with good medical practices.

3. The committee shall ~~[determine]~~ ***:***

(a) Determine whether the services have been provided to the patients in an adequate and appropriate manner by all levels of service ~~[. The committee shall record]~~ ***; and***

(b) Record any deficiencies and make necessary recommendations to the administrator.

4. If the branch offices ***of a home health agency*** are small, two or more offices may establish one committee to review cases from each area. ~~[Each subunit agency must establish a committee to review cases within its area. Minutes]~~

5. The committee shall ensure that minutes of the committee's meetings ~~[must be]~~ ***are*** documented and ***make the minutes*** available ***to personnel of the Division*** for review ~~[.]~~ ***upon request.***

Sec. 58. NAC 449.794 is hereby amended to read as follows:

449.794 ~~[1. Clinical records must be kept for all patients who are receiving services directly from a]~~ ***A*** home health agency ~~[or by contract with other health agencies or therapists. The records must contain pertinent past and current medical, nursing, social and therapeutic data.

2. The]~~ ***shall maintain*** clinical records ~~[of patients who are receiving services must be kept on file in the home office and in each subunit agency and branch office and may not be removed except for activities relating to their utilization and review.

3. Clinical records must be kept on file for 5 years after the discharge of a patient from service.]~~ ***in the manner prescribed by NRS 629.051.***

Sec. 59. NAC 449.797 is hereby amended to read as follows:

449.797 ~~[Clinical]~~ ***The clinical*** records ***of a home health agency*** must contain:

1. ~~[The name, address and telephone number of the person who will be notified in an emergency involving the patient.

2.]~~ Information as to whether home health services are after hospitalization in a hospital, skilled nursing facility or other health service facility and, if so, the dates of admission and discharge from these facilities.

~~[3.]~~ ***2.*** A clinical summary from the hospital, skilled nursing facility or other health service facility from which the patient is transferred to the home health agency.

~~[4. A plan for patient care which includes:~~

~~(a) Objectives and approaches for providing services.~~

~~(b) Diagnoses of all medical conditions relevant to a plan of treatment.~~

~~(c) Physical traits pertinent to the plan for care.~~

~~(d) Nursing services required and the level of care and frequency of visits, special care which is required, such as dressing and catheter changes, and specific observations to be brought to the physician's attention.~~

~~(e) Requirements of therapy, such as physical, speech, occupational or inhalation therapy with specific instructions for each.~~

~~(f) Requirements of activity, such as the degree allowed and any assistance required.~~

~~(g) Medical appliances needed, such as crutches, walkers, braces or equipment for respiratory care.~~

~~(h) Nutritional needs.~~

~~(i) Medical supplies needed, such as dressings or irrigation sets.~~

~~(j) The degree of participation of the family in the care.~~

~~5.]~~ ***3.*** A copy of:

(a) The patient's durable power of attorney for health care, if the patient has executed such a power of attorney pursuant to NRS ~~[449.800 to 449.860,]~~ ***162A.700 to 162A.870,*** inclusive; and

(b) A declaration governing the withholding or withdrawal of life-sustaining treatment, if the patient has executed such a declaration pursuant to NRS 449A.433.

~~[6. Nurses' notes that follow a good medical format, including pertinent observations regarding a patient's physical and mental status, procedures done, examinations, dietary status and recommendations.~~

~~7. Therapists' notes, if applicable, stating the rehabilitative procedures, progress and the types, duration and frequency of the modalities rendered.~~

~~8. A written evaluation for services made at the time the patient is admitted for care. Regular written reevaluations for services and assessments of patients made on a continuing basis.~~

~~9. A report given to the attending physician, written or by phone, whenever unusual findings occur. A written progress note must be submitted to the physician at least every 62 days.~~

~~10.]~~ ***4.*** A record of the termination of services, including the date and reason for termination and the time when the physician was notified of the termination.

Sec. 60. NAC 449.800 is hereby amended to read as follows:

449.800 1. A complete diagnosis must be included with the ~~[medical]~~ orders ***of a physician, physician assistant or advanced practice registered nurse*** as well as any relevant problems.

2. Initial ~~[medical]~~ orders ~~[,]~~ ***of a physician, physician assistant or advanced practice registered nurse,*** renewals and changes of orders for skilled nursing and other therapeutic services submitted by telephone must be recorded before they are carried out. All ~~[medical]~~ orders must bear the signature of the physician ***, physician assistant or advanced practice registered nurse*** who initiated the order within 20 working days after the receipt of the oral order.

3. Orders must be specific regarding the level of care and the service given.

4. Medication orders must include:

(a) The name of the drug.

(b) The exact dosage in units, milligrams, grams or other measurements.

(c) Frequency.

(d) The duration of treatment.

(e) The method of administration.

(f) Any special precautions, including requests for ~~[doctor's]~~ orders ***of a physician, physician assistant or advanced practice registered nurse*** for the use of adrenaline for possible anaphylaxis.

5. The agency must have an established policy regarding the administration of injectable narcotics and other drugs subject to the drug abuse law. If the policy allows the administration of injectable narcotics and other dangerous drugs subject to drug abuse law, they must be prescribed according to state regulations.

6. Specific orders must be given for:

(a) Rehabilitative and restorative care such as physiotherapy;

(b) Skilled nursing and home health aide care;

(c) Nutritional needs;

(d) The degree of activity permitted;

(e) Dressings and the frequency of change;

(f) The instruction of a member of the family in technical nursing procedures; and

(g) Any other items necessary to complete a specific plan of treatment for the patient.

7. ~~[All orders]~~ ***An order*** must be renewed in writing by the physician ***, physician assistant or advanced practice registered nurse who issued the order*** at least every 62 days.

8. New orders are required when there is a change in diagnosis, a change in orders, a change of physician ***, physician assistant or advanced practice registered nurse*** or following hospitalization.

Sec. 61. NAC 449.801 is hereby amended to read as follows:

449.801 As used in NAC 449.801 to 449.861, inclusive, ***and sections 15 and 16 of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 449.802 to 449.816, inclusive, have the meanings ascribed to them in those sections.

Sec. 62. NAC 449.818 is hereby amended to read as follows:

449.818 ***1.*** An application for a provisional ~~[certificate]~~ ***license*** must be submitted to the Division on a form furnished by the Division accompanied by a nonrefundable fee of $100 and must include:

~~[1.]~~ ***(a)*** For an applicant who is a natural person:

~~[(a)]~~ ***(1)*** Three or more letters of professional reference;

~~[(b)]~~ ***(2)*** A certification, signed by the applicant, that the applicant will maintain the confidentiality of information relating to any person who receives services;

~~[(c)]~~ ***(3)*** Proof that the applicant has successfully completed a course in cardiopulmonary resuscitation according to the guidelines of the American Red Cross or American Heart Association;

~~[(d)]~~ ***(4)*** Proof that the applicant is currently certified in standard first aid through a course from the American Red Cross or American Heart Association or, if the applicant submits proof that the course meets or exceeds the requirements of the American Red Cross or the American Heart Association, an equivalent course in standard first aid;

~~[(c)]~~ ***(5)*** Written verification, on a form prescribed by the Division, that the fingerprints of the applicant were taken and forwarded electronically or by another means directly to the Central Repository for Nevada Records of Criminal History and that the applicant has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Division deems necessary for reports on the applicant's background to the Division and the applicant;

~~[(f)]~~ ***(6)*** A copy of the social security card of the applicant;

~~[(g)]~~ ***(7)*** A copy of a form of government-issued identification, which may include, without limitation, a passport, identification card or driver's license;

~~[(h)]~~ ***(8)*** An attestation that the applicant has sufficient working capital to effectively provide services and, if the applicant proposes to provide services in a facility, operate the facility;

~~[(i)]~~ ***(9)*** If applicable, a copy of the applicant's state business license and a copy of the current business license issued for the applicant's business by the county, city or town in which the applicant's business is located or written verification that the applicant is exempt from any requirement to obtain a business license; and

~~[(j)]~~ ***(10)*** Any other information required by the Division.

~~[2.]~~ ***(b)*** For an applicant other than a natural person:

~~[(a)]~~ ***(1)*** If applicable, a copy of the state business license of the organization and a copy of the current business license issued for the applicant's business by the county, city or town in which the applicant's business is located or written verification that the applicant is exempt from any requirement to obtain a business license;

~~[(b)]~~ ***(2)*** The federal tax identification number of the organization;

~~[(c)]~~ ***(3)*** A copy of the bylaws, articles of incorporation, articles of association, articles of organization, partnership agreement, constitution and any other substantially equivalent documents of the applicant, and any amendments thereto;

~~[(d)]~~ ***(4)*** A list of the members of the governing body of the applicant;

~~[(e)]~~ ***(5)*** If the applicant is an association or a corporation:

~~[(1)]~~ ***(I)*** The name, title and principal business address of each officer and member of its governing body;

~~[(2)]~~ ***(II)*** The signature of the chief executive officer or an authorized representative; and

~~[(3)]~~ ***(III)*** If the applicant is a corporation, the name and address of each person holding more than 10 percent of its stock;

~~[(f)]~~ ***(6)*** For each member of the governing body:

~~[(1)]~~ ***(I)*** Three or more letters of professional reference; and

~~[(2)]~~ ***(II)*** Written verification, on a form prescribed by the Division, that the fingerprints of the member of the governing body were taken and forwarded electronically or by another means directly to the Central Repository for Nevada Records of Criminal History and that the member of the governing body has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Division deems necessary for reports on the member's background to the Division and the applicant;

~~[(g)]~~ ***(7)*** An attestation that the applicant has sufficient working capital to effectively provide services and, if the applicant proposes to provide services in a facility, operate the facility;

~~[(h)]~~ ***(8)*** Copies of any policies and procedures of the applicant relating to the provision of services; and

~~[(i)]~~ ***(9)*** Such other information as may be required by the Division.

2. An applicant for a provisional license shall post a surety bond in an amount equal to the operating expenses of the applicant for 2 months, place that amount in escrow or take another action prescribed by the Division to ensure that, if the applicant becomes insolvent, recipients of community-based living arrangement services from the applicant may continue to receive community-based living arrangement services for 2 months at the expense of the applicant.

3. As used in this section:

(a) "Electronic signature" means a user name attached to or logically associated with a record and executed or adopted by a person with the intent to sign an electronic application or other document.

(b) "Signature" includes, without limitation, an electronic signature.

Sec. 63. NAC 449.826 is hereby amended to read as follows:

449.826 A provider shall:

1. Comply with any state or federal statute or regulation as required for the Division to receive state or federal money for the provision of services, including, without limitation, any standard of care set forth in:

(a) The State Plan for Medicaid; and

(b) The *Medicaid Services Manual* established by the Division of Health Care Financing and Policy of the Department of Health and Human Services.

2. Comply with all applicable state or federal requirements concerning fiscal management, reporting and employment.

3. Comply with the individualized plan prepared pursuant to NAC 449.835 for each person who receives services.

4. Assure the health and welfare of persons receiving services. Any assessment by the Division of a provider's compliance with the requirements of this subsection must be based upon the self-reporting of persons receiving services from the provider, the observations of members of the staff of the Division and any other information available to the Division.

5. Establish internal procedures for quality assurance.

6. Promptly report to the Division any change in the officers or ownership of the provider.

7. Cooperate with any investigation by the Division.

8. Monitor the living environment of persons receiving services from the provider and establish policies to immediately assist such persons who are living in unsafe or unhealthy environmental conditions to correct those conditions or in finding alternative residences.

9. Develop and implement policies concerning the hiring of persons who will provide services.

10. Maintain a personnel file for each employee or independent contractor who provides services. The personnel file must contain, without limitation:

(a) Information concerning the job duties, essential functions, physical capabilities and language proficiency of the employee or contractor; and

(b) Proof that the employee or independent contractor is in compliance with the requirements of NAC 449.831, if applicable.

11. Ensure that each employee or independent contractor who provides services is capable of:

(a) Carrying out the responsibilities established in the individualized plan established pursuant to NAC 449.835 for each person to whom the employee or independent contractor provides services and properly qualified by training and experience to do so; and

(b) Communicating effectively with each person to whom the employee or independent contractor provides services.

12. Comply with the policies adopted by the Commission on Behavioral Health pursuant to subsection 1 of NRS 433.314.

13. Maintain a staff sufficient to meet the needs of each person receiving services from the provider in accordance with the individualized plan established for the person pursuant to NAC 449.835.

Sec. 64. NAC 449.97026 is hereby amended to read as follows:

449.97026 1. Except as otherwise provided in subsection 5, a parent facility or independent facility which is issued a license to operate a mobile unit shall ensure that the mobile unit complies with the applicable provisions of the guidelines adopted by reference in paragraphs (c) ***,*** ~~[and]~~ (d) ***and (e)*** of subsection 1 of NAC 449.0105.

2. Except as otherwise provided in subsection 4, before any new construction of a mobile unit or any remodeling of an existing mobile unit is begun:

(a) The parent facility or independent facility that applies for the license to operate the mobile unit or that has been issued the license to operate the mobile unit must submit a copy of the building plans for the new construction or remodeling to the entity designated to review such plans by the Division pursuant to the provisions of NAC 449.0115; and

(b) The building plans must be approved by the Division.

3. The building plans submitted for review and approval as required pursuant to subsection 2 must be drawn to scale and include a statement indicating:

(a) The services and procedures that will be provided at the mobile unit; and

(b) Each staging area designated by the parent facility or independent facility for the mobile unit.

4. A parent facility or independent facility is not required to submit plans for remodeling to the entity designated to review such plans by the Division pursuant to the provisions of NAC 449.0115 if the remodeling is limited to refurbishing an area within a mobile unit, including, without limitation, painting the area, replacing the flooring in the area, repairing the windows in the area, and replacing window or wall coverings in the area.

5. A parent facility or independent facility which is issued a license to operate a mobile facility shall ensure that the mobile unit for which the license is issued:

(a) Complies with any applicable zoning regulation for each staging area designated for the mobile unit;

(b) Is of sufficient size and is arranged in a manner that is appropriate to provide the services for which the mobile unit is licensed;

(c) Is furnished with the appropriate equipment to provide for the comfort and safety of each patient who receives services at the mobile unit;

(d) Is maintained in good repair and in a clean and sanitary manner; and

(e) During any period in which the operator of the mobile unit provides services at the mobile unit:

(1) Is located and illuminated in such a manner that each patient who receives services at the mobile unit may safely and comfortably enter and exit the mobile unit; and

(2) Complies with any applicable statute, ordinance or regulation relating to the parking of the mobile unit.

Sec. 65. NAC 449.971 is hereby amended to read as follows:

449.971 As used in NAC 449.971 to ~~[449.996,]~~ ***449.997,*** inclusive, ***and sections 13 and 14 of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 449.9715 to 449.9743, inclusive, have the meanings ascribed to them in those sections.

Sec. 66. NAC 449.9843 is hereby amended to read as follows:

449.9843 1. An ambulatory surgical center shall comply with the provisions of *NFPA 99: Health Care Facilities Code* concerning medical gases, adopted by reference pursuant to NAC 449.0105, and the provisions of *NFPA 101: Life Safety Code*, adopted by reference pursuant to NAC 449.0105.

2. Any new construction, remodeling or change in the use of an ambulatory surgical center must comply with the applicable provisions of the guidelines adopted by reference in paragraphs (c) ***,*** ~~[and]~~ (d) ***and (e)*** of subsection 1 of NAC 449.0105, unless the remodeling is limited to refurbishing an area within the center, including, without limitation, painting the area, replacing flooring in the area, repairing windows in the area and replacing window or wall coverings in the area.

3. An ambulatory surgical center shall be deemed to be in compliance with the provisions of subsection 2 and subsection 2 of NAC 449.983 if:

(a) The center is licensed on February 1, 1999, the use of the physical space in the center is not changed and there are no deficiencies in the construction of the center that are likely to cause serious injury, harm or impairment to the public health and welfare; or

(b) The center has submitted building plans to the Bureau before February 1, 1999, and:

(1) The Bureau determines that the plans comply with standards for construction in effect before December 11, 1998;

(2) The center is constructed in accordance with those standards;

(3) Construction of the center is begun before August 1, 1999; and

(4) There are no deficiencies in the construction of the center that are likely to cause serious injury, harm or impairment to the public health and welfare.

4. An ambulatory surgical center shall comply with all applicable:

(a) Federal and state laws;

(b) Local ordinances, including, without limitation, zoning ordinances; and

(c) Life safety, environmental, health, fire and local building codes.

➥ If there is a difference between state and local requirements, the more stringent requirements apply.

5. An ambulatory surgical center shall submit building plans for new construction or remodeling to the entity designated to review such plans by the Division pursuant to NAC 449.0115. The entity's review of those plans is advisory only and does not constitute approval for the licensing of the center. Before the construction or remodeling may begin, the plans for the construction or remodeling must be approved by the Division. The Bureau shall not approve a center for licensure until all construction is completed and a survey is conducted at the site of the center.

Sec. 67. NAC 449.9935 is hereby amended to read as follows:

449.9935 1. The operating and recovery rooms of an ambulatory surgical center must be used exclusively for surgical procedures.

2. Except as otherwise provided in subsection 3, surgical procedures must be conducted in ~~[a]~~ ***an ambulatory surgical center designated as*** class A, B or C ~~[operating room]~~ ***pursuant to section 13 of this regulation*** in accordance with the applicable provisions of the guidelines adopted by reference in paragraphs (c) ***,*** ~~[and]~~ (d) ***and (e)*** of subsection 1 of NAC 449.0105.

3. If an ambulatory surgical center is ~~[licensed to perform only endoscopic procedures,]~~ ***designated as Endoscopy Only pursuant to section 13 of this regulation,*** such procedures may be conducted in an endoscopy suite in accordance with the applicable provisions of the guidelines adopted by reference in paragraphs (c) ***,*** ~~[and]~~ (d) ***and (e)*** of subsection 1 of NAC 449.0105.

4. A registered nurse experienced in surgical procedures shall supervise the operating room.

5. Only a registered nurse may function as the circulating nurse in the operating room.

6. Each employee of an ambulatory surgical center who provides medical services and care to a patient must be trained to carry out the medical services and care that the employee will provide.

7. The operating room must be equipped with:

(a) A system for making emergency calls;

(b) Oxygen;

(c) Mechanical ventilatory assistance equipment, including, without limitation, a manual breathing bag and a ventilator;

(d) Cardiac monitoring equipment;

(e) Laryngoscopes and endotracheal and airway tubes in sizes sufficient to meet the needs of the patients of the ambulatory surgical center; and

(f) Suction equipment.

8. The recovery room must:

(a) Meet nationally recognized standards of practice for postanesthesia care, as approved by the governing body, and maintain a copy of those standards at the ambulatory surgical center during all hours of operation and in a location which is accessible to the medical staff;

(b) Comply with the guidelines for postanesthesia patient classification and staffing recommendations as published in the ~~[~~2010-2012~~]~~ ***2021-2022*** *Perianesthesia Nursing Standards* **,** ~~[~~and~~]~~ *Practice Recommendations* ~~[,]~~ ***and Interpretive Statements,*** which is adopted by reference in subsection 10;

(c) Be equipped with or have easily accessible a mobile cart which contains the equipment and supplies specified by the medical staff pursuant to subsection 3 of NAC 449.9902 needed to treat a patient with malignant hyperthermia; and

(d) Be equipped with all other equipment and supplies needed to safely care for patients.

9. If the operating team consists of persons who are not physicians, a physician must be on the premises and immediately available in case of an emergency. As used in this subsection, "immediately available" means the physician is able to respond rapidly to the emergency.

10. The ~~[~~2010-2012~~]~~ ***2021-2022*** *Perianesthesia Nursing Standards* **,** ~~[~~and~~]~~ *Practice Recommendations* ~~[,]~~ ***and Interpretive Statements,*** published by the American Society of PeriAnesthesia Nurses is hereby adopted by reference. A copy of the standards may be obtained at a cost of ~~[~~$60~~]~~ ***$75*** for members and ~~[~~$130~~]~~ ***$180*** for nonmembers from the American Society

of PeriAnesthesia Nurses by mail at 90 Frontage Road, Cherry Hill, New Jersey 08034-1424, by telephone at (877) 737-9696 or at the Internet address **http://www.aspan.org**.

11. The Division shall review each revision of the publication adopted by reference in subsection 10 to ensure its suitability for this State. If the Division determines that a revision is not suitable for this State, the Division shall hold a public hearing to review its determination within 12 months after the date of the publication of the revision and give notice of that hearing. If, after the hearing, the Division does not revise its determination, the Division shall give notice within 30 days after the hearing that the revision is not suitable for this State. If the Division does not give such notice, the revision becomes part of the publication adopted by reference in subsection 10.

Sec. 68. NAC 449.996 is hereby amended to read as follows:

449.996 1. An ambulatory surgical center shall establish written guidelines for transferring patients to a licensed ~~[general]~~ hospital ***that has medical and surgical capabilities*** using an ambulance or air ambulance for emergencies that require medical care which is not provided at the center. The guidelines must be approved by the governing body of the ambulatory surgical center.

2. ~~[Each ambulatory surgical center shall maintain with a licensed general hospital a written agreement concerning the transfer of patients. The agreement must provide for the security of, and the accountability for, the personal effects of the patient.~~

~~3.]~~ If a patient is transferred, all medical and administrative information relating to the patient must be transferred with him or her or promptly made available to the licensed center or agency responsible for the patient's continuing care.

Sec. 69. NAC 449.99718 is hereby amended to read as follows:

449.99718 1. A recovery center must be designed, constructed, equipped and maintained in a manner that protects the health and safety of the patients and personnel of the recovery center and members of the general public.

2. A recovery center shall comply with all applicable:

(a) Federal and state laws;

(b) Local ordinances, including, without limitation, zoning ordinances; and

(c) Life safety, environmental, health, fire and local building codes,

➥ related to the construction and maintenance of the recovery center. If there is a difference between state and local requirements, the more stringent requirements apply.

3. Except as otherwise provided in this section:

(a) Each recovery center shall comply with the provisions of *NFPA 101: Life Safety Code*, as adopted by reference pursuant to NAC 449.0105.

(b) Any new construction, remodeling or change in use of a recovery center must comply with the ~~[Guidelines for Design and Construction of Hospitals and Outpatient Facilities, as]~~ ***applicable provisions of the guidelines*** adopted by reference ~~[pursuant to]~~ ***in paragraphs (c), (d) and (e) of subsection 1 of*** NAC 449.0105, unless the remodeling is limited to refurbishing an area within the recovery center, including, without limitation, painting the area, replacing the flooring, repairing windows or replacing window and wall coverings.

4. A recovery center shall be deemed to be in compliance with the provisions of subsection 3 if:

(a) The recovery center:

(1) Was licensed as a facility for intermediate care pursuant to NRS 449.040 to 449.094, inclusive, before September 21, 2017;

(2) Is seeking to change its operation as an intermediate care facility to a recovery center;

(3) Does not change the use of the physical space in the recovery center; and

(4) Does not have any deficiencies in the construction of the recovery center that are likely to cause serious injury, harm or impairment to the health and welfare of the public; or

(b) Before September 21, 2017, the recovery center initially applied for licensure as an intermediate care facility pursuant to NRS 449.040 to 449.094, inclusive, and:

(1) The recovery center submitted building plans to the Division in the manner set forth in NAC 449.0115;

(2) The Division determines that the plans comply with the standards for construction of intermediate care facilities, which are set forth in NAC 449.685 to 449.728, inclusive;

(3) Construction of the recovery center has commenced;

(4) The center is constructed in accordance with such standards; and

(5) There are no deficiencies in the construction of the recovery center that are likely to cause serious injury, harm or impairment to the health and welfare of the public.

5. A recovery center shall submit building plans for new construction or remodeling to the entity designated to review such plans by the Division pursuant to NAC 449.0115. The entity's review of those plans is advisory only and does not constitute approval for the licensing of the recovery center. Before the construction or remodeling may begin, the plans for the construction or remodeling must be approved by the Division. The Division shall not approve a recovery center for licensure until all construction or remodeling has been completed and a survey is conducted at the site of the recovery center.

Sec. 70. NAC 449.99732 is hereby amended to read as follows:

449.99732 1. A recovery center shall ensure that each patient admitted to the center receives:

(a) Meals at regular intervals; and

(b) A therapeutic diet if such a diet is prescribed by the attending physician ***, physician assistant, dentist, advanced practice registered nurse or podiatric physician*** of the patient ~~.~~ ***or ordered by a licensed dietitian.***

2. A recovery center shall provide to each patient admitted to the center:

(a) Food that is prepared to conserve the nutritional value and flavor of the food.

(b) Food that is nourishing, palatable, attractive and served at the proper temperature.

(c) A well-balanced diet that meets the daily nutritional and special dietary needs of the patient.

3. A recovery center shall provide each patient in the center with sufficient fluids to maintain proper hydration and health.

4. A recovery center shall:

(a) Comply with the applicable provisions of chapter 446 of NRS and chapter 446 of NAC and obtain such permits as are necessary from the Division for the preparation and service of food;

(b) Maintain a report of each inspection concerning the sanitation of the center for at least 1 year after the date of the inspection;

(c) Maintain a report of each corrective action taken to address a deficiency noted in a report described in paragraph (b) for at least 1 year after the date of the corrective action;

(d) Procure food from sources that are approved or considered satisfactory by federal, state and local authorities;

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

(f) Dispose of refuse and garbage properly.

Sec. 71. NAC 449.99758 is hereby amended to read as follows:

449.99758 1. A recovery center shall provide such pharmaceutical services, including, without limitation, acquiring, receiving, dispensing and administering drugs and biologicals, as are required to meet the needs of the patients admitted to the center. The recovery center shall provide such drugs and biologicals as are needed or obtain them from a qualified outside source pursuant to NAC 449.99754.

2. A recovery center shall employ or otherwise obtain the services of a registered pharmacist who shall:

(a) Provide consultations on all matters relating to the pharmaceutical services provided by the center;

(b) Establish a system of records for the receipt and disposition of all controlled substances in the center in sufficient detail to ensure an accurate reconciliation; and

(c) Ensure that those records are in order and that an account of all controlled substances in the center is maintained and periodically reconciled.

3. The regimen of drugs for each patient admitted to the recovery center must be reviewed at least once each month by a registered pharmacist. The pharmacist shall report any irregularities he or she discovers to the patient's attending physician and the chief administrative nurse of the recovery center. The physician and chief administrative nurse shall take such actions as they deem necessary in the response to the report.

4. Drugs and biologicals provided by a recovery center must be:

(a) Labeled in accordance with state and federal law and accepted professional standards. Each label must include the appropriate accessory and cautionary instructions and the expiration date, if applicable.

(b) Stored in accordance with state and federal law in locked compartments with proper controls for the temperature. Only authorized personnel may have access to the keys to unlock such compartments. Substances listed as schedule II controlled substances pursuant to chapter 453 of NRS and other drugs that have the potential for abuse must be stored separately in a locked compartment that is immovable, unless the recovery center uses a system to distribute the substances or drugs in single-unit packages, the quantity stored is minimal and any dosage that is missing can be readily detected.

5. A recovery center that operates a pharmacy shall obtain a license from the State Board of Pharmacy pursuant to NRS 639.2177 and comply with the regulations adopted by the State Board of Pharmacy pursuant to that section.

6. A chart order for a patient at a recovery center must be signed by the prescribing practitioner within the time period set forth in NRS 639.23275.

7. As used in this section, "practitioner" has the meaning ascribed to it in NRS 639.0125.

Sec. 72. NAC 449.9982 is hereby amended to read as follows:

449.9982 As used in NAC 449.9982 to 449.99939, inclusive, ***and section 17 of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 449.99821 to 449.99841, inclusive, have the meanings ascribed to them in those sections.

Sec. 73. NAC 449.99856 is hereby amended to read as follows:

449.99856 1. ~~[The]~~ ***Except as otherwise provided in section 6 of this regulation, the*** Bureau may apply one or more sanctions on the basis of deficiencies found during surveys or investigations of complaints conducted by the Bureau.

2. Deficiencies must be reported to the facility and, if applicable, to the Centers for Medicare and Medicaid Services. The notice to the facility must specify the deficiencies found and the severity and scope score for each deficiency determined by the Bureau.

3. Any deficiency for which a severity and scope score is not specified is presumed to be a de minimis deficiency.

4. A notice of deficiencies is confidential until 14 days after the date on which the notice is sent to the facility.

Sec. 74. NAC 449.9987 is hereby amended to read as follows:

449.9987 1. The facility shall develop a plan of correction for each deficiency and submit the plan to the Bureau for approval within 10 days after receipt of the statement of deficiencies. The plan of correction must include specific requirements for corrective action, which must include times within which the deficiencies are to be corrected.

2. If the plan is not acceptable to the Bureau, the Bureau may direct the facility to resubmit a plan of correction or the Bureau may develop a directed plan of correction with which the facility must comply.

3. Failure to submit the plan of correction to the Bureau within 10 days constitutes a separate deficiency subject to monetary penalties with severity and scope rated at the same levels as the highest deficiency identified on the notice of deficiencies.

4. Except as otherwise provided in this subsection, a plan of correction that has not been approved by the Bureau is confidential. The Bureau may provide such a plan of correction to

any entity within the Department of Health and Human Services or the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. If the Bureau develops a directed plan of correction pursuant to subsection 2, the unapproved plan of correction submitted by the facility pursuant to subsection 1 and the directed plan of correction cease to be confidential 14 days after the date on which the Bureau sends the directed plan of correction to the facility.

Sec. 75. NAC 450B.786 is hereby amended to read as follows:

450B.786 "Center for the treatment of trauma" means a ~~[general]~~ hospital licensed in this State which has been designated as a level I, II or III center by the Administrator of the Division, pursuant to the provisions of NAC 450B.780 to 450B.875, inclusive.

Sec. 76. NAC 450B.838 is hereby amended to read as follows:

450B.838 To be designated as a level I center for the treatment of trauma, a licensed ~~[general]~~ hospital must:

1. Meet all of the criteria for a level I center for the treatment of trauma set forth in chapters 16 and 23 of *Resources for Optimal Care of the Injured Patient*.

2. Receive a verification from the American College of Surgeons, or an equivalent medical organization approved by the Board, that confirms that the center meets the standards for a level I center for the treatment of trauma.

Sec. 77. NAC 450B.845 is hereby amended to read as follows:

450B.845 To be designated as a pediatric center for the treatment of trauma, a licensed ~~[general hospital or licensed medical-surgical]~~ hospital must:

1. Meet all of the criteria for a pediatric center for the treatment of trauma set forth in chapters 5, 10, 16 and 23 of *Resources for Optimal Care of the Injured Patient*.

2. Meet the minimum criteria for a level I or II center for the treatment of trauma and demonstrate a commitment to the treatment of persons who are less than 15 years of age in accordance with chapters 10 and 23 of *Resources for Optimal Care of the Injured Patient*.

3. Receive a verification from the American College of Surgeons, or an equivalent organization approved by the Board, that confirms that the center meets the standards for a pediatric center for the treatment of trauma.

Sec. 78. NAC 450B.852 is hereby amended to read as follows:

450B.852 To be designated as a level II center for the treatment of trauma, a licensed ~~[general]~~ hospital must:

1. Meet all of the criteria for a level II center for the treatment of trauma set forth in chapters 16 and 23 of *Resources for Optimal Care of the Injured Patient*.

2. Receive a verification from the American College of Surgeons, or an equivalent organization approved by the Board, that confirms that the center meets the standards for a level II center for the treatment of trauma.

Sec. 79. NAC 450B.866 is hereby amended to read as follows:

450B.866 To be designated as a level III center for the treatment of trauma, a licensed ~~[general]~~ hospital must:

1. Meet all of the criteria for a level III center for the treatment of trauma set forth in chapters 16 and 23 of *Resources for Optimal Care of the Injured Patient*.

2. Receive verification from the American College of Surgeons, or an equivalent medical organization approved by the Board, that confirms that the center complies with the standards for a level III center for the treatment of trauma.

Sec. 80. This regulation is hereby amended by adding thereto the following transitory language which has the force and effect of law but which will not be codified in the Nevada Administrative Code:

A hospital or the administrator of an independent center for emergency medical care shall:

1. Ensure that each employee of the hospital or independent center for emergency medical care, as applicable, who is employed on the effective date of this regulation and provides care to victims of sexual assault or attempted sexual assault is provided the training required by paragraph (f) of subsection 1 of NRS 449.0302 not later than 60 days after the effective date of this regulation and at least biennially thereafter; and

2. Maintain evidence of compliance with the requirements of paragraph (a) in the personnel file for each employee who is subject to those requirements.

Sec. 81. NAC 449.0127, 449.27821, 449.285, 449.770, 449.773, 449.776, 449.779, 449.785, 449.787, 449.791 and 449.838 are hereby repealed.

TEXT OF REPEALED SECTIONS

449.0127 "Subunit agency" defined. (NRS 449.0302) "Subunit agency" has the meaning ascribed to it in NAC 449.749.

449.27821 "Residential facility for groups" defined. (NRS 449.0302, 449.0305) "Residential facility for groups" has the meaning ascribed to it in NRS 449.017.

449.285 "General hospital" defined. (NRS 449.0302) "General hospital" means a hospital that is designated a general hospital pursuant to NRS 449.202.

449.770 Governing body; bylaws. (NRS 449.0302)

1. A home health agency must have an organized governing body or designated person who is legally responsible for the conduct of the agency.

2. The ownership of the home health agency must be disclosed to the Division. The governing body is responsible for compliance with all applicable local, state and federal laws and regulations.

3. The governing body shall appoint an advisory group of professional personnel, including one or more members who are practicing physicians, one or more professional registered nurses and representatives from other professional disciplines as indicated by the scope of the agency's program.

4. The governing body is responsible for periodic administrative and professional evaluations of the agency.

5. The governing body shall receive, review and take action on recommendations made by the evaluating groups and document those actions.

6. The governing body shall adopt bylaws or an acceptable equivalent in accordance with legal requirements. The bylaws must be written, revised as needed, and made available to all members of the governing body, the Division and the advisory group. The terms of the bylaws must include at least the following:

(a) The basis upon which members of the governing body are selected, their terms of office and their duties and responsibilities.

(b) A provision specifying to whom responsibilities for the administration and supervision of the program and the evaluation of practices may be delegated, and the methods established by the governing body for holding those persons responsible.

(c) A provision specifying the frequency of board meetings and requiring that minutes be taken at each meeting.

(d) A provision requiring the establishment of personnel policies.

(e) The agency's statements of objectives.

7. The governing body shall adopt policies for the agency including policies relating to admissions, care and discharge of patients.

8. The governing body is legally responsible for the appointment of a qualified administrator and the delegation of responsibility and authority.

9. The governing body shall ensure that the administrator has sufficient freedom from other responsibilities to permit adequate attention to the direction and management of the agency.

449.773 Administrator: Qualifications; duties. (NRS 449.0302)

1. The administrator must be a professional registered nurse or licensed physician, either of whom must be licensed in this State, or a person with training or experience in health administration. The administrator must have at least 1 year of supervisory or administrative experience in a field related to health.

2. The administrator shall represent the governing body in the daily operation of the agency. His or her responsibilities include:

(a) Keeping the governing body fully informed of the conduct of the agency through regularly written reports and by attendance at meetings of the governing body.

(b) Employing qualified personnel and arranging for their orientation and continuing education.

(c) Developing and implementing an accounting and reporting system that reflects the fiscal experience and financial position of the agency.

(d) Negotiating for services provided by contract in accordance with legal requirements and established policies of the agency.

(e) Holding periodic meetings to maintain a liaison between the governing body, the advisory groups and the members of the staff.

(f) Other duties as may be assigned.

3. The administrator shall appoint a person authorized to act in his or her absence. The person appointed by the administrator must possess the qualifications set forth in subsection 1.

449.776 Director of professional services. (NRS 449.0302)

1. The director of professional services must be a physician or a registered professional nurse licensed to practice in this State who is readily available through the agency's office to advise the members of the staff.

2. The director of professional services shall:

(a) Direct, supervise and coordinate the skilled nursing services and other therapeutic services provided by the agency.

(b) Develop and revise written objectives for the care of patients, policies and procedure manuals.

(c) Assist in the development of descriptions of jobs.

(d) Assist in the recruitment and selection of personnel.

(e) Recommend to the administrator the number and levels of members of the nursing staff.

(f) Plan and conduct orientations and continuing education for members of the staff engaged in the care of patients.

(g) Evaluate the performance of the nursing staff.

(h) Assist in planning and budgeting for the provision of services.

(i) Assist in establishing criteria for the admission and discharge of patients.

449.779 Professional advisory group. (NRS 449.0302)

1. The professional advisory group must be appointed by the governing body and shall assist in establishing written policies covering skilled nursing, other therapeutic services and other aspects of professional health. These policies must be reviewed at least annually and revised as necessary, and must cover the following:

(a) The scope of services offered;

(b) Administrative records;

(c) Personnel qualifications and responsibilities; and

(d) The evaluation of programs.

2. The professional advisory group must include at least one member who is a licensed practicing physician, one professional registered nurse, representatives from other professional disciplines as indicated by the scope of the agency's program and two members who are representatives of the general public served by the agency. At least one member of the advisory group may not be an owner or employee of the agency. The administrator or his or her designee shall attend all meetings of the advisory group.

3. The advisory group shall meet at regular intervals, but at least once a year. Dated minutes must reflect an evaluation of overall agency performance, including the availability of services,

the utilization of services and the quality of services. Recommendations must be forwarded to the governing body.

4. The advisory group must be available to advise the governing body on policies issued and the evaluation of programs.

5. The advisory group shall participate in a continuing program to acquaint the community with the established policies and the scope and availability of services provided by the agency and to promote appropriate utilization.

6. The member of the advisory group who is a physician shall interpret the established policies to the local medical society and to other physicians.

7. Brochures and pamphlets describing the home health services of the agency must be prepared with the advice of the advisory group and distributed to other community resources and the general public.

449.785 Contracts for home health services. (NRS 449.0302) If a home health agency provides home health services under a contract with another agency, person or nonprofit agency, it must require that such services be furnished in accordance with the terms of the written contract. The contract must:

1. Provide for retention by the primary agency of responsibility for and control of the services.

2. Designate the services which are to be provided, the setting and the geographical area served. Services provided must be within the scope and limitations set forth in the plan of treatment and may not be altered in type, amount, frequency or duration, except in the case of adverse reaction.

3. Describe how the contracted personnel are to be supervised.

4. Describe how services are coordinated with the primary agency.

5. Provide for the reporting of clinical notes and observations by contracted personnel for inclusion in the records of the primary home health agency to facilitate planning and evaluating patient care and to document the care given. Periodic progress notes by appropriate members of the staff must be submitted at least every 14 days and more often if warranted by the patient's condition.

6. Specify the method of determining charges and reimbursement by the primary agency for specific services provided under contract. Only the primary agency may bill for or collect for services.

7. Specify the period of time the contract is to be in effect and how frequently it is to be reviewed. The contract must be reviewed annually.

8. Assure that personnel and services contracted for, meet the requirements specified in NAC 449.749 to 449.800, inclusive, for home health agency personnel and services, including licensure, personnel qualifications, medical examination, functions, supervision, orientation, in-service education and case conferences.

9. Provide for the acceptance of patients for home health service only by the primary home health agency. Patients may not be admitted for home health service by any person without an appropriate review of the case and acceptance of the patient by the agency.

10. Assure that personnel and services contracted for will provide treatment to referred patients without regard to race, creed or national origin.

449.787 Duty to provide skilled nursing care and home health aide services; inclusion of additional services. (NRS 449.0302) A home health agency is directly responsible for providing skilled nursing care and home health aide services, and may include other services

such as physical therapy, occupational therapy, speech therapy, medical-social services, nutritional guidance, pharmaceutical services, appliances and equipment services.

449.791 Duties of personnel. (NRS 449.0302)

1. A registered nurse shall:

(a) Provide nursing guidance and care to patients at home.

(b) Evaluate the home for its suitability for the patient's care.

(c) Teach the patient and those in the home who nurse the patient how his or her care is to be given.

(d) Supervise and evaluate the patient's care on a continuing basis.

(e) Provide necessary professional nursing care.

2. A licensed practical nurse may perform certain nursing procedures under the supervision of the registered nurse.

3. The certified home health aide must be trained to function as a member of the health services team. Under the supervision of a registered nurse, he or she may:

(a) Give the patient personal care, including assistance in the activities of daily living.

(b) Perform certain household services to ensure that the patient's nutritional needs are met and to maintain a safe and clean environment for the patient.

4. The social worker shall:

(a) Help the medical team to understand the social and emotional factors affecting the patient and his or her family.

(b) Help the patient and his or her family to understand the medical team's activities.

(c) Assess the social and emotional impact of the program on the patient and his or her family.

5. The physical therapist shall:

(a) Assist the physician in the evaluation of the patient by giving functional ability tests.

(b) With the physician, help to develop and implement a plan for physical therapy for the patient.

(c) Instruct members of the health care team, the patient and his or her family in the procedures and techniques needed for his or her physical rehabilitation and maintenance.

6. The occupational therapist shall:

(a) Assist the physician in his or her evaluation of the patient's level of function and ability to perform activities of daily living.

(b) Help to develop and implement the patient's care plan.

(c) Instruct members of the health care team and family who participate in the patient's occupational therapy.

449.838 Training concerning administration of medication; persons authorized to administer medication. (NRS 433.324, 433.609, 439.200, 449.0302)

1. Each member of the direct support staff of a provider must successfully complete a program, approved by the Division, concerning the administration of medication.

2. A person who is receiving services may have his or her medication administered by:

(a) A provider of health care; or

(b) A member of the direct support staff of the provider if:

(1) The member of the direct support staff is a personal assistant who is authorized to administer medication by a provider of health care pursuant to NRS 629.091;

(2) The person or his or her parent or guardian, as applicable, provides written authorization to receive medication from a member of the direct support staff of the provider in accordance with NRS 453.375 and 454.213; and

(3) The person submits to a physical examination by his or her provider of health care on an annual basis and the provider of health care determines that the person is medically cleared to receive medication from the member of the direct support staff.

3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Errata – LCB File No. R048-22

Blue italic = Proposed language found in LCB File No. R048-22
~~***Red italic in bold***~~ = Proposed omitted material found in LCB File No. R048-22
Green italic = New language proposed as Errata

Section 1 is to be omitted from the proposed regulations.
~~***If the Chief Medical Officer determines that a pandemic exists or an epidemic exists within this State, the Chief Medical Officer may require any person or entity in this State to report to the Chief Medical Officer information prescribed by the Chief Medical Officer concerning the disease for which the pandemic or epidemic has been determined to exist.***~~

Section 5 is to be omitted from the proposed regulations.
Sec. 5. ~~***1. Except as authorized by this section, 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 shall not use audio or video monitoring equipment to monitor a patient or resident.***~~
~~***2. 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 may use audio or video monitoring equipment to monitor a patient or resident only if:***~~
~~***(a) The patient or resident or a person authorized by subsection 5 or 6 to serve as the representative of the patient or resident has requested or consented to the monitoring and agreed in writing to a specific duration for the monitoring;***~~
~~***(b) The monitoring is only used in the room in which the patient or resident sleeps;***~~
~~***(c) The monitoring does not violate any state or federal law, regulation or rule;***~~
~~***(d) The monitoring is conducted to protect the health, safety or personal property of the patient or resident; and***~~
~~***(e) If the patient or resident has a roommate, the roommate of the patient or resident or a person authorized by subsection 5 or 6 to serve as the representative of the roommate has also consented to the monitoring.***~~
~~***3. 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 must immediately stop using audio or video monitoring equipment to monitor a patient or resident if the patient or resident, a person authorized by subsection 5 or 6 to serve as the representative of the patient or resident, a roommate of the patient or resident or a person authorized by subsection 5 or 6 to serve as the representative of a roommate withdraws consent or becomes unable to consent.***~~
~~***4. At least quarterly, 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 that uses audio or video monitoring equipment to monitor a patient or resident shall, in consultation with the patient or resident or a person authorized by subsection 5 or 6 to serve as the representative of the patient or resident, reevaluate in writing the need for continued monitoring. The reevaluation must be:***~~
~~***(a) Signed and dated by the patient or resident or a person authorized by subsection 5 or 6 to serve as the representative of the patient or resident; and***~~
~~***(b) Maintained in the file of the patient or resident.***~~

~~*5. A court-appointed guardian or attorney-in-fact for a patient, a resident or the roommate of a patient or resident may serve as the representative of the patient, resident or roommate, as applicable, for the purposes of this section if:*~~
~~*(a) The patient, resident or roommate, as applicable, is unable to provide or withdraw consent; and*~~
~~*(b) A court order specifically authorizes the court-appointed guardian or attorney-in-fact to consent to the use of audio or video monitoring equipment to monitor the patient, resident or roommate, as applicable. The facility shall maintain a copy of the court order in the record of the patient, resident or roommate, as applicable.*~~
~~*6. A surrogate of a patient, a resident or the roommate of a patient or resident may serve as the representative of the patient, resident or roommate, as applicable, for the purpose of providing or withdrawing consent pursuant to this section only to the use of video monitoring equipment without audio capabilities to monitor the patient or resident if the patient, resident or roommate, as applicable, is unable to provide or withdraw consent.*~~
~~*7. As used in this section, "surrogate" means the following persons, in order of priority:*~~
~~*(a) The spouse of a patient or resident or of the roommate of a patient or resident;*~~
~~*(b) An adult child of a patient or resident or of the roommate of a patient or resident or, if there is more than one adult child, a majority of the adult children who are reasonably available for consultation;*~~
~~*(c) The parents of a patient or resident or of the roommate of a patient or resident;*~~
~~*(d) An adult sibling of a patient or resident or of the roommate of a patient or resident or, if there is more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation;*~~
~~*(e) The nearest other adult relative of a patient or resident or of the roommate of a patient or resident by blood or adoption who is reasonably available for consultation; or*~~
~~*(f) An adult who has exhibited special care or concern for a patient or resident or for the roommate of a patient or resident, is familiar with the values of the patient, resident or roommate, as applicable, and is willing and able to make health care decisions for the patient, resident or roommate, as applicable.*~~

Section 13 proposed changes are as follows:
Sec. 13. *1. An ambulatory surgical center [~~may~~] must be designated as Class A, Class B, Class C, Class E or Endoscopy Only.*
2. An ambulatory surgical center that is designated as Class A may provide minor surgical procedures performed under local or topical anesthesia. An operating room in an ambulatory surgical center that is designated as Class A must have a minimum clear area of 130 square feet (12.077 square meters) and a minimum clear dimension of 10 feet (3.05 meters).
3. An ambulatory surgical center that is designated as Class B may provide any surgical procedure authorized for an ambulatory surgical center that is designated as Class A and any surgical procedure performed under conscious or deep sedation. An operating room in an ambulatory surgical center that is designated as Class B must have a minimum clear area of 250 square feet (23.23 square meters) and a minimum clear dimension of 15 feet (4.57 meters).
4. An ambulatory surgical center that is designated as Class C may provide any surgical procedure authorized for an ambulatory surgical center that is designated as Class A or B and any surgical procedure that requires general anesthesia. An operating room in an ambulatory surgical center that is designated as Class C must have a minimum clear area of 400 square feet (37.16 square meters) and a minimum clear dimension of 18 feet (5.49 meters).

5. An ambulatory surgical center that is designated as Class E must have been licensed before August 5, 2004.
6. An ambulatory surgical center that is designated as Endoscopy Only may only provide endoscopy procedures. An operating room in an ambulatory surgical center that is designated as Endoscopy Only must have a minimum clear area of 180 square feet (16.7225 square meters).
7. As used in this section:
(a) "Clear area" means the open area of an operating room, excluding fixed cabinets and built-in shelves.
(b) "Clear dimension" means the open space between the operating room and another area of the building.

Section 26 proposed changes are as follows:
Sec. 26. NAC 449.0187 is hereby amended to read as follows:
449.0187 A facility for hospice care must comply with the following requirements:
1. A program of hospice care must be provided for each inpatient pursuant to a written plan of care established pursuant to NAC 449.0186.
2. Nursing services must be provided 24 hours per day in accordance with the plan of care for each patient.
3. Medication must be dispensed to each patient according to the instructions of the patient's physician or the medical director.
4. Treatment must be administered to a patient pursuant to the instructions of the physician of the patient or the plan of care for the patient.
5. Each patient must be maintained in a clean and well-groomed manner.
6. Each patient must be protected from accidents, injuries and infections. --35-- LCB Draft of Revised Proposed Regulation R048-22
7. At least one registered nurse must be on duty for each work shift, providing direct care to patients.
8. A written plan of the procedures to be followed during a local disaster, a widespread disaster or a disaster which occurs within the facility for hospice care must be adopted. The plan must:
(a) Provide procedures designed to protect each patient and to care for any casualty which may arise from such a disaster;
(b) Be reviewed and the procedures set forth therein rehearsed by all members of the staff at least once in each quarter of the year; and
(c) Be approved by the Division.
9. A private room with an adjoining bath must be provided for each patient.
10. An anteroom, a room adjoining the room of each patient or a private area must be provided and furnished with a bed and chairs for use by the members of the patient's family.
11. A facility for hospice care must comply with the provisions of ~~NFPA 101: Life Safety Code, adopted by reference in NAC 449.0105.~~ 42 Code of Federal Regulation §418.110 (d) Standard: Fire protection.

Section 41 proposed changes are as follows:
Sec. 41. *1. A hospital shall have written policies concerning the qualifications, responsibilities and conditions of employment for each type of hospital personnel, including the licensure and certification of each employee when required by law.*
2. The written policies must be reviewed and updated as needed and must be made available to the members of the hospital staff.
3. Personnel policies must provide for: (a) The orientation of all health personnel to the policies and objectives of the hospital; and (b) The maintenance of records of current employees which confirm that the personnel policies are being followed.

4. The hospital shall have evidence of a current license or certification on file at the hospital for each person employed by the hospital, or under contract with the hospital, who is required to be licensed or certified by law to perform his or her job.
5. The hospital shall ensure that the health records of its employees contain documented evidence of surveillance and testing of those employees for tuberculosis in accordance with chapter 441A of NAC.
6. A hospital shall~~: (a) Provide the training required by~~ comply with the requirements of paragraph (f) of subsection 1 of NRS 449.0302 by:
a) Ensuring each employee who provides care to victims of sexual assault or attempted sexual assault has access to the most current version of the document developed pursuant to NRS 449.1885 (1)(a);
b) Reviewing the most current version of the document developed pursuant to NRS 449.1885 (1)(a) with each employee who provides care to victims of sexual assault or attempted sexual assault; and
c) Having a competency evaluation completed for each employee who provides care to victims of sexual assault or attempted sexual assault within 30 days of receiving the training, which shows the employee is competent to provide medically and factually accurate information concerning emergency contraception and prophylactic antibiotics, including, without limitation, possible side effects of using those medications.
7. Ensuring ~~to~~ each employee who provides care to victims of sexual assault or attempted sexual assault receives the training pursuant to subsection 6 not later than 60 days after the date on which the employee commenced his or her employment and at least biennially thereafter; and
(b) ~~M~~Maintains evidence of compliance with the requirements of ~~paragraph (a)~~ subsection 6 in the personnel file for each employee who is subject to those requirements.

Section 47 proposed changes are as follows:
Sec. 47.
Except as otherwise provided in NAC 449.61322, the governing body of an independent center for emergency medical care shall appoint a person to administer the center. The administrator is responsible for: 1. The daily operation of the center;
2. Serving, along with any committee appointed for the purpose of serving, as a liaison between the governing body, the medical staff and all the departments of the center;
3. Reporting the pertinent activities of the center to the governing body at regular intervals;
4. Appointing a person responsible for the center in the absence of the administrator; [and]
5. Planning for the services provided by the center and the operation of the center [.] ; and
6. Ensuring that: (a) Each employee who provides care to victims of sexual assault or attempted sexual assault is provided the training required by paragraph (f) of subsection 1 of NRS 449.0302 by:
a) Ensuring each employee who provides care to victims of sexual assault or attempted sexual assault has access to the most current version of the document developed pursuant to NRS 449.1885 (1)(a);
b) Reviewing the most current version of the document developed pursuant to NRS 449.1885 (1)(a) with each employee who provides care to victims of sexual assault or attempted sexual assault; and
c) Having a competency evaluation completed for each employee who provides care to victims of sexual assault or attempted sexual assault within 30 days of receiving the training, which shows the employee is competent to provide medically and factually accurate information

concerning emergency contraception and prophylactic antibiotics, including, without limitation, possible side effects of using those medications.
7. Ensuring that each employee who provides care to victims of sexual assault or attempted sexual assault receives the training pursuant to subsection 6 not later than 60 days after the date on which the employee commenced his or her employment and at least biennially thereafter; and
(b) Maintains ~~E~~evidence of compliance with the requirements of ~~paragraph (a)~~ subsection 6 ~~is maintained~~ in the personnel file for each employee who is subject to those requirements.

Sec. 80. This regulation is hereby amended by adding thereto the following transitory language which has the force and effect of law but which will not be codified in the Nevada Administrative Code:

A hospital or the administrator of an independent center for emergency medical care shall:

1. Ensure that each employee of the hospital or independent center for emergency medical care, as applicable, who is employed on the effective date of this regulation and provides care to victims of sexual assault or attempted sexual assault is provided the training required by paragraph (f) of subsection 1 of NRS 449.0302, ***subsection 6 of section 41 and subsection 6 of section 47*** not later than 60 days after the effective date of this regulation and at least biennially thereafter; and 2. Maintain evidence of compliance with the requirements of paragraph (a) in the personnel file for each employee who is subject to those requirements.

SMALL BUSINESS IMPACT STATEMENT 2022
PROPOSED AMENDMENTS TO NEVADA ADMINISTRATIVE CODE (NAC) 449

The Division of Public and Behavioral Health (DPBH) has determined that certain sections/provisions of the proposed amendments will have an adverse economic impact upon a small business and may discourage the formation, operation or expansion of a small business in Nevada while other sections may not have a negative financial impact or may have a positive financial impact on a small business and may encourage the formation, operation or expansion of a small business in Nevada. The proposed regulations may have a different impact on different facility types, and have a different impact on similar facility types, depending on the individual circumstances of each facility.

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

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

Background

The proposed regulations align Chapter 449 of NAC with the passage of several bills, including, Senate Bill 92 and Assembly Bill's 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 proposed regulations make the following changes:

Section 1 authorizes the Chief Medical Officer to impose reporting requirements, in addition to those currently prescribed in chapter 441A of NRS, concerning a disease for which a pandemic or epidemic is ongoing without adopting additional regulations. Consideration is be given to remove this section of the proposed regulations.

Section 3 adopts by reference certain guidelines concerning the use of personal protective equipment, and section 4 of this regulation 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 imposes certain requirements relating to the use of audio and video monitoring equipment to monitor a patient or resident at a medical facility, facility for the dependent or other licensed facility.

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.

Section 26 requires a facility for hospice care to comply with certain requirements for fire safety.

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.

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 that the Division perform an investigation and survey of 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 also apply to be a certified intermediary service organizations; and exempts certain facilities, such as agencies that provide services in a patient's home but do not provide direct patient care in their physical facility, from the requirement to receive a fire inspection.

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.

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.

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

Pursuant to NRS 233B.0608 (2)(a), the Division of Public and Behavioral Health 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	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.	

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 $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,		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 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	

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 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.		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.	

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

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

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

A small business impact questionnaire was disseminated to licensed health care facilities, licensed/certified emergency services providers and through the Division's medical and non-medical facility List Servs, as described in number 1. The data collected from the questionnaire was reviewed, along with a review of the proposed regulations, and applicable statutes. This information was then analyzed by a Health Program Manager III to determine the impact of the proposed regulations on small business.

A public workshop will be scheduled at a future date to continue to obtain feedback on the proposed regulations during the regulatory development process.

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

Adverse Economic 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 main 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 center applicants 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 obtain meet the CMS certification requirements, a facility for hospice must comply with the 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.

Beneficial Effects –

Section 20 exempts certain facilities, such as agencies that provide services in a patient's home but do not provide direct patient care in their physical facility, from the requirement to receive a fire inspection and therefore; any associated costs, such as the costs of a sprinkler system, to come into compliance with the findings of a fire inspection, if applicable. 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.

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

The agency considered alternative ways a small business would be able to meet the intent of a regulation and avoid duplication, where possible. For example, in section 10 the proposed regulations note that an agency that provides the required training on the premises of the agency is not required to arrange or pay the costs of training provided at another location, if certain criteria are met.

The proposed regulations also adopt by reference the federal CMS regulations governing home health agencies and omits a large portion of state home health agency regulations, which avoids duplication in the majority of cases, which may increase efficiencies. In addition, it reduces the need to amend regulations each time the federal regulations are updated; therefore, benefiting the majority of home health agencies from trying to comply with older state regulations that have not been updated and updated federal regulations.

The proposed regulations also establish different classes of ambulatory surgical centers so that centers performing less complex surgeries, such as those that only require local or topical anesthesia, may have a reduced cost to set up a surgical center compared to a surgical center that performs more complex surgeries which require general anesthesia.

5) 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.

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

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.

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

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. 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.

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

The reasons for the conclusions regarding the impact of a regulation on small business is based on an interpretation of the proposed regulations and how they impact a small business, the feedback provided by small business regarding the impact to their businesses and looking at the different components of the proposed regulations and their individual impact on a small business. These are the reasons why the overall conclusion is that the proposed regulation may have a significant adverse fiscal impact on some industries and may discourage the opening of a small business in some instances while having a beneficial financial impact on certain small businesses and may encourage the formation of opening a small business. In other cases, the proposed regulations may not have an impact or may not have a significant impact on small business, or a small business may avoid an adverse economic impact by remaining in compliance with the proposed regulations.

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

Division of Public and Behavioral Health
4150 Technology Way, Suite 300
Carson City, NV 89701
Leticia Metherell
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Email: lmetherell@health.nv.gov

Certification by Person Responsible for the Agency

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

Signature  Date: 08/26/2022

Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Helping people. It's who we are and what we do.

Lisa Sherych
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

NOTICE OF PUBLIC WORKSHOP

NOTICE IS HEREBY GIVEN that the Division of Public and Behavioral Health will hold a public workshop to consider amendments to Nevada Administrative Code (NAC) Chapter 449.

The workshop will be conducted virtually and via telephone beginning at 3:00 PM on Wednesday, September 28, 2022. You can join in on your computer, mobile app or by calling in via telephone using the following information:

- Click here to join the meeting using Microsoft Teams
  - Meeting ID: 267 833 929 251
    Passcode: YsjxPk
  - Download Teams | Join on the web
- Or call in (audio only): 775-321-6111 (Phone Conference ID: 901 416 511#)

These workshops will be conducted in accordance with NRS 241.020, Nevada's Open Meeting Law.

AGENDA

1. Introduction of workshop process
2. Public comment on proposed amendments to Nevada Administrative Code Chapter 449.
3. Public Comment

The proposed changes will revise Chapter 449 of the Nevada Administrative Code and are being proposed in accordance with:

§ 1, NRS 233B.039, 439.200 and 441A.120; §§ 2-5, 7, 8, 10-13, 15-18, 20, 21, 25-28, 36-44, 47-51, 53-57, 59-68, 72, 80 and 81, NRS 439.200 and 449.0302; §§ 6, 73 and 74, NRS 439.200, 449.0302 and 449.165; §§ 9 and 29-35, NRS 439.200, 449.0302 and 449.0305; § 14, NRS 439.200, 449.0302 and 449.24185; § 19, NRS 439.200, 449.0302 and 449.040; §§ 22 and 23, NRS 439.150, 439.200, 449.0302 and 449.050; § 24, NRS 439.150, 439.200 and 449.0302; §§ 45 and 69-71, NRS 439.200, 449.0302 and 449.0303; §§ 46 and 52, NRS 439.200, 449.0302 and 449.1915; § 58, NRS 439.200, 449.0302 and 629.051; §§ 75-79, NRS 439.200, 450B.120 and 450B.237.

The proposed regulations provide provisions for the following:

The proposed regulations align Chapter 449 of NAC with the passage of several bills, including, Senate Bill 92 and Assembly Bill's 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 proposed regulations make the following changes:

Section 1 authorizes the Chief Medical Officer to impose reporting requirements, in addition to those currently prescribed in chapter 441A of NRS, concerning a disease for which a pandemic or epidemic is ongoing without adopting additional regulations. Consideration is be given to remove this section of the proposed regulations.

Section 3 adopts by reference certain guidelines concerning the use of personal protective equipment, and section 4 of this regulation 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 imposes certain requirements relating to the use of audio and video monitoring equipment to monitor a patient or resident at a medical facility, facility for the dependent or other licensed facility.

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.

Section 26 requires a facility for hospice care to comply with certain requirements for fire safety.

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.

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 that the Division perform an investigation and survey of 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 also apply to be a certified intermediary service organizations; and exempts certain facilities, such as agencies that provide services in a patient's home but do not provide direct patient care in their physical facility, from the requirement to receive a fire inspection.

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.

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.

Members of the public may make oral comments at this meeting. Persons wishing to submit written testimony or documentary evidence may submit the material to Leticia Metherell, Health Program Manager at the following address:

Division of Public and Behavioral Health
Bureau of Health Care Quality and Compliance
727 Fairview Drive, Suite E
Carson City, NV 89701
775-684-1073 (FAX)

Members of the public who require special accommodations or assistance at the workshops are required to notify Leticia Metherell, in writing, to the Division of Public and Behavioral Health, 727 Fairview Dr, Suite E, Carson City, NV 89701, by email at lmetherell@health.nv.gov or by calling 775-684-1030 at least five (5) working days prior to the date of the public workshop.

You may contact Leticia Metherell by calling 775-684-1045 for further information on the proposed regulations or how to obtain copies of the supporting documents.

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

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

Division of Public and Behavioral Health
4220 S. Maryland Parkway, Suite 100, Bldg. A
Las Vegas, NV

Nevada State Library and Archives
100 Stewart Street
Carson City, NV

A copy of the public workshop notice, regulations and small business impact statement can be found on the Division of Public and Behavioral Health's web page:
https://dpbh.nv.gov/Reg/HealthFacilities/State_of_Nevada_Health_Facility_Regulation_Public_Workshops/

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

A copy of this notice has been posted at the following locations:

1. Division of Public and Behavioral Health, 4150 Technology Way, First Floor Lobby, Carson City
2. Nevada State Library and Archives, 100 Stewart Street, Carson City
3. Legislative Building, 401 S. Carson Street, Carson City
4. Southern Nevada Health District, 280 S Decatur Blvd, Las Vegas
5. Washoe County District Health Department, 9TH and Wells, Reno

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

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