NEVADA STATE BOARD of DENTAL EXAMINERS

Board Teleconference Meeting

Tuesday, March 15, 2022

6:00 p.m.

PUBLIC BOOK

Agenda Item 5(c):
NRS 631.3635

NRS 631.3635 Appointment of panel to review investigation or informal hearing; members; requirements of review; findings and recommendation.

1. The Board shall appoint a panel to review an investigation or informal hearing conducted pursuant to NRS 631.363. Such a panel must consist of:

(a) If the subject of the investigation or informal hearing is a holder of a license to practice dental hygiene, one member of the Board who is a holder of a license to practice dentistry, one member of the Board who is a holder of a license to practice dental hygiene and one holder of a license to practice dental hygiene who is not a member of the Board and is not the subject of the investigation or informal hearing.

(b) If the subject of the investigation or informal hearing is a holder of a license to practice dentistry or any other person not described in paragraph (a), one member of the Board who is a holder of a license to practice dentistry, one member of the Board who is a holder of a license to practice dental hygiene and one holder of a license to practice dentistry who is not a member of the Board and is not the subject of the investigation or informal hearing.

2. A review panel appointed pursuant to subsection 1 shall, in conducting a review of an investigation or informal hearing conducted pursuant to NRS 631.363, review and consider, without limitation:

(a) All files and records collected or produced by the investigator;

(b) Any written findings of fact and conclusions prepared by the investigator; and

(c) Any other information deemed necessary by the review panel.

3. The investigator who conducted the investigation or informal hearing pursuant to NRS 631.363 shall not participate in a review conducted pursuant to subsection 1.

4. Before the Board takes any action or makes any disposition relating to a complaint, the review panel appointed pursuant to subsection 1 to conduct a review of the investigation or informal hearing relating to the complaint shall present to the Board its findings and recommendation relating to the investigation or informal hearing, and the Board shall review and consider those findings and recommendations.

5. Meetings held by a review panel appointed pursuant to subsection 1 are not subject to the provisions of chapter 241 of NRS.

(Added to NRS by 2017, 988)

Agenda Item 5(c)(2):
Consideration, review, and possible approval/rejection of Stipulation Agreements – NRS 631.3635; NRS 622A.170; NRS 622.330

NRS 631.3635 Appointment of panel to review investigation or informal hearing; members; requirements of review; findings and recommendation.

1. The Board shall appoint a panel to review an investigation or informal hearing conducted pursuant to NRS 631.363. Such a panel must consist of:

(a) If the subject of the investigation or informal hearing is a holder of a license to practice dental hygiene, one member of the Board who is a holder of a license to practice dentistry, one member of the Board who is a holder of a license to practice dental hygiene and one holder of a license to practice dental hygiene who is not a member of the Board and is not the subject of the investigation or informal hearing.

(b) If the subject of the investigation or informal hearing is a holder of a license to practice dentistry or any other person not described in paragraph (a), one member of the Board who is a holder of a license to practice dentistry, one member of the Board who is a holder of a license to practice dental hygiene and one holder of a license to practice dentistry who is not a member of the Board and is not the subject of the investigation or informal hearing.

2. A review panel appointed pursuant to subsection 1 shall, in conducting a review of an investigation or informal hearing conducted pursuant to NRS 631.363, review and consider, without limitation:

(a) All files and records collected or produced by the investigator;

(b) Any written findings of fact and conclusions prepared by the investigator; and

(c) Any other information deemed necessary by the review panel.

3. The investigator who conducted the investigation or informal hearing pursuant to NRS 631.363 shall not participate in a review conducted pursuant to subsection 1.

4. Before the Board takes any action or makes any disposition relating to a complaint, the review panel appointed pursuant to subsection 1 to conduct a review of the investigation or informal hearing relating to the complaint shall present to the Board its findings and recommendation relating to the investigation or informal hearing, and the Board shall review and consider those findings and recommendations.

5. Meetings held by a review panel appointed pursuant to subsection 1 are not subject to the provisions of chapter 241 of NRS.

(Added to NRS by 2017, 988)

NRS 622A.170 Informal dispositions; consent and settlement agreements; designation of hearing panels.

1. The provisions of this chapter do not affect or limit the authority of a regulatory body, at any stage of a contested case, to make an informal disposition of the contested case pursuant to subsection 5 of NRS 233B.121 or to enter into a consent or settlement agreement approved by the regulatory body pursuant to NRS 622.330.

2. The provisions of this chapter do not affect or limit the authority of a regulatory body to designate a panel of its members to hear a contested case pursuant to this chapter.

(Added to NRS by 2005, 744)

NRS 622.330 Consent and settlement agreements: Conditions for entry; deemed public records; exceptions.

1. Except as otherwise provided in this section, a regulatory body may not enter into a consent or settlement agreement with a person who has allegedly committed a violation of any provision of this title which the regulatory body has the authority to enforce, any regulation adopted pursuant thereto or any order of the regulatory body, unless the regulatory body discusses and approves the terms of the agreement in a public meeting.

2. A regulatory body that consists of one natural person may enter into a consent or settlement agreement without complying with the provisions of subsection 1 if:

(a) The regulatory body posts notice in accordance with the requirements for notice for a meeting held pursuant to chapter 241 of NRS and the notice states that:

(1) The regulatory body intends to resolve the alleged violation by entering into a consent or settlement agreement with the person who allegedly committed the violation; and

(2) For the limited time set forth in the notice, any person may request that the regulatory body conduct a public meeting to discuss the terms of the consent or settlement agreement by submitting a written request for such a meeting to the regulatory body within the time prescribed in the notice; and

(b) At the expiration of the time prescribed in the notice, the regulatory body has not received any requests for a public meeting regarding the consent or settlement agreement.

3. If a regulatory body enters into a consent or settlement agreement that is subject to the provisions of this section, the agreement is a public record.

4. The provisions of this section do not apply to a consent or settlement agreement between a regulatory body and a licensee that provides for the licensee to enter a diversionary program for the treatment of an alcohol or other substance use disorder.

(Added to NRS by 2003, 3417)

Agenda Item 5(d):
Authorized Investigative Complaints – NRS 631.360

NRS 631.360 Investigation, notice and hearing; subpoena; search warrant; continuances; retention of complaints; regulations. [Effective January 1, 2020.]

1. Except as otherwise provided in NRS 631.364, the Board may, upon its own motion, and shall, upon the verified complaint in writing of any person setting forth facts which, if proven, would constitute grounds for initiating disciplinary action, investigate the actions of any person who practices dentistry, dental hygiene or dental therapy in this State. A complaint may be filed anonymously. If a complaint is filed anonymously, the Board may accept the complaint but may refuse to consider the complaint if anonymity of the complainant makes processing the complaint impossible or unfair to the person who is the subject of the complaint.

2. The Board shall, before initiating disciplinary action, at least 10 days before the date set for the hearing, notify the accused person in writing of any charges made. The notice may be served by delivery of it personally to the accused person or by mailing it by registered or certified mail to the place of business last specified by the accused person, as registered with the Board.

3. At the time and place fixed in the notice, the Board shall proceed to hear the charges. If the Board receives a report pursuant to subsection 5 of NRS 228.420, a hearing must be held within 30 days after receiving the report.

4. The Board may compel the attendance of witnesses or the production of documents or objects by subpoena. The Board may adopt regulations that set forth a procedure pursuant to which the Executive Director may issue subpoenas on behalf of the Board. Any person who is subpoenaed pursuant to this subsection may request the Board to modify the terms of the subpoena or grant additional time for compliance.

5. The Board may obtain a search warrant from a magistrate upon a showing that the warrant is needed for an investigation or hearing being conducted by the Board and that reasonable cause exists to issue the warrant.

6. If the Board is not sitting at the time and place fixed in the notice, or at the time and place to which the hearing has been continued, the Board shall continue the hearing for a period not to exceed 30 days.

7. The Board shall retain all complaints received by the Board pursuant to this section for at least 10 years, including, without limitation, any complaints not acted upon.

[Part 11:152:1951] — (NRS A 1969, 95; 1981, 99; 1983, 1114; 1993, 784; 2007, 508; 2009, 883; 2013, 2219; 2017, 4415, effective January 1, 2020)

Agenda Item 6(a):
Discussion and Consideration of Possible Decision Regarding the Delegation of Board Authority to the Board's Executive Director to Employ and Terminate All Employees of the Board, Inclusive of All General Counsel Positions – NRS 631.160

NRS 631.160 Officers and Executive Director.

1. At the first regular meeting of each year, the Board shall elect from its membership one of its members as President and one of its members as Secretary-Treasurer, each of whom shall hold office for 1 year and until a successor is elected and qualified.

2. The Board shall define the duties of the President, the Secretary-Treasurer and the Executive Director.

3. The Executive Director shall receive such compensation as determined by the Board, and the Board shall fix the amount of the bond to be furnished by the Secretary-Treasurer and the Executive Director.

[Part 4:152:1951; A 1953, 363] — (NRS A 1995, 275)

Agenda Item 6(b):
Request for an Advisory Opinion Regarding Clarification of the Effect of the Mask Mandate Removal on Dental Offices – NAC 631.279

NAC 631.279 Proceedings to determine applicability and construction of statutes and regulations. (NRS 631.190)

1. Any applicant or licensed dentist or dental hygienist may obtain a determination or advisory opinion from the Board as to the applicability of any provision of chapter 631 of NRS or any regulation adopted pursuant thereto by bringing an action for a declaratory judgment before the Board.

2. The Board will construe any statute or regulation reviewed pursuant to this section in a manner consistent with the declared policy of the State of Nevada.

(Added to NAC by Bd. of Dental Exam'rs, eff. 12-15-87)

Agenda Item 6(b)(1):
William G Pappas, DDS

Nevada Board of Dental Examiners
6010 S. Rainbow Blvd., Bldg. A, Ste. 1 • Las Vegas, NV 89118
(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

PETITION FOR ADVISORY OPINION

Applicant/Licensee: William G. Pappas, D.D.S. Date: February 17, 2022

Address: [redacted] Suite No.: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Telephone: [redacted] Fax: [redacted] Email: [redacted]

[redacted]

In the matter of the petition for an advisory opinion of NRS & NAC Chapter 631:

This request is for clarification of the following statue, regulation, or order:
(Identify the particular aspect thereof to which the request is made.)
Note: If you require additional space you may attach separate pages to the petition form.

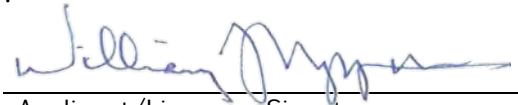
Please clarify how the Governor's recent lifting of the indoor mask mandate affects dental offices in the state.

The substance and nature of this request is as follows:
(State clearly and concisely petitioner's question.)
Note: If you require additional space you may attach separate pages to the petition form.

In contacting the Board office we were referred to the CDC's most recent guidance which was referenced in the email from the Board. The CDC guidance did not seem to address our situation. I have two questions; are patients required to wear masks inside our offices and are dental hygienists allowed to utilize ultrasonic scalers? Some patients are expressing anger at being made to wear masks when they hear from the Governor that they do not (even though he said some businesses might still require masks).

(Please submit any additional supporting documentation with the petition form)

Wherefore, applicant/licensee requests that the Nevada State Board of Dental Examiners grant this petition and issue an advisory opinion in this matter.



Applicant/Licensee Signature

Nevada State Board of Dental Examiners

2651 N Green Valley Parkway, Ste.104 • Henderson, NV 89014 • (702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

MEMORANDUM

Date: February 11, 2022
To: All Nevada Dental Licensees
From: Nevada State Board of Dental Examiners
Re: **Use of masks in dental offices following Governor Sisolak's 2/10/22 Lifting of Mask Mandate**

On February 10, 2022, Governor Sisolak held a press conference removing mask mandates in Nevada. The press release information posted by the Nevada Governor's Office can be found here:

Emergency Directive 052

https://dental.nv.gov/uploadedFiles/dentalnvgov/content/Home/2-10-2022_Directive-052_Release-1.pdf

Mask Mandate Rescinded

https://dental.nv.gov/uploadedFiles/dentalnvgov/content/Home/2-10-22-Removal-of-Masks.pdf

At its October 19, 2021 board meeting, the Nevada State Board of Dental Examiners adopted the CDC's "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," (hereinafter "Interim Infection Control Recommendations") which can be found at:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

The Interim Infection Control Recommendations state that healthcare personnel "should wear source control (e.g. masks) when they are in areas of the healthcare facility where they could encounter patients (e.g., hospital cafeteria, common halls/corridors.)" The Board reminds its licensees to continue to abide by the adopted CDC recommendations and to ensure that dental staff wear source control when in areas of the dental office where they may encounter patients.

OFFICE OF GOVERNOR STEVE SISOLAK
gov.nv.gov @GovSisolak

FOR IMMEDIATE RELEASE
February 9, 2022
Meghin Delaney
Communications Director
CONTACT: press@gov.nnv.gov

Governor Sisolak lifts mask mandate in Nevada

CARSON CITY, NV – Today, Nevada Governor Steve Sisolak announced that effective immediately, the State's mask mandate has been lifted.

"Just like vaccines, masks are still a great tool we have to slow the spread of the virus. I expect going forward to still see Nevadans and visitors occasionally utilizing masks when they are out in public," **said Gov. Sisolak.** "The State will no longer require masks in public places, but employers and organizations, including school districts, may set their own policies, and I encourage them to work with their employees and communities to ensure that policies are in place."

Masks will no longer be required in public places, but there are locations where Nevadans and visitors may still be asked to wear a mask.
Masks and protective equipment requirements in facilities serving vulnerable populations - like hospitals, clinics and long-term care facilities - will be overseen at the direction of the Department of Health and Human Services. The safety of health care staff and patients remain the top priority.
Also, federally, masks are still mandated in airports, on planes and on public buses and school buses.

Teachers and schools will no longer be required to wear masks, but school districts will need to work with their local health authorities to have plans in

place to manage and respond to outbreaks. Masks will stay on through the school day today, so families can have a conversation together.

More guidance is available here.

The emergency directive is available here.

Nevada's State-wide Mask Mandate Removed

Updated February 10, 2022

EMERGENCY DIRECTIVE 052 GUIDANCE

As Nevada continues to recover from the Omicron variant of the COVID-19 pandemic, and tools to combat the severity of illness are more widely available, Emergency Directive 052 lifts the requirements for face masks statewide.

Since the early days of the pandemic, masks have been a critical tool to help slow the spread of the virus that causes COVID-19. They will continue to be a useful tool in times of high transmission, for people with underlying health conditions, and for those who make a personal decision for the added protection of wearing a mask.

School Settings

County school districts, charter schools and private schools can adopt a face mask policy that outlines if face mask are required for students and staff while in school buildings or on school campuses. These policies cannot conflict with any face mask requirements by a county government or local health authority.

Regardless of a county school district, charter school or private school's policy, if an outbreak of COVID-19 is identified by a local health authority, masks and other mitigation measures may be required for all students and staff and must be immediately implemented at the direction of the local health authority. The mask requirement and any other mitigation measures will be in effect until the local health authority determines the outbreak is closed.

Higher Education

The Nevada System of Higher Education and other higher education institutions in the state may adopt a mask requirement for their students, staff and visitors to their campus. These institutions may implement a mask requirement generally or in response to an outbreak on their campus.

Correctional Settings

The Nevada Department of Corrections (NDOC) and the Nevada Department of Health and Human Services (DHHS) will continue to work closely to ensure the proper policies remain in place to prevent infections in staff, residents and visitors. The health and safety of inmates, staff and visitors is the highest priority and infection prevention protocols will continue to be implemented by NDOC in consultation with DHHS.

Public Transportation

On January 29, 2021, CDC issued an Order that required face masks to be worn by all people while on public transportation, which includes all passengers and all personnel operating vehicles traveling into, within, or out of the United States. The Order also required all people to wear masks while at indoor transportation hubs (e.g., airports, bus terminals, train stations, U.S. ports of entry, and other locations where people board public transportation in the United States).

The types of public transportation that masks are still required include airplanes, trains, subways, buses (including school busses), taxis, ride-shares, monorails, maritime transportation, trolleys and cable cars.

Nevada's State-wide Mask Mandate Removed

Updated February 10, 2022

Frequently Asked Questions

Can masks still be required in Nevada?

Yes, counties, cities, school districts, businesses and other settings are still allowed to require masks. This directive lifts the state-wide mask requirement, but it does not prevent an entity to require masks in settings they have jurisdiction in or own.

Can someone still wear masks?

Absolutely! These individuals should feel comfortable being in our communities while still wearing a mask and they should not be asked to remove them unless it is necessary to temporarily lower or remove the mask to verify one's identity such as during a security screening, verifying one's age when it is required or when asked to do so by any law enforcement official.

When should someone consider wearing a mask?

Masks are still encouraged for those that might have health conditions, might live or interact with someone that is immunocompromised or is just not comfortable being in a public setting without a mask. If there is a period of high transmission in your community, it is recommended you wear a face covering, even when it is not required.

Can an employee still wear a mask at work?

Yes, employees can continue to wear a mask if they choose to do so. An employer should not create a policy preventing the use of masks by any employees.

Agenda Item 6(c):
Request for an Advisory Opinion Regarding Clarification of NRS 631.3124(1)(d), NAC 631.210(2)(d), and NAC 631.220(2)(j) Concerning Impressions – NAC 631.279

NAC 631.279 Proceedings to determine applicability and construction of statutes and regulations. (NRS 631.190)

1. Any applicant or licensed dentist or dental hygienist may obtain a determination or advisory opinion from the Board as to the applicability of any provision of chapter 631 of NRS or any regulation adopted pursuant thereto by bringing an action for a declaratory judgment before the Board.

2. The Board will construe any statute or regulation reviewed pursuant to this section in a manner consistent with the declared policy of the State of Nevada.

(Added to NAC by Bd. of Dental Exam'rs, eff. 12-15-87)

Agenda Item 6(c)(1):
Samantha Sturges, RDH

Nevada Board of Dental Examiners
6010 S. Rainbow Blvd., Bldg. A, Ste. 1 • Las Vegas, NV 89118
(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

PETITION FOR ADVISORY OPINION

Applicant/Licensee: Samantha Sturges, RDH Date: 2/22/2022

Address: [redacted] Suite No.: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Telephone: [redacted] Fax: _____ Email: [redacted]

In the matter of the petition for an advisory opinion of NRS & NAC Chapter 631:

This request is for clarification of the following statue, regulation, or order:
(Identify the particular aspect thereof to which the request is made.)
Note: If you require additional space you may attach separate pages to the petition form.

NRS 631.3124 1.(d) - regarding impressions
NAC 631.210 2.(d) - impressions
NAC 631.220 2.(j) - impressions

The substance and nature of this request is as follows:
(State clearly and concisely petitioner's question.)
Note: If you require additional space you may attach separate pages to the petition form.

Please see attached

(Please submit any additional supporting documentation with the petition form)

Wherefore, applicant/licensee requests that the Nevada State Board of Dental Examiners grant this petition and issue an advisory opinion in this matter.

Applicant/Licensee Signature

REVISED 1/2014

Per the statute and regulations listed above, a dentist may authorize a dental therapist, dental hygienist, and/or dental assistant to take the following types of impressions ONLY:

1. Those used for the preparation of diagnostic models
2. Those used for the fabrication of temporary crowns or bridges, and
3. Those used for the fabrication of temporary removable appliances, provided no missing teeth are replaced by those appliances.

Per these statutes and regulations, any impressions for a permanent restoration must be completed by the dentist.

My dentist recently purchased a digital scanner for impressions, and the dental assistant asked me for clarification on who must take the final (digital) impression for the permanent crowns, since she is aware the doctor must take it for traditional impressions. I referred to the NRS, NAC and posted advisory opinions to see if there was any specific mention of digital impressions and having found none, I contacted NSBDE for clarification. I spoke with legal counsel regarding the statute and regulations as they are. I was advised that since the NRS and NAC does not specify any different types of impressions, that the dentist would be the one required to take the digital impression, not delegate this to the assistant and just review, design, or approve it.

This made me think, I have previously worked in offices that were fully digital, doing same day crowns, and never recalled seeing a dentist perform the actual scan after preparing for a crown. I conferred with a few colleagues that work for PDS corporate offices that run primarily on Cerec - same day crowns, and private offices using a digital scanner, to see if maybe I was mistaken. I was advised by all them that the dental assistants are the ones that actually perform the digital scan (impression). In some cases, the dentist will review and/or design the crown before milling it or sending it to the lab, but sometimes even the dental assistant is the one that does the designing. Technology has made advancements to simplify the impression process, and although I do not think that dentists are intentionally violating the statute and regulations, this appears to be a gray area of concern that requires some investigation, discussion, and clarification from the board. Additionally, I spoke to the trainer for the Itero scanner today to clarify what is being taught to dentists and staff regarding who is performing the scans (impressions) for final restorations, and she admitted that in her training, most dentists are delegating this to their assistants.

I am asking for the board to review these statutes and regulations as it pertains to the digital impression, and if the board intends for the permanent digital impression to be performed solely by the dentist as with traditional impressions, to please notify licensees to ensure compliance.

NRS 631.3124 Dental therapists: Authorized services; referral of patient to authorizing dentist for certain purposes; supervision of dental assistants and dental hygienists. [Effective January 1, 2020.]

1. In accordance with the written practice agreement required pursuant to NRS 631.3122, a dental therapist may perform the following acts:

(a) Expose radiographs.

(b) Conduct an assessment of the oral health of the patient through medical and dental histories, radiographs, indices, risk assessments and intraoral and extraoral procedures that analyze and identify the oral health needs and problems of the patient.

(c) After conducting an assessment pursuant to paragraph (b), develop a dental hygiene care plan to address the oral health needs and problems of the patient.

(d) Take the following types of impressions:

(1) Those used for the preparation of diagnostic models;

(2) Those used for the fabrication of temporary crowns or bridges; and

(3) Those used for the fabrication of temporary removable appliances, provided no missing teeth are replaced by those appliances.

(e) Remove stains, deposits and accretions, including dental calculus.

(f) Smooth the natural and restored surface of a tooth by using the procedures and instruments commonly used in oral prophylaxis, except that an abrasive stone, disc or bur may be used only to polish a restoration. As used in this paragraph, "oral prophylaxis" means the preventive dental procedure of scaling and polishing which includes the removal of calculus, soft deposits, plaques and stains and the smoothing of unattached tooth surfaces in order to create an environment in which hard and soft tissues can be maintained in good health by the patient.

(g) Provide dental hygiene care that includes:

(1) Implementation of a dental hygiene care plan to address the oral health needs and problems of patients pursuant to paragraph (c).

(2) Evaluation of oral and periodontal health after the implementation of the dental hygiene care plan described in subparagraph (1) in order to identify the subsequent treatment, continued care and referral needs of the patient.

(h) Perform subgingival curettage.

(i) Remove sutures.

NAC 631.210 Dental hygienists: Authorization to perform certain services; referral of patient to authorizing dentist for certain purposes. (NRS 631.190, 631.310, 631.313, 631.317)

1. A dentist who is licensed in this State may authorize a dental hygienist in his or her employ to perform the following acts before a patient is examined by the dentist:

(a) Expose radiographs.

(b) Conduct an assessment of the oral health of the patient through medical and dental histories, radiographs, indices, risk assessments and intraoral and extraoral procedures that analyze and identify the oral health needs and problems of the patient.

(c) After conducting an assessment pursuant to paragraph (b), develop a dental hygiene care plan to address the oral health needs and problems of the patient.

(d) Take impressions for the preparation of diagnostic models.

➥ The dental hygienist must obtain authorization from the licensed dentist of the patient on whom the services authorized pursuant to this subsection are to be performed.

2. A dentist who is licensed in this State may authorize a dental hygienist in his or her employ to:

(a) Remove stains, deposits and accretions, including dental calculus.

(b) Smooth the natural and restored surface of a tooth by using the procedures and instruments commonly used in oral prophylaxis, except that an abrasive stone, disc or bur may be used only to polish a restoration. As used in this paragraph, "oral prophylaxis" means the preventive dental procedure of scaling and polishing which includes the removal of calculus, soft deposits, plaques and stains and the smoothing of unattached tooth surfaces in order to create an environment in which hard and soft tissues can be maintained in good health by the patient.

(c) Provide dental hygiene care that includes:

(1) Assessment of the oral health of patients through medical and dental histories, radiographs, indices, risk assessments and intraoral and extraoral procedures that analyze and identify the oral health needs and problems of patients.

(2) Implementation of a dental hygiene care plan to address the oral health needs and problems of patients described in subparagraph (1).

(3) Evaluation of oral and periodontal health after the implementation of the dental hygiene care plan described in subparagraph (2) in order to identify the subsequent treatment, continued care and referral needs of the patient.

(d) Take the following types of impressions:

(1) Those used for the preparation of diagnostic models;

(2) Those used for the fabrication of temporary crowns or bridges; and

(3) Those used for the fabrication of temporary removable appliances, provided no missing teeth are replaced by those appliances.

(e) Perform subgingival curettage.

(f) Remove sutures.

(g) Place and remove a periodontal pack.

(h) Remove excess cement from cemented restorations and orthodontic appliances. A dental hygienist may not use a rotary cutting instrument to remove excess cement from restorations or orthodontic appliances.

(i) Train and instruct persons in the techniques of oral hygiene and preventive procedures.

(j) Recement and repair temporary crowns and bridges.

(k) Recement permanent crowns and bridges with nonpermanent material as a palliative treatment.

(l) Place a temporary restoration with nonpermanent material as a palliative treatment.

(m) Administer local intraoral chemotherapeutic agents in any form except aerosol, including, but not limited to:

(1) Antimicrobial agents;

(2) Fluoride preparations;

(3) Topical antibiotics;

(4) Topical anesthetics; and

(5) Topical desensitizing agents.

(n) Apply pit and fissure sealant to the dentition for the prevention of decay.

➥ Before performing any of the services set forth in this subsection, the dental hygienist must obtain authorization from the licensed dentist of the patient on whom the services are to be performed and the patient must have been examined by that dentist not more than 18 months before the services are to be performed. After performing any of the services set forth in this

NAC 631.220 Dental assistants: Authorization to perform certain services; supervision by dental hygienist for certain purposes. (NRS 631.190, 631.313, 631.317)

1. A dentist who is licensed in the State of Nevada may authorize a dental assistant in his or her employ and under his or her supervision to perform the following procedures before the patient is examined by the dentist:

(a) Expose radiographs; and

(b) Take impressions for the preparation of diagnostic models.

2. A dentist who is licensed in the State of Nevada may authorize a dental assistant in his or her employ and under his or her supervision only to do one or more of the following procedures after the patient has been examined by the dentist:

(a) Retract a patient's cheek, tongue or other tissue during a dental operation.

(b) Remove the debris that normally accumulates during or after a cleaning or operation by the dentist by using mouthwash, water, compressed air or suction.

(c) Place or remove a rubber dam and accessories used for its placement.

(d) Place and secure an orthodontic ligature.

(e) Remove sutures.

(f) Place and remove a periodontal pack.

(g) Remove excess cement from cemented restorations and orthodontic appliances. A dental assistant may not use a rotary cutting instrument to remove excess cement from restorations or orthodontic appliances.

(h) Administer a topical anesthetic in any form except aerosol.

(i) Train and instruct persons in the techniques of oral hygiene and preventive procedures.

(j) Take the following types of impressions:

(1) Those used for the preparation of counter or opposing models;

(2) Those used for the fabrication of temporary crowns or bridges; and

(3) Those used for the fabrication of temporary removable appliances, provided no missing teeth are replaced by those appliances.

Agenda Item 6(e):
Discussion, Consideration, and Possible Approval/ Rejection of Recommendation by the Legislative, Legal, & Dental Practice Committee to the Full Board Regarding Possible Changes and/or Additions to Regulations Regarding Administration of Board Disciplinary Proceedings – NRS 631.190

NRS 631.190 Powers and duties. [Effective January 1, 2020.] In addition to the powers and duties provided in this chapter, the Board shall:

1. Adopt rules and regulations necessary to carry out the provisions of this chapter.

2. Appoint such committees, review panels, examiners, officers, employees, agents, attorneys, investigators and other professional consultants and define their duties and incur such expense as it may deem proper or necessary to carry out the provisions of this chapter, the expense to be paid as provided in this chapter.

3. Fix the time and place for and conduct examinations for the granting of licenses to practice dentistry, dental hygiene and dental therapy.

4. Examine applicants for licenses to practice dentistry, dental hygiene and dental therapy.

5. Collect and apply fees as provided in this chapter.

6. Keep a register of all dentists, dental hygienists and dental therapists licensed in this State, together with their addresses, license numbers and renewal certificate numbers.

7. Have and use a common seal.

8. Keep such records as may be necessary to report the acts and proceedings of the Board. Except as otherwise provided in NRS 631.368, the records must be open to public inspection.

9. Maintain offices in as many localities in the State as it finds necessary to carry out the provisions of this chapter.

10. Have discretion to examine work authorizations in dental offices or dental laboratories.

[Part 4:152:1951; A 1953, 363] — (NRS A 1963, 150; 1967, 865; 1993, 2743; 2009, 3002; 2017, 989, 2848; 2019, 3205, effective January 1, 2020)

Agenda Item 6(e):
Additional [Draft] Regulations Regarding Administration of Board Disciplinary Proceedings

DISCIPLINARY ACTION

NAC 631.230 Unprofessional conduct. (NRS 631.190, 631.346, 631.347, 631.350)

1. In addition to those specified by statute and subsection 3 of NAC 631.177, the following acts constitute unprofessional conduct:

(a) The falsification of records of health care or medical records.

(b) Writing prescriptions for controlled substances in such excessive amounts as to constitute a departure from prevailing standards of acceptable dental practice.

(c) The consistent use of dental procedures, services or treatments which constitute a departure from prevailing standards of acceptable dental practice ~~even though~~ if the use ~~does not~~ constitutes malpractice or gross malpractice.

(d) The acquisition of any controlled substances from any pharmacy or other source by misrepresentation, fraud, deception or subterfuge.

~~(e) Making an unreasonable additional charge for laboratory tests, radiology services or other testing services which are ordered by the dentist and performed outside his or her own office.~~

(f) The failure to report to the Board as required in NAC 631.155. ~~or to sign any affidavit required by the Board.~~

(g) Employing any person in violation of NAC 631.260 or failing to attest ~~report~~ to the Board as required by that section.

(h) The failure of a dentist who is administering or directly supervising the administration of general anesthesia, deep sedation or moderate sedation to be physically present while a patient is under general anesthesia, deep sedation or moderate sedation.

(i) Administering moderate sedation to more than one patient at a time, unless each patient is directly supervised by a person authorized by the Board to administer moderate sedation.

(j) Administering general anesthesia or deep sedation to more than one patient at a time.

(k) The failure to have any patient who is undergoing general anesthesia, deep sedation or moderate sedation monitored with a pulse oximeter or similar equipment required by the Board.

(l) Allowing a person who is not certified in basic cardiopulmonary resuscitation to care for any patient who is undergoing general anesthesia, deep sedation or moderate sedation.

(m) The failure to obtain a patient's written, informed consent before administering general anesthesia, deep sedation or moderate sedation to the patient or, if the patient is a minor, the failure to obtain his or her parent's or guardian's consent unless the dentist determines that an emergency situation exists in which delaying the procedure to obtain the consent would likely cause permanent injury to the patient.

(n) The failure to maintain a record of all written, informed consents given for the administration of general anesthesia, deep sedation or moderate sedation.

(o) The failure to report to the Board, in writing, the death or emergency hospitalization of any patient to whom general anesthesia, deep sedation or moderate sedation was administered. The report must be made within 30 days after the event.

(p) Allowing a person to administer general anesthesia, deep sedation or moderate sedation to a patient if the person does not hold a permit to administer such anesthesia or sedation unless the anesthesia or sedation is administered in a facility for which a permit is held as required by NRS 449.442.

(q) The failure of a dentist who owns a dental practice to provide copies of the records of a patient to a dentist, dental therapist, or dental hygienist who provided the services as an employee or independent contractor of the dentist when the records are the basis of a complaint before the Board. Nothing in this paragraph relieves the treating dentist, dental therapist, or dental hygienist from the obligation to provide records of the patient to the Board.

(r) The failure of a dentist who owns a dental practice to verify the license of a dentist, dental therapist, or dental hygienist before offering employment or contracting for services with the dentist, dental therapist, or dental hygienist as an independent contractor unless the employee or independent contractor fraudulently misrepresents credentials.

(s) ~~The failure of a dentist who owns a dental practice and participates in the diagnosis and treatment of any patient to ensure that the services rendered by a dentist or dental hygienist who is an employee or independent contractor of that dentist meet the prevailing standards of acceptable dental practice. If a dentist or dental hygienist who is an employee or independent contractor of the dentist is found by substantial evidence to have provided services below the prevailing standards of acceptable dental practice, the dentist who owns the dental practice may be required to reimburse the patient to whom the services were provided pursuant to paragraph (l) of subsection 1 of NRS 631.350.~~

(t) The failure ~~of a dentist who owns a dental practice to record the name~~ of the dentist, dental therapist, or dental hygienist who provided the services in the records of a patient each time the services are rendered.

(u) The failure of a dentist who is registered to dispense controlled substances with the State Board of Pharmacy pursuant to chapter 453 of NRS to conduct annually a minimum of one self-query regarding the issuance of controlled substances through the Prescription Monitoring Program of the State Board of Pharmacy.

(v) If the Board takes action pursuant to NRS 631.350 (l) the person required to reimburse is defined as the licensee subject to the action.

2. ~~For purposes of NRS 631.347, a plan or practice requiring a patient to select a dentist from a specific group does not provide the patient with a reasonable opportunity to select a dentist of his or her own choice, and constitutes unprofessional conduct on~~

~~the part of any dentist participating in such a plan or practice, unless it, or another plan concurrently available to the patient, allows the patient to:~~

~~(a) Have an annual opportunity, lasting for a minimum of 30 days, to select a dentist of his or her own choice for all dental work to be performed during the subsequent 12 months. Any new patient added to the plan or practice must immediately be given an initial opportunity, lasting at least 30 days, to select the coverage supplied by the plan or practice or a dentist of his or her own choice.~~

~~(b) Receive the allowance for a procedure performed by a dentist of his or her own choice in substantially the same amount as he or she would if he or she used the services of one of the group of dentists specified by the plan or practice.~~

[Bd. of Dental Exam'rs, § XXVII, eff. 7-21-82] — (NAC A 10-21-83; 7-30-84; 9-13-85; 9-16-85; 4-3-89; 11-28-90; R005-99, 9-7-2000; R023-06, 9-18-2006; R159-08, 4-23-2009; R020-14, 6-23-2014; R004-17, 5-16-2018)

NAC 631.235 "Insurer" defined for purposes of NRS 631.348. (NRS 631.190, 631.348) For the purposes of NRS 631.348, "insurer" includes any entity licensed or required to be licensed by the Commissioner of Insurance pursuant to title 57 of NRS, Medicare, Medicaid or any third party payor.

(Added to NAC by Bd. of Dental Exam'rs, eff. 7-30-84)

NAC 631.240 Complaints against licensees. (NRS 631.190)

1. ~~Any aggrieved person may file a complaint with the Board against a licensee. The complaint must:~~

~~(a) Be submitted on the public complaints form on the Nevada State Dental Examiners website written;~~

~~(b) Be attested to signed and verified by the complainant ; and~~

~~(c) Contain specific charges.~~Must qualify as violations of NRS 631 or NAC 631~~which are listed specifically on the public complaints form.~~

~~2. The Board will send a notice and a copy of the complaint to the licensee. The licensee may must file a response to the complaint within 30 15 days after receiving the notice and copy of the complaint.~~

~~[Bd. of Dental Exam'rs, § XVII, eff. 7-21-82] (NAC A 4-3-89)~~

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1. A complaint filed by an aggrieved person must be:

(a) Attested under oath and filed on a form prescribed on the Board website.

(b) Submitted with sufficient evidence to support the allegations in order to make a determination of whether the Board has jurisdiction in the matter and whether there is sufficient evidence to support the allegation of a violation. The complaint form shall list each violation of unprofessional conduct under Chapter 631. The complainant shall indicate on the complaint form, the specific violation that corelates with the allegation and shall provide sufficient evidence to support the allegation of the violation. Allegations involving financial disputes do not qualify as violations of professional misconduct. The complaint form shall contain the authorization for use/disclosure of protected health information of the complainant.

(c) The complaint form shall be redacted of any information identifying the accused person before it is reviewed for jurisdiction by the Board counsel.

(d) Upon receipt of a complaint filed pursuant to paragraph (a), (b) and (c) the Board Counsel shall make a determination whether to accept jurisdiction in the matter and whether the evidence submitted with the complaint is sufficient to warrant an investigation pursuant to NRS 631.360 in the matter. This determination shall be made within 30 days after receiving the redacted complaint. Board counsel shall attest on the document for the determination:

(i) have no knowledge of the identity of the accused person and
(ii) had no communication with any person with regard to the subject matter of the complaint
(iii) have not been unduly influenced in making the determination

(e) If the Board Counsel determines the Board does not have jurisdiction in the matter or the complainant fails to submit sufficient evidence in the matter, the redacted complaint will be referred to the Review Panel with a recommendation to dismiss the complaint. Upon receiving a recommendation from the Board counsel, the Review Panel will within 45 days:

(i) reject the recommendation without prejudice and instruct the Executive Director to assign the matter to a Nevada licensed investigator; or
(ii) accept the recommendation and recommend the Board dismiss the redacted complaint. The Board counsel's recommendation shall be presented, with the redacted complaint, to the Board for dismissal.

(f) Each member of the Review Panel shall attest on the document of their recommendation:

(i) have no knowledge of the identity of the accused person; and
(ii) had no communication with any person with regard to the subject matter of the complaint
(iii) have not been unduly influenced in making the recommendation

(g) If the Board receives a recommendation of the Review Panel to dismiss the redacted complaint the Board will within 60 days:

(i) reject the recommendation without prejudice and instruct the Executive Director to assign the matter to a Nevada licensed investigator; or
(ii) accept the recommendation and dismiss the complaint.
(iii) the Executive Director shall, in writing, obtain the identity of the licensee and notify the complainant and the accused person of the dismissal within ten days.

(h) If the Board counsel determines that the Board has jurisdiction in the matter to investigate all or a portion of the complaint, the Executive Director shall assign the redacted complaint to a Nevada licensed investigator. The Executive Director shall notify the licensee that the matter has been forwarded to a Nevada licensed investigator.

(i)The Executive Director and the Nevada licensed investigator shall attest on the notice of complaint that they:
(i) have knowledge of the identity of the accused person; and
(ii) will maintain the identity of the accused person confidential from the Board Dental Expert and the Review Panel.

NAC 631…….. Authorized Board Investigation upon its own motion:

1. If the Board receives information that leads the Executive Director and Board counsel to reasonably conclude that a licensee may have committed a violation under the jurisdiction of chapter 631, the Executive Director and Board counsel may make a recommendation to the Board that the Board initiate a complaint upon its own motion.

2. A recommendation from the Executive Director and Board counsel pursuant to subsection 1 must:

(a) contain a written statement setting forth the information that supports the recommendation; and

(b) list the specific violation of unprofessional conduct under Chapter 631.
(c) Include any reliable and competent form of proof, including, without limitation, statements of witnesses, public or private records, audio or visual recordings, documents, exhibits, concrete objects or another form of proof, that supports the recommendation.
(d) redact the identifying information of the accused person

3.The Executive Director and the Board counsel shall attest on the recommendation of the authorized investigation that they:

(i) have knowledge of the identity of the accused person; and
(ii) will maintain the identity of the accused person confidential from the Board Dental Expert and the Review Panel.

4. Upon receiving a recommendation from the Executive Director and General Counsel pursuant to subsection 1, the Board will:

(a) Reject the recommendation without prejudice; or

(b) Accept the recommendation and initiate a notice of complaint upon its own motion pursuant to NRS 631.360

Such a motion shall:

(1) be a determination by the Board that it has jurisdiction in the matter and the evidence is sufficient to warrant an investigation in the matter; and

(2) will direct the Executive Director to investigate the complaint as required pursuant to NRS 631.360

5. The notice of complaint shall contain:

(a) contain a written statement setting forth the information that supports the recommendation; and
(b) list the specific violation of unprofessional conduct under Chapter 631; and
(c) Include any reliable and competent form of proof, including, without limitation, statements of witnesses, public or private records, audio or visual recordings, documents, exhibits, concrete objects or another form of proof, that supports the recommendation.

NAC 631.250 Investigation by Board. (NRS 631.190**,** 631.360**,** 631.363**)**

1. If the Board conducts an investigation upon a complaint against a licensee, the Board will ~~not~~ limit the scope of its investigation to the matters set forth in the public complaints form and ~~but~~ will not extend the investigation to any additional matters beyond the complaint. ~~which appear to constitute a violation of any provision of chapter 631 of NRS or of this chapter.~~

2. If, the investigation deems that there is no violation of NRS 631 or NAC 631~~after its investigation~~, the Board shall dismisses the complaint. ~~,~~ The complaint shall not be remanded over the licensee to be used in ~~the dismissal does not operate as a limitation on or a detriment to~~ any subsequent complaints or investigations or other action by the Board unless the Board receives additional information from the complainant relevant to that complaint.

3. Whenever the Board directs that an investigation be conducted into a disciplinary matter, the results of the investigation or any information relating to the investigation will not be examined by and must not be disclosed to, the members of the disciplinary committee of the Board before the Board's hearing on the matter.

[Bd. of Dental Exam'rs, § XVIII, eff. 7-21-82]

4. The Nevada licensed investigator shall forward the notice of complaint to the accused person to the addresses on file at the Board via ~~certified~~ registered U.S. Mail and electronic mail.

5. The accused person shall have thirty (30) days upon receipt of the notice of complaint to provide all records for the patient within the past 5 years.

6. The Executive Director may grant reasonable requests for extensions as needed by the licensee.

7. Failure to provide requested records pertaining to the notice of complaint may be deemed unprofessional conduct pursuant to NAC 631.230.

NAC 631… Assignment of matter to Board Dental Expert

1.Upon receipt of the records and/or written response including any expert opinions from the accused person the Nevada licensed investigator shall redact any identifying information of the accused person from the records and response and forward to a Board Dental Expert.

2.The Board shall retain a Board Dental Expert to review the redacted complaint and records. The complaint and the dental records shall be redacted of any identifying information about the accused person.

3. A Board Dental Expert shall be licensed dental professionals with no board action within the past ten years and a minimum of 5 years actively practicing in Nevada. Redacted complaints against licensed dentists or specialists shall be sent to Board Dental Expert dentists or specialists. Redacted complaints against dental therapists shall be sent to Board Dental Expert dentists or Board Dental Expert dental therapists. Redacted complaints against registered dental hygienists shall be sent to Board Dental Expert dentists, Board Dental Expert dental therapists or Board Dental Expert registered dental hygienists. Redacted complaints shall be assigned to Board Dental Expert's with expertise in the relevant subject matter of the complaint.

4.The Board Dental Expert shall include in their expert opinion and attest to the Nevada licensed investigator within 45 days of receipt of the records:

(a) whether there was a breach of the standard of care under Chapter 631; and

(b) provide sufficient evidence that supports the specific violation which corelates with the allegation

(c) have no knowledge of the identity of the accused person and

(d) had no communication with any person with regard to the subject matter of the complaint

(e) have not been unduly influenced in making the determination

5.The Executive Director may grant reasonable extensions to the Board Dental Expert as needed to

complete the expert opinion.

6.The Board Dental Expert's opinion shall be deemed confidential, except from the licensee,

pursuant to NRS 631.368.

7. The Board may retain other expert opinions from dental professionals who have experienced no board action within the past ten years and a minimum of 5 years actively practicing outside the state of Nevada. The Executive Director must submit, in writing, a reasonable reason for using an out of state Board Dental Expert.

8. The Nevada licensed investigator shall forward a copy of the Board Dental Expert opinion to the accused person within 15 days of receipt of the opinion.

9. The accused person shall have thirty (30) days upon receipt of the Board Dental Expert opinion to provide a written response including any expert opinions.

10. A complainant may withdraw their complaint:

(a) at any time before the Nevada licensed investigator forwards the matter to the Board Dental Expert; or

(b) With the consent of the Board, after the Nevada licensed investigator forwards the matter to the Board Dental Expert.

NAC 631……. Assignment of file to Review Panel

1. Pursuant to NRS 631.3635, the Nevada licensed investigator shall forward the redacted complaint, Board Dental Expert opinion and accused person's redacted records and response including any expert opinions relating to the investigation to a Review Panel appointed by the Board pursuant to NRS 641.3635.

2. The Review Panel shall conduct a review of an investigation or informal hearing conducted pursuant to NRS 631.363, review and consider, without limitation:

(a) All files and records collected or produced by the investigator, Board, and/or Board Dental Expert.

(b) Any written findings of fact and conclusions prepared by the investigator; and

(c) Any other information deemed necessary by the review panel.

3. The Review panel may:

(i) make a recommendation to dismiss the complaint; or

(ii) request the Board Dental Expert, Nevada licensed investigator or licensee to respond to any other questions presented by the Review Panel. They shall have 60 days to respond to the Review Panel; or

(iii)make a recommendation for an informal disposition by stipulation. If an informal disposition is made, the parties may waive the requirement for findings of fact and conclusions of law.

(iv)make a recommendation for an informal hearing

(v)make a recommendation for a formal hearing

4. The Review Panel shall present their findings and recommendations to a

Hearing Panel delegated by the Board to conduct a formal hearing

pursuant to NRS 631.350(3)

NAC 631…….. Board Delegation to a Hearing Panel

1. Pursuant to NRS 631.350 (3) and NRS 622a.170 (2) the Board shall designate a Hearing Panel to take

any disciplinary action pursuant to NRS 631.350.

2. The Hearing Panel may retain the services of a Hearing Advisor who is an

independent contractor retained by the Board to attend hearings and advise the hearing panel. The Hearing Advisor may advise the Hearing Panel regarding

any aspects of the hearing as well as the admissibility of any evidence

produced during administrative proceedings.

3. The Hearing Panel shall have three (3) members of the Nevada State

Board of Dental Examiners Disciplinary Committee to preside over any formal hearing conducted pursuant to NRS 631.350 (3) and NRS 622a.170 (2). One member shall be named the Chair for the formal hearing.

4. Each member of the Hearing Panel shall have one vote as to the verdict of any formal hearing conducted by the Panel.

5. Any disciplinary action taken by the Hearing Panel is subject to the same procedural requirements which apply to disciplinary actions taken by the Board, and the Hearing Panel has those powers and duties given to the Board in relation thereto. Before taking any disciplinary action the Hearing Panel shall review and consider the findings of a review panel pursuant to NRS 631.365

6. The Hearing Advisor may advise the Hearing Panel in reviewing the Order and findings of fact and conclusions of law within thirty (30) days after the conclusion of any disciplinary hearing. All members of the Hearing Panel must attach their signature on the Findings within forty five (45) days after the conclusion of the hearing.

7. Failure to comply with the above timetable is not grounds for dismissal of the underlying charges

NAC 631…… Board Approval of Hearing Panel actions.

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1. The Board shall consider the actions taken by the Hearing Panel at the first Board meeting after the Findings have been adopted by the Hearing Panel.

2. The Board may either adopt the Findings as presented or they may reject the findings and schedule a subsequent hearing where the full Board may

consider the matter.

Commented [ADM1]: Violates NRS 631.355 (2) Hearing panel decision is final.

NAC 631.255 Record of hearing conducted by investigator or hearing officer or panel. (NRS 631.190**,** 631.350**,** 631.360**,** 631.363**)** If the Board has delegated its responsibility pursuant to the provisions of subsection 3 of NRS 631.350 or NRS 631.363, the informal or formal hearing conducted as a result of that delegation of authority must be recorded and transcribed in permanent form by a shorthand reporter licensed to do business in this State.

(Added to NAC by Bd. of Dental Exam'rs, eff. 4-3-89)

Agenda Item 6(f):
Discussion, Consideration, and Possible Approval/ Rejection of Council of Interstate Testing Agency ("CITA") as an Approved Testing Agency for the Administration of the ADEX Exam – NRS 631.190

NRS 631.190 Powers and duties. [Effective January 1, 2020.] In addition to the powers and duties provided in this chapter, the Board shall:

1. Adopt rules and regulations necessary to carry out the provisions of this chapter.

2. Appoint such committees, review panels, examiners, officers, employees, agents, attorneys, investigators and other professional consultants and define their duties and incur such expense as it may deem proper or necessary to carry out the provisions of this chapter, the expense to be paid as provided in this chapter.

3. Fix the time and place for and conduct examinations for the granting of licenses to practice dentistry, dental hygiene and dental therapy.

4. Examine applicants for licenses to practice dentistry, dental hygiene and dental therapy.

5. Collect and apply fees as provided in this chapter.

6. Keep a register of all dentists, dental hygienists and dental therapists licensed in this State, together with their addresses, license numbers and renewal certificate numbers.

7. Have and use a common seal.

8. Keep such records as may be necessary to report the acts and proceedings of the Board. Except as otherwise provided in NRS 631.368, the records must be open to public inspection.

9. Maintain offices in as many localities in the State as it finds necessary to carry out the provisions of this chapter.

10. Have discretion to examine work authorizations in dental offices or dental laboratories.

[Part 4:152:1951; A 1953, 363] — (NRS A 1963, 150; 1967, 865; 1993, 2743; 2009, 3002; 2017, 989, 2848; 2019, 3205, effective January 1, 2020)

NRS 631.170 Examination of applicants; restriction on participation in grading examinations; meetings; quorum. [Effective through December 31, 2019.]

1. The Board shall meet whenever necessary to examine applicants. The dates of the examinations must be fixed by the Board. The Board may conduct examinations outside this State, and for this purpose may use the facilities of dental colleges.

2. The members who are dental hygienists may vote on all matters but may not participate in grading any clinical examinations required by NRS 631.240 for the licensing of dentists. If a member is not licensed under the provisions of this chapter, the member shall not participate in grading any examination required by the Board.

3. The Board may also meet at such other times and places and for such other purposes as it may deem proper.

4. A quorum consists of five members who are dentists and two members who are dental hygienists.

[Part 4:152:1951; A 1953, 363] — (NRS A 1957, 343; 1963, 82; 1981, 1973; 1983, 1113; 1987, 857; 2003, 520; 2007, 505)

ABOUT CITA

The CITA staff and examiners are committed to being professional, proficient, and efficient in exam administration. As we continue to grow, we continue to develop streamlined processes that provide candidates with access to the tools they will need to be successful while also equipping examiners and educators with resources they can use to help facilitate the development of a national dental community.

WHO IS CITA?

The Council of Interstate Testing Agencies, Inc. (CITA) is a non-profit corporation that was founded on July 15, 2005. As an independent regional testing agency that administers the ADEX dental clinical licensure examination and the ADEX dental hygiene clinical licensure examination at various testing sites, CITA continues to set standards of excellence in its testing administration. CITA is composed of 13 member jurisdictions – Alabama, Louisiana, North Carolina, Puerto Rico, the US Virgin Islands, West Virginia, Arkansas, Utah, Tennessee, Virginia, South Carolina, Texas, and Georgia.

Executive Board Members:

Conrad "Chip" McVea, III, DDS MAGD--President

Renea Chapman, RDH--Vice-President

Isaac "Ike" House, DDS--Secretary

Kevin Collins, DDS--Treasurer

M.W. "Buddy" Wester, III, DDS--Immediate Past President

Cindy Washburn--Executive Director

MISSION STATEMENT

To provide psychometric, technical, and administrative services in the administration and delivery of clinical licensure examinations in dentistry and dental hygiene. CITA will demonstrate integrity and fairness as it provides assistance to state boards of dentistry in their mission to protect the health, safety, and welfare of the public by assuring that only competent and qualified individuals are allowed to practice dentistry and dental hygiene.

WHY JOIN CITA?

- If you are a member of your state's board of dentistry, you can play an integral role in the delivery and administration of the examination by serving as a Chief Examiner, Clinic Floor Examiner, or grader.
- CITA will pay an allotted amount toward the expenses associated with examination administration.
- CITA will assist in the logistics of examination administration and the reporting of test scores to school liaisons, state boards of dentistry, and national examination authorities.
- CITA will provide all necessary materials for the administration of the ADEX Dental and ADEX Hygiene examinations.
- CITA will provide an interface with the applicants and serve as a resource to address questions regarding the exam administration.
- CITA continues to improve the technology required to track candidate information, score reporting, and candidate notification.
- CITA will represent each member state in the national debate regarding the future of licensing examinations.

Any state wishing to join CITA should submit a request in writing to the CITA Main Office.

1518 Elm Street, Suite A
Sanford, North Carolina 27330

(919) 460-7750 PHONE
(919) 460-7715 FAX

1 (866) 678-9795

Agenda Item 6(g):
Review, Discussion, and Consideration of Updates to CDC Guidance for Dental Settings, and Possible Approval/ Rejection of the Same – NAC 631.178

NAC 631.178 Adoption by reference of certain guidelines; compliance with guidelines required. (NRS 631.190)

1. Each person who is licensed pursuant to the provisions of chapter 631 of NRS shall comply with:

(a) The provisions of the *Guidelines for Infection Control in Dental Health-Care Settings-2003* adopted by the Centers for Disease Control and Prevention which is hereby adopted by reference. The publication is available, free of charge, from the Centers for Disease Control and Prevention at the Internet address **http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5217a1.htm**; and

(b) As applicable to the practice of dentistry, the provisions of the *Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008*, adopted by the Centers for Disease Control and Prevention which is hereby adopted by reference. The publication is available, free of charge, from the Centers for Disease Control and Prevention at the Internet address **http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf**.

2. The Board will periodically review the guidelines adopted by reference in this section and determine within 30 days after the review whether any change made to the guidelines is appropriate for application in this State. If the Board does not disapprove a change to the guidelines within 30 days after the review, the change is deemed to be approved by the Board.

(Added to NAC by Bd. of Dental Exam'rs, eff. 9-6-96; A by R025-05, 11-17-2005; R201-09, 8-13-2010)

Agenda Item 6(g)(1):

February 2, 2022 “Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic” https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Centers for Disease Control and Prevention

COVID-19

Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

Updated Feb. 2, 2022

CDC's new COVID-19 Community Levels recommendations do not apply in healthcare settings, such as hospitals and nursing homes. Instead, healthcare settings should continue to use community transmission rates and continue to follow CDC's infection prevention and control recommendations for healthcare settings.

CDC has updated guidance

- Isolation and work restriction guidance for healthcare personnel
- Contingency and crisis management in the setting of significant healthcare worker shortages

Summary of Recent Changes

Updates as of February 2, 2022

Due to concerns about increased transmissibility of the SARS-CoV-2 Omicron variant, this guidance is being updated to enhance protection for healthcare personnel, patients, and visitors and to address concerns about potential impacts on the healthcare system given a surge in SARS-CoV-2 infections. These updates will be refined as additional information becomes available to inform recommended actions.

- Empiric use of Transmission-Based Precautions (quarantine) is recommended for patients who have had close contact with someone with SARS-CoV-2 infection if they are not up to date with all recommended COVID-19 vaccine doses.
  - In general, quarantine is not needed for asymptomatic patients who are up to date with all recommended COVID-19 vaccine doses or who have recovered from SARS-CoV-2 infection in the prior 90 days; potential exceptions are described in the guidance. However, some of these patients should still be tested as described in the testing section of the guidance.
- A test-based strategy and (if available) consultation with infectious disease experts is now recommended for determining the duration of Transmission-Based Precautions for patients with SARS-CoV-2 infection who are moderately to severely immunocompromised.
- Included additional examples when universal respirator use could be considered
- Additional updates that will have implications for healthcare facilities were made in the following guidance documents:
  - Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC
  - Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC
  - Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes | CDC

Key Points

- This guidance applies to all U.S. settings where healthcare is delivered, including home health.

Introduction

This interim guidance has been updated based on currently available information about COVID-19 and the current situation in the United States.

This guidance is applicable to all U.S. settings where healthcare is delivered (including home health). **This guidance is not intended for non-healthcare settings (e.g., restaurants) and not for persons outside of healthcare settings.** CDC's main landing page for COVID-19 content will help readers navigate to information regarding modes of transmission, clinical management, laboratory settings, COVID-19 vaccines and CDC guidance on other COVID-19-related topics.

Employers should be aware that other local, territorial, tribal, state, and federal requirements may apply, including those promulgated by the Occupational Safety and Health Administration (OSHA).

Defining Community Transmission of SARS-CoV-2

Several of the IPC measures (e.g., use of source control, screening testing) are influenced by levels of SARS-CoV-2 transmission in the community. Two different indicators in CDC's COVID-19 Data Tracker are used to determine the level of SARS-CoV-2 transmission for the county where the healthcare facility is located. If the two indicators suggest different transmission levels, the higher level is selected.

1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic

Encourage everyone to remain up to date with all recommended COVID-19 vaccine doses.

Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection

- Ensure everyone is aware of recommended IPC practices in the facility.
  - Post visual alert (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) with instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations.
- Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following three criteria so that they can be properly managed:
  - 1) a positive viral test for SARS-CoV-2,
  - 2) symptoms of COVID-19, or
  - 3) close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higher-risk exposure (for healthcare personnel (HCP).

Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.

- HCP should report any of the 3 above criteria to occupational health or another point of contact designated by the facility, even if they are up to date with all recommended COVID-19 vaccine doses. Recommendations for evaluation and work restriction of these HCP are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.
- Even if they have met community criteria to discontinue isolation or quarantine, visitors **should not visit** if they have any of the following and have not met the same criteria used to discontinue isolation and quarantine for patients. Additional information is available in Clinical Questions about COVID-19: Questions and Answers | CDC.
  - 1) a positive viral test for SARS-CoV-2,
  - 2) symptoms of COVID-19, or
  - 3) close contact with someone with SARS-CoV-2 infection
- Additional information about visitation for nursing homes and intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities is available from the Centers for Medicare and Medicaid Services (CMS).
- Patients meeting any of the 3 above criteria should be managed as described in Section 2.
- HCP, patients and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine.

Implement Source Control Measures

Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.

Source control options for HCP include:

- A NIOSH-approved N95 or equivalent or higher-level respirator OR
- A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated) OR
- A well-fitting facemask.

When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If they are used during the care of patient for which a NIOSH-approved

respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH-approved N95 or equivalent or higher-level respirator) during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions, they should be removed and discarded after the patient care encounter and a new one should be donned.

Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for **everyone in a healthcare setting.** This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission or who have:

- Are not up to date with all recommended COVID-19 vaccine doses; or
- Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
- Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection for 10 days after their exposure, including those residing or working in areas of a healthcare facility experiencing SARS-CoV-2 transmission (i.e., outbreak); or
- Have moderate to severe immunocompromise; or
- Have otherwise had source control and physical distancing recommended by public health authorities

While it is generally safest to implement universal use of source control for everyone in a healthcare setting, the following allowances could be considered for **individuals who are up to date with all recommended COVID-19 vaccine doses** (who do not otherwise meet the criteria described above) in healthcare facilities **located in counties with low to moderate community transmission**. These individuals might choose to continue using source control if they or someone in their household is immunocompromised or at increased risk for severe disease, or if someone in their household is not up to date with all recommended COVID-19 vaccine doses.

- **HCP who are up to date with all recommended COVID-19 vaccine doses:**
  - Could choose not to wear source control or physically distance when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms, kitchen).
    - They **should wear source control** when they are in areas of the healthcare facility where they could encounter patients (e.g., hospital cafeteria, common halls/corridors).
- **Patient Visitation:**
  - **Indoor visitation (in single-person rooms; in multi-person rooms, when roommates are not present; or in designated visitation areas when others are not present):** The safest practice is for patients and visitors to wear source control and physically distance, particularly if either of them are at risk for severe disease or are unvaccinated.
    - If the patient and all their visitor(s) are up to date with all recommended COVID-19 vaccine doses, they can choose not to wear source control and to have physical contact.
    - Visitors should wear source control when around other residents or HCP, regardless of vaccination status.
  - **Outdoor Visitation:** Patients and their visitors should follow the source control and physical distancing recommendations for outdoor settings described on the page addressing Your Guide to Masks | CDC.
- **Residents who are up to date with all recommended COVID-19 vaccine doses in Nursing Homes in Areas of Low to Moderate Transmission:**
  - Nursing homes are healthcare settings, but they also serve as a home for long-stay residents and quality of life should be balanced with risks for transmission. In light of this, consideration could be given to allowing residents who are up to date with all recommended COVID-19 vaccine doses to not use source control when in communal areas of the facility; however, residents at increased risk for severe disease should still consider continuing to practice physical distancing and use of source control

Implement Universal Use of Personal Protective Equipment for HCP

If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis). Additionally, HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below:

NIOSH-approved N95 or equivalent or higher-level respirators should be used for:

All aerosol-generating procedures (refer to Which procedures are considered aerosol generating procedures in healthcare settings?)

All surgical procedures that might pose higher risk for transmission if the patient has SARS-CoV-2 infection (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract).

NIOSH-approved N95 or equivalent or higher-level respirators can also be used by HCP working in other situations where additional risk factors for transmission are present such as the patient is not up to date with all recommended COVID-19 vaccine doses, unable to use source control, and the area is poorly ventilated. They may also be considered if healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCP working in affected areas is not already in place.

To simplify implementation, facilities in counties with substantial or high transmission may consider implementing universal use of NIOSH-approved N95 or equivalent or higher-level respirators for HCP during all patient care encounters or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission.

Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.

Encourage Physical Distancing

In situations when patients are not up to date with all recommended COVID-19 vaccine doses could be in the same space (e.g., waiting rooms, cafeterias, dialysis treatment room), arrange seating so that patients can sit at least 6 feet apart, especially in counties with substantial or high transmission. This might require scheduling appointments to limit the number of patients in waiting rooms, treatment areas, or participating in group activities.

Optimize the Use of Engineering Controls and Indoor Air Quality

Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals (e.g., physical barriers at reception / triage locations and dedicated pathways to guide symptomatic patients through waiting rooms and triage areas).

Explore options, in consultation with facility engineers, to improve ventilation delivery and indoor air quality in all shared spaces.

Guidance on ensuring that ventilation systems are operating properly are available in the following resources:

Guidelines for Environmental Infection Control in Health-Care Facilities

American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) resources for healthcare facilities , which also provides COVID-19 technical resources for healthcare facilities

Ventilation in Buildings, which includes options for non-clinical spaces in healthcare facilities

Perform SARS-CoV-2 Viral Testing

FDA evaluates test characteristics and facilities should be aware of how tests perform for circulating variants.

Anyone with even mild symptoms of COVID-19, **regardless of vaccination status**, should receive a viral test as soon as possible.

Asymptomatic patients with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately (but generally not earlier than 24 hours after the exposure) and, if negative, again 5–7 days after the exposure. In general, testing is not necessary for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 90 days; however, if testing is performed on these individuals an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.

Guidance for work restrictions, including recommended testing for HCP with higher-risk exposures are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.

Guidance for use of Transmission-Based Precautions (quarantine) for patients with close contact with someone with SARS-CoV-2 infection are described in Section 2.

Testing considerations for healthcare facilities with an outbreak of SARS-CoV-2 are described below.

Expanded screening testing of asymptomatic HCP without known exposures is required in nursing homes and could be considered in other settings.

HCP who are up to date with all recommended COVID-19 vaccine doses may be exempt from expanded screening testing.

Guidance for expanded screening testing for nursing homes is described in the Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes | CDC.

Performance of pre-procedure or pre-admission viral testing is at the discretion of the facility. The yield of this testing for identifying asymptomatic infection is likely low when performed on vaccinated individuals or those in counties with low or moderate transmission. However, these results might continue to be useful in some situations (e.g., when performing higher risk procedures on people who are not up to date with all recommended COVID-19 vaccine doses) to inform the type of infection control precautions used (e.g., room assignment/cohorting, or PPE used).

Create a Process to Respond to SARS-CoV-2 Exposures Among HCP and Others

Healthcare facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. Guidance on assessing the risk for exposed patients and HCP is available in the Healthcare Infection Prevention and Control FAQs for COVID-19.

If healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP and patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. For example, in an outpatient dialysis facility with an open treatment area, testing should ideally include all patients and HCP. Depending on testing resources available or the likelihood of healthcare-associated transmission, facilities may elect to initially expand testing only to HCP and patients on the affected units or departments, or a particular treatment schedule or shift, as opposed to the entire facility. If an expanded testing approach is taken and testing identifies additional infections, testing should be expanded more broadly. If possible, testing should be repeated every 3-7 days until no new cases are identified for at least 14 days.

Guidance for outbreak response in nursing homes is described in the Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes | CDC.

Healthcare facilities responding to SARS-CoV-2 transmission within the facility should always notify and follow the recommendations of public health authorities.

2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection

The IPC recommendations described below also apply to patients with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic patients who have met the criteria for empiric Transmission-Based Precautions (quarantine) based on close contact with someone with SARS-CoV-2 infection. However, these patients should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing.

Patients placed in empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the following time periods.

- Patients can be removed from Transmission-Based Precautions after day 10 following the exposure (day 0) if they do not develop symptoms. Although the residual risk of infection is low, healthcare providers could consider testing for SARS-CoV-2 within 48 hours before the time of planned discontinuation of Transmission-Based Precautions
- Patients can be removed from Transmission-Based Precautions after day 7 following the exposure (day 0) if a viral test is negative for SARS-CoV-2 and they do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned discontinuation of Transmission-Based Precautions

Note: In general, asymptomatic patients who are up to date with all recommended COVID-19 vaccine doses or who have recovered from SARS-CoV-2 infection in the prior 90 days do not require empiric use of Transmission-Based Precautions

(quarantine) for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. However, these patients should still be tested as described in the testing section.

However, there may be circumstances when Transmission-Based Precautions (quarantine) for these patients might be recommended (e.g., patient is moderately to severely immunocompromised). In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for patients on affected units and work restriction of HCP with higher-risk exposures, even if they are up to date with all recommended COVID-19 vaccine doses. In addition, there might be other circumstances for which the jurisdiction's public health authority recommends these and additional precautions.

Patient Placement

Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). The patient should have a dedicated bathroom.

Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with SARS-CoV-2 infection. Dedicated means that HCP are assigned to care only for these patients during their shifts.

Only patients with the same respiratory pathogen should be housed in the same room.

Limit transport and movement of the patient outside of the room to medically essential purposes.

Communicate information about patients with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.

Personal Protective Equipment

HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).

Additional information about using PPE is available in Protecting Healthcare Personnel | HAI | CDC

Aerosol Generating Procedures (AGPs)

Procedures that could generate infectious aerosols should be performed cautiously and avoided if appropriate alternatives exist.

AGPs should take place in an airborne infection isolation room (AIIR), if possible.

The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.

Visitation

For the safety of the visitor, in general, patients should be encouraged to limit in-person visitation while they are infectious. However, facilities should adhere to local, territorial, tribal, state, and federal regulations related to visitation. Visitation guidance for nursing homes and intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities is available from CMS.

Counsel patients and their visitor(s) about the risks of an in-person visit.

Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.

Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.

Visitors should be instructed to only visit the patient room. They should minimize their time spent in other locations in the facility.

Duration of Transmission-Based Precautions

The following are criteria to determine when Transmission-Based Precautions could be discontinued for patients with SARS-CoV-2 infection. These patients should self-monitor and seek re-evaluation if symptoms recur or worsen. In general, patients

who are hospitalized for SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the time period described for patients with severe to critical illness.

Information about antigen tests and NAAT is available in Testing | CDC. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT.

In general, patients should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation below. Then they should revert to usual facility source control policies for patients.

Patients with mild to moderate illness **who are *not* moderately to severely immunocompromised:**

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Patients who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised**:**

- At least 10 days have passed since the date of their first positive viral test.

Patients with severe to critical illness and **who are *not*** moderately to severely immunocompromised**:**

- At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- The test-based strategy as described for moderately to severely immunocompromised patients below can be used to inform the duration of isolation.

The exact criteria that determine which patients will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific patients. For a summary of the literature, refer to Ending Isolation and Precautions for People with COVID-19: Interim Guidance (cdc.gov)

Patients who are moderately to severely immunocompromised**:** may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these patients.

The criteria for the test-based strategy are:

Patients who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved, **and**
- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an antigen test or NAAT (see Testing | CDC).

Patients who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an antigen test or NAAT (see Testing | CDC).

The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a patient with suspected SARS-CoV-2 infection can be made based upon having negative results from at least one

respiratory specimen tested using an FDA-authorized COVID-19 viral test.

If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and performing a second test for SARS-CoV-2 RNA.

If a patient suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described above.

Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions.

Environmental Infection Control

Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection.

All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.

Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which AGPs are performed.

Refer to List N on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2.

Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.

Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles [more information (to include important footnotes on its application) on clearance rates under differing ventilation conditions is available]. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

3. Setting-specific considerations

In addition to the recommendations described in the guidance above, here are additional considerations for the settings listed below.

Dialysis Facilities

Considerations for Patient Placement

- Patients on dialysis with suspected or confirmed SARS-CoV-2 infection or who have reported close contact should be dialyzed in a separate room with the door closed.
  - Hepatitis B isolation rooms can be used if: 1) the patient is hepatitis B surface antigen positive or 2) the facility has no patients on the census with hepatitis B infection who would require treatment in the isolation room.
- If a separate room is not available, patients with confirmed SARS-CoV-2 infection should be cohorted to a specific well-ventilated unit or shift (e.g., consider the last shift of the day). Only patients with confirmed SARS-CoV-2 infection should be cohorted together:
  - In the context of an outbreak or an increase in the number of confirmed SARS-CoV-2 infections at the facility, if a separate shift or unit is not initially available, efforts should be made to create specific shifts or units for patients with confirmed SARS-CoV-2 infection to separate them from patients without SARS-CoV-2 infection.

Additional Guidance for Use of Isolation Gowns

- When caring for patients with suspected or confirmed SARS-CoV-2 infection, gowns should be worn over or instead of the cover gown (e.g., laboratory coat, gown, or apron with incorporate sleeves) that is normally worn by hemodialysis personnel.

Cleaning and Disinfecting Dialysis Stations

Current procedures for routine cleaning and disinfection of dialysis stations are appropriate for patients with SARS-CoV-2 infection.

Internal disinfection of dialysis machines is not required immediately after use unless otherwise indicated (e.g., post-blood leak). It should be done according to the dialysis machine manufacturer's instructions (e.g., at the end of the day).

Emergency Medical Services

Considerations for vehicle configuration when transporting a patient with suspected or confirmed SARS-CoV-2 infection

Isolate the ambulance driver from the patient compartment and keep pass-through doors and windows tightly shut.

When possible, use vehicles that have isolated driver and patient compartments that can provide separate ventilation to each area.

Before entering the isolated driver's compartment, the driver (if they were involved in direct patient care) should remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment.

Close the door/window between these compartments before bringing the patient on board.

During transport, vehicle ventilation in both compartments should be on non-recirculated mode to maximize air changes that reduce potentially infectious particles in the vehicle.

If the vehicle has a rear exhaust fan, use it to draw air away from the cab, toward the patient-care area, and out the back end of the vehicle.

Some vehicles are equipped with a supplemental recirculating ventilation unit that passes air through high-efficiency particulate air (HEPA) filters before returning it to the vehicle. Such a unit can be used to increase the number of air changes per hour (ACH) Health Hazard Evaluation Report 95–0031–2601 pdf icon [1.52 MB, 10 Pages].

After patient unloading, allowing a few minutes with ambulance module doors open will rapidly dilute airborne viral particles.

If a vehicle without an isolated driver compartment must be used, open the outside air vents in the driver area and turn on the rear exhaust ventilation fans to the highest setting to create a pressure gradient toward the patient area.

Before entering the driver's compartment, the driver (if they were involved in direct patient care) should remove their gown, gloves and eye protection and perform hand hygiene to avoid soiling the compartment. They should continue to wear their NIOSH-approved N95 or equivalent or higher-level respirator.

Additional considerations when performing AGPs on patients with suspected or confirms SARS-CoV-2 infection:

If possible, consult with medical control before performing AGPs for specific guidance.

Bag valve masks (BVMs) and other ventilatory equipment should be equipped with HEPA filtration to filter expired air.

EMS systems should consult their ventilator equipment manufacturer to confirm appropriate filtration capability and the effect of filtration on positive-pressure ventilation.

If possible, the rear doors of the stationary transport vehicle should be opened and the HVAC system should be activated during AGPs. This should be done away from pedestrian traffic.

If possible, discontinue AGPs prior to entering the destination facility or communicate with receiving personnel that AGPs are being implemented.

Dental Facilities

Dental healthcare personnel (DHCP) should regularly consult their state dental boards and state or local health departments for current information and recommendations and requirements specific to their jurisdictions, which might change based on level of community transmision.

Postpone all non-urgent dental treatment for: 1) patients with suspected or confirmed SARS-CoV-2 infection until they meet criteria to discontinue Transmission-Based Precautions and 2) patients who meet criteria for quarantine until they complete quarantine as described for healthcare settings above.

Dental care for these patients should only be provided if medically necessary. Follow all recommendations for care and placement for patients with suspected or confirmed SARS-CoV-2 infection.

If a patient has a fever strongly associated with a dental diagnosis (e.g., pulpal and periapical dental pain and

intraoral swelling are present) but no other symptoms consistent with COVID-19 are present, dental care can be provided following the practices recommended for routine health care during the pandemic.

When performing aerosol generating procedures on patients who are not suspected or confirmed to have SARS-CoV-2 infection, ensure that DHCP correctly wear the recommended PPE (including a NIOSH-approved N95 or equivalent or higher-level respirator in counties with substantial or high levels of transmission) and use mitigation methods such as four-handed dentistry, high evacuation suction, and dental dams to minimize droplet spatter and aerosols.

Commonly used dental equipment known to create aerosols and airborne contamination include ultrasonic scaler, high-speed dental handpiece, air/water syringe, air polishing, and air abrasion.

Dental treatment should be provided in individual patient rooms whenever possible.

For dental facilities with open floor plans, to prevent the spread of pathogens there should be:

At least 6 feet of space between patient chairs.

Physical barriers between patient chairs. Easy-to-clean floor-to-ceiling barriers will enhance effectiveness of portable HEPA air filtration systems (check to make sure that extending barriers to the ceiling will not interfere with fire sprinkler systems).

Operatories should be oriented parallel to the direction of airflow if possible.

Where feasible, consider patient orientation carefully, placing the patient's head near the return air vents, away from pedestrian corridors, and toward the rear wall when using vestibule-type office layouts.

Ensure to account for the time required to clean and disinfect operatories between patients when calculating your daily patient volume.

Nursing Homes

Additional considerations for nursing homes are available in this Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes | CDC

Assisted Living Communities

In general, assisted living communities should follow recommendations for retirement communities or other non-healthcare congregate settings. Residents should also be counseled about strategies to protect themselves and others; CDC has a number of resources for older adults. However, in circumstances when healthcare is being delivered (e.g., by home health agency, staff providing care for a resident with SARS-CoV-2 infection), assisted living communities should follow the IPC recommendations in this guidance.

Definitions:

Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Healthcare settings refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long-term acute-care facilities, inpatient rehabilitation facilities, nursing homes, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, dental offices, and others.

Source control: Use of respirators, well-fitting facemasks, or well-fitting cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control devices should not be placed on children under age 2, anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing one safely, or anyone who is unconscious, incapacitated, or otherwise unable to remove their source control device without assistance. Face shields alone are not recommended for source control.

Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. **They are not personal**

protective equipment (PPE) appropriate for use by healthcare personnel. Guidance on design, use, and maintenance of cloth masks is available.

Facemask: OSHA defines facemasks as "a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as 'medical procedure masks." Facemasks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare.

Airborne Infection Isolation Rooms (AIIRs):

- AIIRs are single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 12 ACH (6 ACH are allowed for AIIRs last renovated or constructed prior to 1997).
- Air from these rooms should be exhausted directly to the outside or be filtered through a HEPA filter directly before recirculation.
- Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized.
- Facilities should monitor and document the proper negative-pressure function of these rooms.

Immunocompromised: For the purposes of this guidance, moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC

- Other factors, such as end-stage renal disease, may pose a lower degree of immunocompromise. However, people in this category should still consider continuing to practice physical distancing and use of source control while in a healthcare facility, even if they are up to date with all recommended COVID-19 vaccine doses.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Close contact: Being within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period with someone with SARS-CoV-2 infection.

SARS-CoV-2 Illness Severity Criteria (adapted from the NIH COVID-19 Treatment Guidelines)

The studies used to inform this guidance did not clearly define "severe" or "critical" illness. This guidance has taken a conservative approach to define these categories. Although not developed to inform decisions about duration of Transmission-Based Precautions, the definitions in the National Institutes of Health (NIH) COVID-19 Treatment Guideline are one option for defining severity of illness categories. The highest level of illness severity experienced by the patient at any point in their clinical course should be used when determining the duration of Transmission-Based Precautions. Clinical judgement regarding the contribution of SARS-CoV-2 to clinical severity might also be necessary when applying these criteria to inform infection control decisions.

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO_2) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO_2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO_2/FiO_2) <300 mmHg, or lung infiltrates >50%.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.

Previous Updates

Updates as of September 10, 2021

- Updated source control recommendations to address limited situations for healthcare facilities in counties with low to moderate community transmission where select fully vaccinated individuals could choose not to wear source control. However, in general, the safest practice is for everyone in a healthcare setting to wear source control.
- Updated quarantine recommendations for fully vaccinated patients who have had close contact with someone with SARS-CoV-2 infection to more closely align with recommendations for the community.
- Clarified the recommended intervals for testing asymptomatic HCP with a higher-risk exposure and patients with close contact with someone with SARS-CoV-2 infection.
- Added content from previously posted CDC guidance addressing:
  - Recommendations for fully vaccinated HCP, patients, and visitors
  - SARS-CoV-2 testing
  - Duration of Transmission-Based Precautions for patients with SARS-CoV-2 infection
  - Specialized healthcare settings (e.g., dental, dialysis, EMS)

As of February 10, 2021

- Updated the Implement Universal Use of Personal Protective Equipment section to expand options for source control and patient care activities in areas of moderate to substantial transmission and describe strategies for improving fit of facemasks. Definitions of source control are included at the end of this document.
- Included a reference to Optimizing Personal Protective Equipment (PPE) Supplies that include a hierarchy of strategies to implement when PPE are in short supply or unavailable.

As of December 14, 2020

- Added links to Frequently Asked Questions addressing Environmental Cleaning and Disinfection and assessing risks to patients and others exposed to healthcare personnel who worked while infected with SARS-CoV-2
- Described recommended IPC practices when caring for patients who have met criteria for a 14-day quarantine based on prolonged close contact with someone with SARS-CoV-2 infection.
- Added reminders that:
  - Double gloving is not recommended when providing care to patients with suspected or confirmed SARS-CoV-2 infection
  - In general, HCP caring for patients with suspected or confirmed SARS-CoV-2 infection should not wear more than one isolation gown at a time.

As of November 4, 2020

- Provided different options for screening individuals (healthcare personnel, patients, visitors) prior to their entry into a healthcare facility
- Provided information on factors that could impact thermometer readings
- Provided resources for evaluating and managing ventilation systems in healthcare facilities
- Added link to Frequently Asked Questions about use of Personal Protective Equipment

Last Updated Feb. 2, 2022

Agenda Item 6(h):
Approval/Rejection of Temporary Anesthesia Permit – NAC 631.2254

NAC 631.2254 Temporary permits. (NRS 631.190, 631.265)

1. The Board may grant a temporary permit to administer general anesthesia and deep sedation or a temporary permit to administer moderate sedation to an applicant who meets the qualifications for a permit to administer that type of anesthesia or sedation pursuant to NAC 631.2213.

2. A temporary permit is valid for not more than 90 days, but the Board may, in any case it deems appropriate, grant a 90-day extension of the permit.

3. The Board may require the holder of a temporary permit to pass an on-site inspection as a condition of retaining the permit. If the holder fails the inspection, his or her permit will be revoked. In case of revocation, the holder of a temporary permit may apply to be reinspected in accordance with the procedures set forth in NAC 631.2235.

(Added to NAC by Bd. of Dental Exam'rs, eff. 11-28-90; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

Agenda Item 6(i):
Approval/Rejection of Permanent Anesthesia Permit – NAC 631.2235

NAC 631.2235 Inspections and evaluations: Grading; report of recommendation of evaluator; issuance of permit for passing; failure to pass; request for reevaluation; issuance of order for summary suspension. (NRS 631.190, 631.265)

1. The persons performing an inspection or evaluation of a dentist and his or her office for the issuance or renewal of a general anesthesia permit or moderate sedation permit shall grade the dentist as passing or failing to meet the requirements set forth in NAC 631.2219 to 631.2231, inclusive. Within 72 hours after completing the inspection or evaluation, each evaluator shall report his or her recommendation for passing or failing to the Executive Director, setting forth the details supporting his or her conclusion.

2. If the dentist meets the requirements set forth in NAC 631.2219 to 631.2231, inclusive, the Board will issue the general anesthesia permit or moderate sedation permit, as applicable.

3. If the dentist does not meet the requirements set forth in NAC 631.2219 to 631.2231, inclusive, the Executive Director shall issue a written notice to the dentist that identifies the reasons he or she failed the inspection or evaluation.

4. A dentist who has received a notice of failure from the Board pursuant to subsection 3:

(a) Must cease the administration of any general anesthesia, deep sedation or moderate sedation until the dentist has obtained the general anesthesia permit or moderate sedation permit, as applicable; and

(b) May, within 15 days after receiving the notice, request the Board in writing for a reevaluation. The request for a reevaluation must state specific grounds supporting it.

5. If the reevaluation is granted by the Board, it will be conducted by different persons in the manner set forth by NAC 631.2219 to 631.2231, inclusive, for an original evaluation.

6. No dentist who has received a notice of failing an inspection or evaluation from the Board may request more than one reevaluation within any period of 12 months.

7. Pursuant to subsection 3 of NRS 233B.127, if an inspection or evaluation of a dentist or his or her office indicates that the public health, safety or welfare imperatively requires emergency action, the President of the Board may, without any further action by the Board, issue an order of summary suspension of the license of the dentist pending proceedings for revocation or other action. An order of summary suspension issued by the President of the Board must contain findings of the exigent circumstances which warrant the issuance of the order of summary suspension. The President of the Board shall not participate in any further proceedings relating to the order.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000; R004-17, 5-16-2018)

Agenda Item 6(j):
Approval/Rejection of Voluntary Surrender of License – NAC 631.160

NAC 631.160 Voluntary surrender of license. (NRS 631.190)

1. If a licensee desires voluntarily to surrender his or her license, he or she may submit to the Board a sworn written surrender of the license accompanied by delivery to the Board of the certificate of registration previously issued to him or her. The Board may accept or reject the surrender of the license. If the Board accepts the surrender of the license, the surrender is absolute and irrevocable. The Board will notify any agency or person of the surrender as it deems appropriate.

2. The voluntary surrender of a license does not preclude the Board from hearing a complaint for disciplinary action filed against the licensee.

[Bd. of Dental Exam'rs, § XX, eff. 7-21-82]

Agenda Item 6(j)(1):
Jong Min Um, DDS

Nevada State Board of Dental Examiners

6010 S. Rainbow Blvd., Bldg. A, Ste.1 • Las Vegas, NV 89118 • (702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

VOLUNTARY SURRENDER OF LICENSE

I, Jong Um (Print name), hereby surrender my (Dental) / Dental Hygiene (circle one)
License number 6883 on the 15 day of November, 2021

By signing this document, I understand, pursuant to Nevada Administrative Code (NAC) 631.160, the surrender of this license is absolute and irrevocable. Additionally, I understand that the voluntary surrender of this license does not preclude the Board from hearing a complaint for disciplinary action filed against this licensee.

Provide full current mailing address including city, state and zip on the line below:

[redacted]

Jong Um
Licensee Signature

1/21/22
Date of Signature (must correspond with notary date)

State of _____

County of _____

The statements on this document are subscribed and sworn before me this _____ *day of* _____, *20*____

Notary Public

My Commission Expires

Received
FEB 14 2022
NSBDE

06/2019

This certificate is attached to a 1 page document dealing with/entitled NEVA STATE BOARD OF DENTAL EXAMINERS and dated 01/21/2022

California JURAT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of ORANGE

Subscribed and sworn to (or affirmed) before me on this 21 day of JANUARY, 2022, by CYRIL ANDERSON, NOTARY PUBLIC,

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

CYRIL ANDERSON
COMM.# 2279638
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires March 4, 2023

Signature _____ (Seal)

Printed 01-18

Received
FEB 14 2022
NSBDE

Agenda Item 6(j)(2):
Nancy Bogan, RDH

Nevada State Board of Dental Examiners

6010 S. Rainbow Blvd., Bldg. A, Ste.1 • Las Vegas, NV 89118 • (702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

VOLUNTARY SURRENDER OF LICENSE

I, Nancy Bogan, hereby surrender my Dental / Dental Hygiene (circle one)
Print name

License number 1021 on the 7 day of March, 20 22.

By signing this document, I understand, pursuant to Nevada Administrative Code (NAC) 631.160, the surrender of this license is absolute and irrevocable. Additionally, I understand that the voluntary surrender of this license does not preclude the Board from hearing a complaint for disciplinary action filed against this licensee.

Provide full current mailing address including city, state and zip on the line below:

[redacted]

Received
MAR 09 2022
NSBDE

Nancy Bogan
Licensee Signature

3-7-2022
Date of Signature (must correspond with notary date)

State of Nevada

County of Clark

The statements on this document are subscribed and sworn before me this 7 *day of* March, *20* 22.

JANIS MORALES
NOTARY PUBLIC • STATE OF NEVADA
Appointment Recorded in Clark County
No: 19-1962-1
Expires March 1, 2023

Janis Morales
Notary Public

March 1, 2023
My Commission Expires

Agenda Item 6(k):
Consideration, Discussion, and Possible Clarification of Cost of Living Adjustment (COLA) and Pay Merit Increases to Board Staff Members Including Salaried Staff – NRS 631.190

NRS 631.190 Powers and duties. [Effective January 1, 2020.] In addition to the powers and duties provided in this chapter, the Board shall:

1. Adopt rules and regulations necessary to carry out the provisions of this chapter.

2. Appoint such committees, review panels, examiners, officers, employees, agents, attorneys, investigators and other professional consultants and define their duties and incur such expense as it may deem proper or necessary to carry out the provisions of this chapter, the expense to be paid as provided in this chapter.

3. Fix the time and place for and conduct examinations for the granting of licenses to practice dentistry, dental hygiene and dental therapy.

4. Examine applicants for licenses to practice dentistry, dental hygiene and dental therapy.

5. Collect and apply fees as provided in this chapter.

6. Keep a register of all dentists, dental hygienists and dental therapists licensed in this State, together with their addresses, license numbers and renewal certificate numbers.

7. Have and use a common seal.

8. Keep such records as may be necessary to report the acts and proceedings of the Board. Except as otherwise provided in NRS 631.368, the records must be open to public inspection.

9. Maintain offices in as many localities in the State as it finds necessary to carry out the provisions of this chapter.

10. Have discretion to examine work authorizations in dental offices or dental laboratories.

[Part 4:152:1951; A 1953, 363] — (NRS A 1963, 150; 1967, 865; 1993, 2743; 2009, 3002; 2017, 989, 2848; 2019, 3205, effective January 1, 2020)

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Legislative Counsel Bureau
Budget Account 327-2631
Governor's Recommended Budget
2019-2021 Biennium

Overview

The Legislative Counsel Bureau (LCB) is the central, non-partisan staff for the Legislature. The LCB consists of the Legislative Commission, the Interim Finance Committee, a Director and five divisions. The five divisions include:

- Administrative Division
- Audit Division
- Fiscal Analysis Division
- Legal Division
- Research Division

Budget Development Process

For the first time in many biennia, the preparation of the budget for the LCB did not begin with the consideration of a cap or other restriction regarding what could be requested. I asked the Division Chiefs of the five LCB divisions to provide me with their requests, and after some minor adjustments, those requests were submitted to the Legislative Commission for its consideration at its meeting conducted on December 19, 2018. At that meeting, the Legislative Commission authorized the Director to submit to the Governor the proposed budget with only a few minor changes from what was requested for inclusion in the Governor's recommended budget. The members of the Legislative Commission did not approve all of the items in the budget but approved forwarding the budget to the Governor so that it could be considered by the money committees during the legislative session.

The Governor's recommended budget includes enhancement requests for new positions, upgrades for existing positions, increased funds for travel and training and technology and other equipment improvements. Each of these enhancement will be discussed in greater detail as we proceed through the remainder of this presentation. The Governor's recommended budget also includes a one-shot appropriation totaling a little over $1.8 million for the payment of dues to national organizations, for computer hardware replacements for various divisions and units of the LCB and for two building maintenance projects. Those one-shot requests will be discussed in further detail when the bill including the appropriation is heard by the money committees. At that time I will also provide details regarding additional one-time projects totaling approximately $3 million

that we are proposing to fund with uncommitted money from the Legislative Fund.

After the Legislative Commission approved the submittal of the recommendation for inclusion in the Governor's budget, the Administration notified LCB staff that the Governor was including a cost of living adjustment (COLA) of 3 percent in FY 2020 for state employees in his recommended budget. As the Legislature has done in past biennia when it has approved a COLA for state employees, the Governor has pooled the funding for the COLA rather than including it in the agencies' individual budgets. Although the Governor's recommended budget does not include a separate amount for the COLA for Legislative Branch employees, the Salary Adjustment account (BA 4883) administered by the Governor's Office of Finance includes a lump sum of $31.3 million in FY 2020 and $31.6 million in FY 2021 for all state employee COLAs. I will work with the Fiscal Analysis Division to ensure that the appropriation necessary to fund the 3 percent COLA for Legislative Branch employees is reduced from Salary Adjustment account and is made directly to the Legislative Fund at the end of the budget review process. We requested $856,191 in FY 2020 and $864,106 in FY 2021 for the costs of COLAs for Legislative Branch employees.

The Legislative Commission's recommendation was submitted to the Budget Office on December 30, 2016. Other than adjustments to fringe benefits and rate changes, the Governor's recommended budget is identical to the request that was approved by the Legislative Commission on December 19, 2018.

General Fund Appropriations

The Governor's recommended budget for the LCB calls for appropriations from the State General Fund totaling approximately $36.0 million in FY 2020 and $35.3 million in FY 2021. The total proposed biennial appropriation of approximately $71.3 million for the 2019-2021 biennium is an increase of approximately $5.5 million (8.4 percent) over the appropriation approved for the current biennium.

Personnel

The LCB budget account includes base funding for the continuation of 266.25 funded full-time equivalent (FTE) permanent positions for the 2019-2021 biennium. The staff provides a variety of services to Legislators and the public and is required to maintain neutrality and to avoid participation in partisan activities or groups. The Governor's recommended budget includes enhancement funding for a net addition of 6.75 FTE permanent positions for the LCB.

Salary Increases for Director and Division Chief Positions

Based on a recommendation from the Legislative Commission when the budget for the LCB was approved for transmittal to the Governor's Office of Finance, the Governor's recommended budget includes funding for 5 percent salary increases for six LCB Division Chiefs and the LCB Director. The Governor's recommended budget includes an additional one grade increase for the Chief of the Administrative Division position to bring that position more in line with the salaries for the LCB's other Division Chief positions. The 5 percent salary increases for Division Chiefs and the LCB Director are reflected in Decision Unit E805 in the Governor's recommended budget. The cost for those increases is $58,055 in each year of the 2019-2021 biennium. The requested additional increase

for the Chief of the Administrative Division is included in E807 in the Governor's recommended budget. The cost associated with that increase is $7,188 in each year of the biennium.

Funding Summary

The LCB budget account is funded primarily through General Fund appropriations (98.4 percent) with almost all of the remaining revenue coming from gift shop sales and charges for services by the Legal Division.

	FY 2018 Budgeted	FY 2020 Gov. Rec.	FY 2019 Budgeted	FY 2021 Gov. Rec.
Revenue				
General Fund	$32,711,836	$36,016,871	$33,081,325	$35,322,604
Highway Fund	$5,000	$5,000	$5,000	$5,000
Balance Forward	$0	$0	$0	$0
Transfers	$251,945	$252,883	$249,870	$251,864
Other	$789,609	$324,033	$383,918	$335,120
Total Revenue	**$33,758,390**	**$36,598,787**	**$33,720,113**	**$35,914,588**
Expenditures				
Payroll	$28,346,367	$30,531,140	$29,316,150	$31,062,498
Operating	$5,412,023	$6,067,647	$4,403,963	$4,852,090
Total Expenditures	**$33,758,390**	**$36,598,787**	**$33,720,113**	**$35,914,588**
Positions (FTE)	**266.25**	**273.00**	**266.25**	**273.00**

Legislative Commission and Committees

Overview

The LCB budget includes funding for the activities of the Legislative Commission and other committees that meet during the interim between legislative sessions.

Budget Highlights

The base budget for Legislative Commission includes funding for the annual independent audit of the Legislative Counsel Bureau's financial statements, the costs of sign language interpreters that are needed for Interim committee meetings and for meetings with individual Legislators when the Legislature is not in session, and the costs for the meetings of statutory committees and interim studies and travel for Legislators to attend non-legislative meetings of committees to which they are appointed during the Interim. For the 2019-2021 biennium, the base budget also includes funding for the contract to administer the Legislature's confidential sexual harassment reporting system.

Prior to the current biennium, the budget for the Legislative Commission had not included funding for out-of-state travel for Legislators to attend meetings of national organizations for many years. The 2017 Legislature approved $1,000 per Legislator per year to attend meetings of organizations to which the Legislature pays dues, and funding for attendance of those meetings is continued in the base budget. With the approval of the Chair of the Legislative Commission, the base budget was increased to provide $16,634 for the operations of the Nevada Youth Legislature for the 2019-2021 biennium.

The Commission and committees portion of the budget assumes that all meetings, except meetings of the Public Lands Committee and the Committee for the Review and Oversight of the Tahoe Regional Planning Agency and the Marlette Lake Water System, will be conducted via videoconference and that members will attend the meetings in the location nearest their homes. The recommendation includes $35,000 for interim committees or new statutory committees as the Legislature deems appropriate. **Any new committees or additional studies will need to be funded before the Legislature closes the budget at the end of session.**

Funding Summary

	FY 2018 Budgeted	FY 2020 Gov. Rec.	FY 2019 Budgeted	FY 2021 Gov. Rec.
Revenue				
General Fund	$289,724	$297,247	$192,661	$209,763
Highway Fund	$5,000	$5,000	$5,000	$5,000
Transfers	$24,949	$25,328	$22,874	$23,064
Other	$8,989	$7,947	$1,498	$3,034
Total Revenue	**$328,662**	**$335,522**	**$222,033**	**$240,861**
Expenditures				
Payroll	$0	$0	$0	$0
Operating	$328,662	$335,522	$222,033	$240,861
Total Expenditures	**$328,662**	**$335,522**	**$222,033**	**$240,861**

Administrative Division

Overview

The Administrative Division provides operating and technical support to LCB divisions and the Legislature. The division is responsible for accounting and human resources; audio and video; communications; inventory; information technology; janitorial; maintenance of buildings and grounds; purchasing; legislative police; parking; and shipping and receiving.

Budget Highlights

The base budget includes funding for the continuation of 89.25 FTE positions throughout the 2019-2021 biennium.

The base budget includes $25,000 in each year of the biennium for contract services expenses for the Information Technology Services Unit. This amount has historically been built into the budget to allow us the ability to use consultants as necessary for the design of new programs and to improve functionality of existing systems. The base budget also reflects increases in costs for ongoing maintenance of Broadcast and Production and Information technology equipment and software and reflects projected increases in building maintenance costs for the upcoming biennium.

- **Decision Unit E226** includes a restructuring of positions within the Accounting Unit, which would eliminate a half-time Accounting Technician position and would increase a 0.75 FTE Accounting Technician to full-time. With two part-time positions is such a small unit, it has been difficult to find qualified applicants who are looking for the specific part-time schedules we have had available. We believe that even though this request would reduce the total FTE for the Accounting Unit by 0.25, it will be easier to ensure that the Unit's positions are filled rather than vacant in the future. This request would reduce General Fund appropriations by $28,328 in FY 2020 and by $30,496 in FY 2021.

- **Decision Unit E710** provides for the replacement of the mailing machine used by the General Services Unit to provide mail services for the Legislative Branch. The request would increase General Fund appropriations by $9,000 in FY 2020.

- **Decision Unit E807** includes a one-grade increase for an Administrative Assistant position in the Legislative Police Unit due to the review of the position's duties with respect to other similar positions within the Administrative Division. This request would increase General Fund appropriations by $2,374 in FY 2020 and by $2,274 in FY 2021.

- **Decision Unit E900** transfers the Silver-Haired Legislative Forum Coordinator position from the Administrative Division's Las Vegas Office Unit to the Research Division to improve the policy and research services provided to the Forum. Although the request results in a reduction in General Fund appropriations for the Administrative Division, the identical amount of funds are added to the budget for the Research Division.

Funding Summary

With the exception of some minor amounts received for cell phone tower rental and compensation for services from other accounts, the Administrative Division is funded through General Fund appropriations.

	FY 2018 Budgeted	FY 2020 Gov. Rec.	FY 2019 Budgeted	FY 2021 Gov. Rec.
Revenue				
General Fund	$9,811,052	$10,454,664	$10,178,687	$10,637,929
Transfers	$30,000	$30,000	$30,000	$30,000
Other	$20,370	$23,586	$15,020	$14,586
Total Revenue	**$9,861,422**	**$10,508,250**	**$10,223,707**	**$10,682,515**
Expenditures				
Payroll	$7,714,907	$8,247,156	$7,346,336	$8,304,095
Operating	$2,146,515	$2,261,094	$2,196,359	$2,378,420
Total Expenditures	**$9,861,422**	**$10,508,250**	**$9,542,695**	**$10,682,515**
Positions (FTE)	**89.25**	**88.00**	**89.25**	**88.00**

Audit Division

Overview

The Audit Division performs post audits of the Executive and Judicial Branches of state government as part of the Legislature's oversight responsibility for public programs. The Division also ensures that an audit of Nevada State Government (the single-audit) is conducted each year. This audit is necessary to ensure the continued funding of federal programs.

Budget Highlights

The base budget for the Audit Division includes funding for the continuation of 29 FTE positions throughout the 2019-2021 biennium. The Division still is one auditor position short of the staffing level it had achieved prior to the budget reductions that resulted from the Great Recession. The base budget also includes sufficient in-state travel funds to conduct the audits that are included in the Basic Audit program for the next two years that was approved by the Legislative Commission at its August 30, 2018, meeting. Finally, the base budget reflects significant increased costs for contract services based on the Audit Subcommittee's recent approval of the contract for the statewide audit.

- **Decision Unit E226** includes funding for two new Deputy Auditor positions to allow the Audit Division to maintain a constant presence at the Division of Health Care Financing and Policy given the significant funding that flows through the Medicaid program. The two positions would be supervised by an existing Audit Supervisor, and existing audit staff could assist when needed. The Audit Division's last two audits of the Division of Health Care Financing and Policy were issued in 2008 and 2015 and both audits identified significant overpayments to providers.

  A separate team of dedicated staff will allow the Audit Division to develop and maintain expertise regarding Medicaid, which will enable the Division to be more efficient and effective in conducting Medicaid audits. The two new positions would result in increased General Fund appropriations totaling $178,762 in FY 2020 and $227,716 in FY 2021.

- **Decision Unit E226** also includes an additional new Deputy Auditor to assist with oversight of governmental and private facilities for children and child welfare agencies. Pursuant to NRS 218G.575 the Audit Division performs a variety of oversight activities of governmental and private facilities for children. This includes, in part, receiving and reviewing complaints filed by a child or other person on behalf of child, conducting on-site reviews and inspections, performing unannounced site visits, reviewing policies and procedures, and conducting surveys. The Division also reviews case files of child fatalities and near fatalities when a child welfare agency had prior contact with a child or family. This involves a detailed review of approximately 100 case files each biennium.

  In total, Nevada has about 60 facilities which include correction and detention, child welfare, mental health treatment, substance abuse treatment, group homes, residential centers, and foster care entities. These facilities house more than

1,600 children and approximately 1,500 complaints are filed with our office annually. Of these facilities, the Audit Division conducts approximately 3 detailed reviews and 4 unannounced site visits annually. Therefore, Audit Division on-site coverage of these facilities can be improved with an additional position. The additional position would increase General Fund appropriations by $72,899 in FY 2020 and $91,376 in FY 2021.

Funding Summary

The Audit Division is funded entirely through appropriations from the State General Fund.

	FY 2018 Budgeted	FY 2020 Gov. Rec.	FY 2019 Budgeted	FY 2021 Gov. Rec.
Revenue				
General Fund	$3,657,913	$4,166,600	$3,836,267	$4,334,137
Total Revenue	**$3,657,913**	**$4,166,600**	**$3,836,267**	**$4,334,137**
Expenditures				
Payroll	$3,426,041	$3,832,654	$3,578,744	$4,004,746
Operating	$231,872	$333,946	$257,523	$329,391
Total Expenditures	**$3,657,913**	**$4,166,600**	**$3,836,267**	**$4,334,137**
Positions (FTE)	**29.00**	**32.00**	**29.00**	**32.00**

Fiscal Analysis Division

Overview

The Fiscal Analysis Division provides the Legislature with the capability for independent review and analysis of budgetary, tax and fiscal matters. The division examines the Governor's recommended budget and suggests possible adjustments and provides expenditure and revenue analyses to aid the legislative money and tax and revenue committees. The division is also responsible for providing administrative support and revenue projections for the Economic Forum and for ensuring that fiscal notes are provided for legislation as required by law.

Budget Highlights

The base budget for the Fiscal Analysis Division includes funding for the continuation of 29 FTE positions throughout the 2019-2021 biennium. The base budget includes funding for the continuation of contracts with Moody's for revenue projection services and with InSite for school expenditure reporting.

- **Decision Unit E227** includes General Fund appropriations totaling $6,371 in FY 2020 and $3,185 in FY 2021 for increased training costs for the Fiscal Analysis Division. The Fiscal Analysis Division requests to send two staff members in FY 2020 and one staff member in FY 2021 to the Legislative Staff Management Institute training conducted in Sacramento each year. This 8-day course is conducted by The University of Southern California Sol Price School of Public Policy and the California State University Sacramento Center for California Studies. The course provides the opportunity for legislative staff to develop leadership and consensus building skills in preparation for further leadership opportunities.

- **Decision Unit E228** requests $156,000 in General Fund appropriations for FY 2020 for upgrades to the Budget Analysis System of Nevada (BASN), which is used by the Division to analyze and review the Agency Request and The Executive Budget and to finalize the legislatively approved budget.

  BASN is the Legislative Branch's counterpart to the Nevada Executive Budget System (NEBS) that is utilized by the Executive Branch to build and transmit the Agency Request and Governor's Executive Budget, and then to receive and load the legislatively approved budget. Both NEBS and BASN are built with similar system architecture/functionality, and were developed and built by the same vendor. The Governor's Finance Office has included in its budget request $1.44 million to upgrade NEBS. This request is contingent upon the approval of the companion one-shot appropriation request (BDR 1165) made by the Governor's Finance Office.

- **Decision Unit E230** requests $7,635 in FY 2020 and $5,000 in FY 2021 to ensure the Division's SharePoint system is functionally maintained and immediate assistance is available in the event the system malfunctions. The funding would allow a Program Analyst to attend a SharePoint 2016 Power End User Course in Reno. This training will provide the attendee with the ability to manage and share

our content, create new pages in our SharePoint site, and automate business processes. This person will then be responsible for training additional staff, to ensure continuity of SharePoint in the future. The funding would also be used to secure the services of a vendor to provide helpdesk support for SharePoint during the biennium if issues arise that cannot be addressed by LCB staff.

- **Decision unit E720** requests General Fund appropriations of $14,020 in FY 2020 for a new video conferencing system for the Division's west conference room and to replace the conference table in the west conference room and the chairs in both of the Division's conference rooms.

Funding Summary

The budget for the Fiscal Analysis Division is funded entirely through General Fund appropriations.

	FY 2018 Budgeted	FY 2020 Gov. Rec.	FY 2019 Budgeted	FY 2019 Gov. Rec.
Revenue				
General Fund	$3,945,225	$4,286,410	$4,099,010	$4,169,177
Other	$0	$0	$0	$0
Total Revenue	**$3,945,225**	**$4,286,410**	**$4,099,010**	**$4,169,177**
Expenditures				
Payroll	$3,572,310	$3,699,339	$3,689,338	$3,734,846
Operating	$372,915	$587,071	$409,672	$434,331
Total Expenditures	**$3,945,225**	**$4,286,410**	**$4,099,010**	**$4,169,177**
Positions (FTE)	**29.00**	**29.00**	**29.00**	**29.00**

Research Division

Overview

The Research Division is the general information and service arm of the Legislature. It conducts research into a wide variety of subjects at the request of Legislators, legislative committees, other State and local officials, and citizens of Nevada. It also responds to inquiries concerning Nevada's government, laws, and public policy issues from residents, counterpart agencies, and public officials in other states. Division employees also provide primary staff report for most standing committees and some statutory and interim committees.

Budget Highlights

The base budget for the Research Division includes funding for the continuation of 44 FTE positions throughout the 2019-21 biennium. The base budget has been adjusted for the projected In-State travel needs of the division as well for projected increase in costs for publications purchased for the Research Library.

- **Decision unit E226** includes $45,562 in FY 2020 and $93,167 in FY 2021 for the costs of continuing as permanent a session Geographic Information Systems (GIS) Analyst position increasing the Grade level for the position based on the duties associated with the permanent nature of the position. In addition to serving as LCB's primary redistricting specialist in the run-up to and during the 2021 Legislative Session, the position would also assist the various divisions of the LCB with responding to requests for "story maps" and other spatial representations.

- **Decision Unit E227** includes $1,750 in each year of the 2019-2021 biennium for additional anticipated Out-of-State travel costs associated with the Research Librarian's tenure as Chair of NCSL's Legislative Research Librarians group.

- **Decision Unit E807** includes $24,463 in FY 2020 and $24,413 in FY 2021 to upgrade an existing Grade 44 Principal Research Analyst position to a Grade 46 Senior Principal Policy Analyst position and to upgrade the Manager of Research Policy Assistants position from a Grade 33 to a Grade 36. The upgrade for the Principal Research Analyst is a continuation of the Division's efforts to create a more defined career track for Division personnel and to enhance succession planning efforts within the Division. The upgrade for the Manager of the Research Policy Assistants is to recognize the incumbent's to take on additional duties associated with recruiting and training Policy Assistants in addition to her other supervisory duties.

- **Decision Unit E900** transfers the Silver-Haired Legislative Forum Coordinator position from the Administrative Division's Las Vegas Office Unit to the Research Division to improve the policy and research services provided to the Forum. Although the request results in a reduction in General Fund appropriations for the Administrative Division, the identical amount of funds are added to the budget for the Research Division.

Funding Summary

The activities of the Research Division are funded almost entirely with General Fund appropriations. The Division receives a small amount of funding from outside agencies for the funding of particular positions dedicated to the subject matter of the funding agencies.

	FY 2018 Budgeted	FY 2020 Gov. Rec.	FY 2019 Budgeted	FY 2021 Gov. Rec.
Revenue				
General Fund	$5,030,889	$5,356,899	$5,113,217	$5,416,480
Transfers	$68,405	$68,405	$68,405	$68,405
Other	$0	$0	$0	$0
Total Revenue	**$5,099,294**	**$5,425,304**	**$5,181,622**	**$5,484,885**
Expenditures				
Payroll	$4,956,460	$5,236,871	$5,055,349	$5,342,905
Operating	$142,834	$188,433	$126,273	$141,980
Total Expenditures	**$5,099,294**	**$5,425,304**	**$5,181,622**	**$5,484,885**
Positions (FTE)	**44.00**	**46.00**	**44.00**	**46.00**

Legal Division

Overview

The Legal Division drafts bills, resolutions and legal opinions, provides Committee Counsel for all interim studies and most standing legislative committees, drafts and reviews administrative regulations, and serves as legal adviser to the Legislature and the other divisions of the LCB. The Division also codifies and publishes the NRS and NAC, state agency pamphlets and several compilations of selected portions of NRS. The staff produces an electronic version of the statutes and regulations and other publications titled the *Official Nevada Law Library*. The Division also produces and distributes the BDR list and the *Register of Administrative Regulations.* In conjunction with its publications program, the Division also operates the State Printing Office and the Nevada Legislative Gift Shop.

Budget Highlights

The base budget for the Legal Division includes funding for the continuation of 75 FTE permanent positions throughout the 2019-2021 biennium. The base budget also includes increased funding for In-State travel and contract services in the upcoming biennium and funding for a projected increase in printing costs.

Decision unit E226 includes General Fund appropriations totaling $122,999 in FY 2020 and $168,726 in FY 2021 for two new positions for the Legal Division. The request includes a new Associate Law Indexer position to assist with the indexing function of the Division's workload and a new Paralegal position to assist with a current significant overtime requirement within the paralegal function of the office.

Decision unit E227 includes General Fund appropriations totaling $8,099 in FY 2020 and $13,859 in FY 2021 for additional travel and training to provide additional opportunities for Division staff to develop expertise in areas of concern to the Legislature.

Decision unit E229 includes General Fund appropriations totaling $4,962 in each fiscal year of the 2019-2021 biennium to provide for increased advertising of the Legal Division's publications, which currently support the Division's budget and are being proposed to offset session costs in the upcoming biennium. The proposal to use the publications revenue to offset session costs is addressed in more detail below.

Decision unit E231 transfers publications sales revenues totaling $471,770 in FY 2020 and $80,950 in FY 2021 from the LCB account to instead offset the costs of legislative sessions. Due to the timing associated with completion of publications, the revenues can vary drastically from year to year and would be better suited to cover costs that are tracked by biennium rather than by fiscal year. Additionally, the transfer of the revenues would allow the Legal Division to focus more on providing legal services than selling publications.

Although this request increases General Fund appropriations in this account by $552,720 over the biennium, a corresponding decrease has been made in the Governor's recommended budget to the General Fund appropriation for the costs of the 2021 Legislative Session. There is no net impact to the General Fund in the 2019-2021 biennium resulting from this recommendation, and the LCB as a whole will continue to ensure that sales of legislative publications are promoted aggressively.

- **Decision unit E807** includes $152,890 in FY 2020 and $154,727 in FY 2021 for the reclassification of a part-time secretary to full-time and grade increases for 16 of the division's employees. The request also includes a decrease in grade level for two positions as part of the restructuring of the office.

  The reclassification is requested to convert a 0.75 intermittent Secretary position to a full-time permanent Administrative Assistant position. The cost for the reclassification would total $30,141 in FY 2020 and $30,160 in FY 2021. The reclassification is warranted based on the Division being required to take on a larger role in staffing committees during the Interim.

  The position upgrades include the following:

  - 2 Associate Law Indexer positions from Grade 38 to Grade 40
  - 1 Assistant Law Indexer from Grade 33 to Grade 35
  - 1 Computer Programmer from Grade 40 to Grade 42
  - 1 Application Specialist from Grade 40 to Grade 43
  - 1 Manager of Publications and Gift Shop from Grade 35 to Grade 38
  - 1 Assistant Manager of Publications and Gift Shop from Grade 31 to Grade 35
  - 1 Publications Clerk from Grade 29 to Grade 30
  - 1 Deputy Administrator from Grade 37 to Grade 40
  - 1 Editor from Grade 36 to Grade 40 with a title change to Paralegal Manager
  - 1 Data Specialist from Grade 29 to Grade 30
  - 4 Document Specialist positions from Grade 29 to Grade 30
  - 1 Document Control Clerk from Grade 29 to Grade 30

  The decrease in Grade levels are for the following:

  - 1 Senior Paralegal at Grade 37 reduced to a Paralegal at Grade 36
  - 1 Grade 37 Paralegal position reduced to a Grade 36 Paralegal

Funding Summary

If decision unit E231 is approved, much of the sources of revenue other than General Funds will be removed from the Legal Division budget. The remaining non-General Fund revenue sources will include regulation review fees and Gift Shop sales revenues.

	FY 2018 Budgeted	FY 2020 Gov. Rec.	FY 2019 Budgeted	FY 2021 Gov. Rec.
Revenue				
General Fund	$9,977,033	$11,455,051	$9,661,483	$10,555,118
Transfers	$128,591	$129,150	$128,591	$130,395
Other	$760,250	$292,500	$367,400	$317,500
Total Revenue	**$10,865,874**	**$11,876,701**	**$10,157,474**	**$11,003,013**
Expenditures				
Payroll	$8,676,649	$9,515,120	$9,009,859	$9,675,906
Operating	$2,189,225	$2,361,581	$1,147,615	$1,327,107
Total Expenditures	**$10,865,874**	**$11,876,701**	**$10,157,474**	**$11,003,013**
Positions (FTE)	**75.00**	**78.00**	**75.00**	**78.00**