COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

To: Members of the State Board of Health

From: Laurie Schoder, Policy Analyst, Health Facilities and Emergency Medical Services Division

Through: D. Randy Kuykendall, MLS; Director *DRK*

Date: April 18, 2018

Subject: **Rulemaking Hearing**
Proposed Amendments to 6 CCR 1011-1, Ch. 7, Assisted Living Residences, for the April 18, 2018 rulemaking hearing.

The Division is requesting that the Board adopt the Division's proposed revisions to Chapter 7, Assisted Living Residences.

The Division's rules regarding assisted living residences (ALRs) have not been comprehensively reviewed and revised since they were initially promulgated in 1985, while the provision of health care in general and residential care in particular has changed significantly during that time. The number of assisted living residences in Colorado has consistently increased and has risen from 500 to over 671 in the last decade. Along with this increase in licenses has come an increase in consumer complaints and care deficiencies found by the Department. The chart attached to this cover memo illustrates the Department's increased workload due to both facility growth and on-site surveys.

The Division has made numerous changes to the rule proposal that was originally presented to the Board in the February 21, 2018 request for rulemaking packet. These changes include technical clarifications recommended by the Office of the Attorney General and others along with substantive modifications that the Division agreed to make in response to feedback from various stakeholders. The Factsheet attached to this cover memo outlines the major concerns raised by stakeholders along with the Division's responses and has been previously shared with stakeholders.

At the February 21, 2018 request for hearing, Board members raised several distinct issues for the Division to consider further. The Division's response to those issues follows.

Member Matthew VanAuken asked whether there should be a limit to the "break in service" language used in section 7.17 to exempt a personal care worker from the orientation and training requirements. The Division explored various options and determined that three years or less would be a reasonable time limit given the other competency assurances listed in 7.17 (A) through (D). The three year time limit has been added to the proposed rules.

Dr. Daniel Pastula suggested that the Division to be mindful of the wording used in the resident rights section, particularly regarding references to race, ethnicity and gender. The Division concurred with this suggestion and modified the wording where appropriate.

Commissioner Lew Gaiter asked the Division to explore whether anything in the at-risk youth reporting would be useful to add to the at-risk adult reporting requirements at section 5.1. The Department researched the reporting requirements for both at-risk youth and at-risk adults and found they were quite

similar. However; since there is a section of the Colorado criminal code regarding “wrongs to at-risk adults” and the procedure for mandatory reporting, the Division believes that reference to that criminal statute alone is sufficient.

Member Nadeen Ibrahim asked the Division about section 16.37 regarding mop water and how it compared to the regulations for Colorado Retail Food Establishments at 6 CCR 1010-2. The Division consulted with the Division of Environmental Health and Sustainability on this issue and was informed that the retail food regulations at section 5-210 require a mop sink where a floor sink is not available. Since most residential settings like small ALRs are not going to have floor sinks, the requirement that mop water be disposed of in a sanitary sewer such as a toilet bathtub or utility sink was determined to be the best alternative.

Member Patricia Hammon inquired about how an ALR would contact its CPR trained staff in the event of an emergency. The proposed rules require that there be at least one CPR trained staff member on-site at all times and that there be list of all CPR certified staff posted in visible location that is readily available at all times. Each ALR must then determine, based upon their building size and design, how to coordinate communication with CPR certified staff to ensure compliance with section 8.10 that requires staff to promptly provide CPR when appropriate.

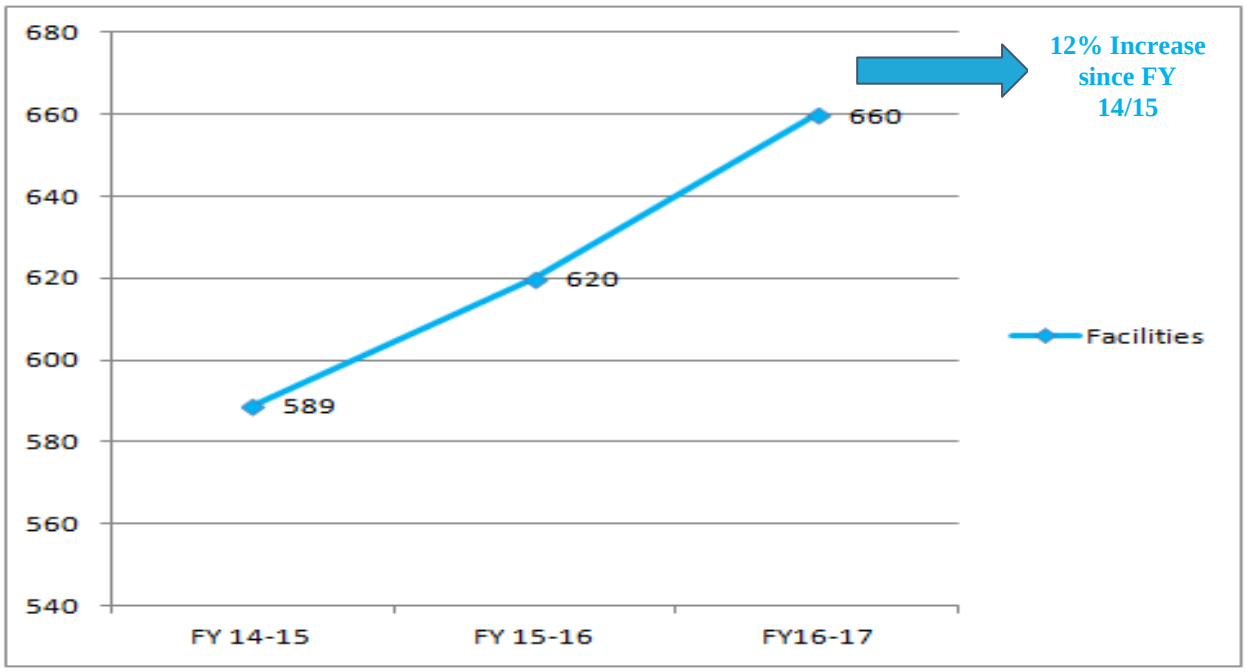
Ms. Hammon also asked the Division to consider adding a requirement for bathroom call lights and/or resident panic buttons. The Division agrees that such a requirement would certainly enhance the health, safety and welfare of residents. However; given the variability in the types of settings, size, resident acuity, etc., it would be difficult to achieve consensus on this issue. Moreover, because of stakeholder feedback about cost and burden, the Department has already compromised on rules with less financial impact than this one.

Lastly, the Board asked the Division include any letters of support for the proposed rules. The Department received eight letters of support which are included in this rule-making packet for the Board’s consideration.

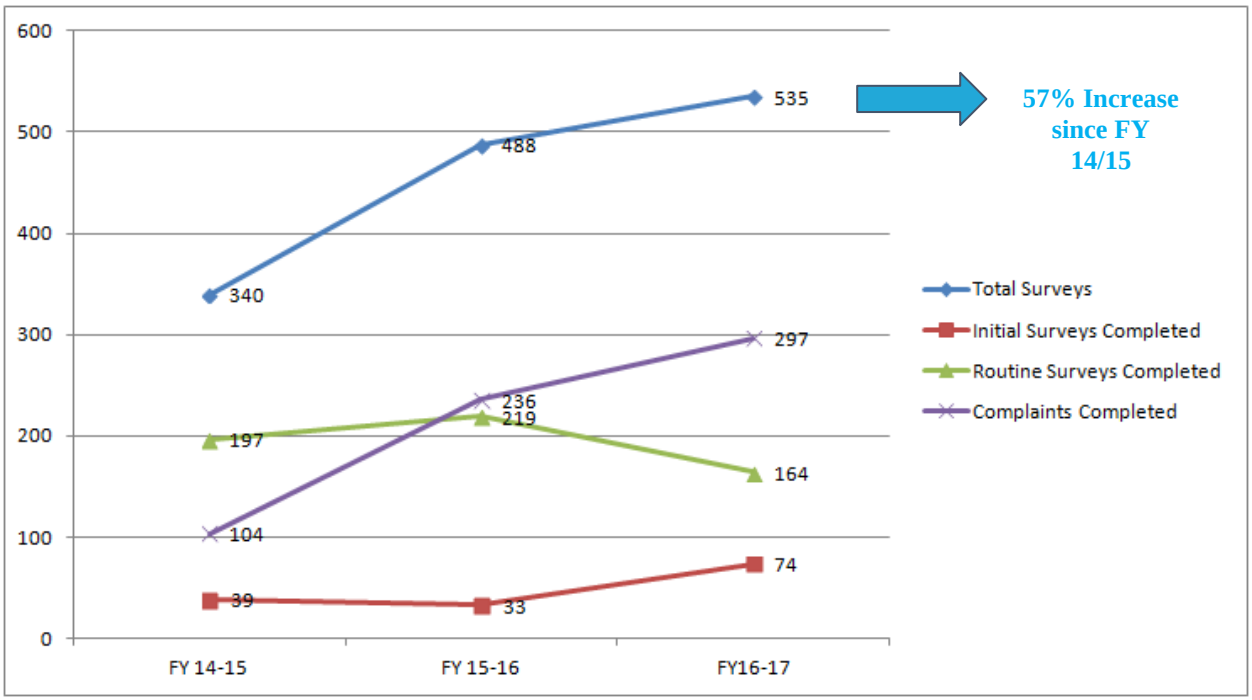
Yellow highlighting indicates a signficant change from, or clarification of, the rulemaking packet since the request for rulemaking presentation.

Therefore, the Division respectfully requests that the Board adopt the proposed revisions to 6 CCR 1011-1, Chapter 7, Assisted Living Residences.

Increased ALR Workload- Facility Growth



Increased ALR Workload- Onsite Surveys



Factsheet

Proposed Assisted Living Regulations

Below are the main concerns expressed by stakeholders along with Department responses. Modifications to the draft rules are denoted by the "▲" symbol.

1. Administrator qualifications

▲ Regulation: Section 6.3 increases administrator qualifications. Concern: This change unduly limits who can be an administrator. Response: Existing administrators are grandfathered. Modification - Effective July 1, 2019, the minimum qualifications for administrators will be: 21 years of age, have a high school diploma or equivalent, one year of personal care services supervisory experience, and completion of the administrator course.

2. Physical plant – Facilities Guidelines Institute (FGI)

▲ Regulation: Sections 20.3 and 20.4 require compliance with FGI design standards effective 06/01/19 for new licensees and 12/01/19 for renovations by existing licensees. Concern: Various sections of the FGI are unduly burdensome. Response: Modification – ALRs with 10 beds or less do not have to meet the FGI requirements regarding elevators and bathroom access requirements. Existing facilities that do not renovate are grandfathered.

3. Fees

▲ Regulation: Sections 3.6 and 3.7 increase fees. Concern: The fee increases are too high. Response: Modification – reduction of the initial licensure fee for 3-8 bed ALRs from $7,300 to $6,300. Additional reductions would prevent the department from meeting its statutory obligations to protect the health and safety of consumers. The per-bed, per-day increase for renewal licensure is:

	HMU	Non-HMU
8 Beds	11 cents	22 cents
20 beds	8 cents	18 cents
50 beds	6 cents	16 cents

4. Night checks in non-dementia care units

▲ Regulation: Section 8.2 requires staff to check on residents (who consent to checks) at least every 4 hours between 10 pm and 6 am. Concern: Requiring staff to wake up at night is unduly burdensome. Response: Modification - Between 10 pm and 6 am, staff shall conduct a status check of consenting residents.

5. Food safety

▲ **Commercial kitchens**. Regulation: Section 16 requires certain kitchen equipment. Concern: Facilities with less than 20 beds must have commercial kitchens. Response: Modification – Clarification that a commercial kitchen is not required for facilities with less than 20 beds.

Monitoring food serving temperatures. Regulation: Sections 16.24-16.26 establish cooking and holding temperatures for potentially hazardous foods (e.g., meat and fish) to control the growth of bacteria that lead to foodborne illness. Concern: Facilities must log food serving temperatures. Response: A food temperature log is not required. Compliance will be verified by policy review and observation of facility practices.

6. Oversight of hospice services

Regulation: Section 8.13 requires facilities with residents on hospice to have a written agreement with hospice providers addressing service coordination. Concern: Facilities must oversee hospice care. Response: This provision is mirrored in current hospice regulations. Modification – Clarification that coordination, rather than oversight, is required to ensure that resident needs are met.

7. Staff training

General Care Delivery. Regulation: Sections 7.8 and 7.9 require orientation and training for personal care workers (PCWs) on various topics relevant to their duties. Concern: Training is costly. Response: PCWs are caregivers that assist residents with activities of daily living such as eating and ambulation. They are typically laypersons who are not a licensed or registered health care professionals. The training, which concerns assignments and duties, is needed to ensure staff know how to deliver appropriate care and protect patient safety.

Specialized Techniques. Regulation. Section 7.22 establishes who can train personal care workers on specialized techniques, such as catheter care and the application of splints. Concern: All personal care workers (PCWs) must receive training on specialized techniques. Response: Training on a specialized technique is only required for PCWs who are going to use that technique.

CPR/Obstructed Airway/First Aid. Regulation: Sections 8.6 and 8.7 require a staff member onsite who is certified in cardiopulmonary resuscitation (CPR) and obstructed airway (choking) techniques, as well a staff member certified in first aid. Concern: Training is costly. Response: These basic life saving techniques are responsive to the following issues raised by the emergency responder community: 1) CPR and assistance with choking should not be delayed until 911 arrives and 2) staff knowledge and application of first aid prevents unnecessary 911 calls. The American Red Cross offers CPR/First Aid courses that can be completed in 3 hours (2 hours online plus 1 hour classroom).

Fall Prevention. Regulation: Section 7.9 (H) requires training on fall prevention. Concern: Training is costly. Response: This requirement is responsive to the concern expressed by the emergency responder community regarding the large numbers of 911 calls from ALRs seeking resident lift assistance - a burden that draws resources away from other emergency calls. Falls are the leading cause of injury-related death and hospitalization among older adults in Colorado. Risk of falls increases directly with age. Each week, there are 394 emergency department discharges among residents ages 65+, 158 inpatient hospitalizations, and 14 deaths due to fall injuries (2015 data).

Care for Residents with Dementia. Regulation: Section 25.14 requires secure environment staff to have 8 hours of dementia care training. Concern: Training is costly. Response: Secure units care for residents in danger of harming themselves and others. Since staff are typically laypeople who are not licensed or registered health care professionals, training prevents abuse and neglect.

8. Awake staff in dementia care units

Regulation: Section 25.17 requires awake staff on duty at all times in secure units. Concern: Requirement is burdensome. Response: The requirement aligns with the ALR statutory definition which provides that assisted living residents shall be provided with "at least the following services: …regular supervision that shall be available on a twenty-four hour basis…" (See Section 25-27-102 (1.3), C.R.S.) Twenty four hour monitoring is important because of the following behaviors associated with dementia: wandering, verbal and physical aggression, incontinence, sleeplessness, and sun-downing (late day confusion that can span through the night).

9. Waste management

Regulation: Section 24.2 requires the disposal of medical waste in accordance with specified regulations. Concern: Requirement is burdensome. Response: This references an environmental regulation in effect since the 1980s.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
Amendments to 6CCR 1011-1, Chapter 7, Assisted Living Residences
April 18, 2018

Basis and Purpose

The proposed rules consist of two distinct issues: 1) Revising the minimum standards for Assisted Living Residences (ALRs) to ensure resident safety and well-being and bring the rules into alignment with current industry practices; and 2) Increasing the license related fees paid by ALRs to ensure the Department has the appropriate level of resources to meet its statutory obligations to provide a comprehensive system of ALR regulation, oversight, and enforcement, including periodic on-site surveys of ALRs and timely response to complaints. The requested fee increase is separate from and not due to the revised health and safety standards.

Pursuant to §25-27-107(1.5)(b), C.R.S., the Department held multiple public stakeholder meetings on behalf of the Board of Health to discuss issues pertaining to license fees. Specifically, the Department held six town hall style meetings across the State to solicit feedback on the proposed rules, including the fee proposals. Two of the meetings were in the Denver metropolitan area while the other four were in Grand Junction, Pueblo, Colorado Springs, and Greeley. The Department notified all licensed facilities of those town halls as well as posting details on its website and blog for the general public. The Department has also posted drafts of the rule revisions and accompanying fee proposals on its public webpages and invited all its licensees as well as other interested stakeholders to submit comments and recommendations.

Health and Safety Standards:

The first and foremost reason for the proposed rules regarding health and safety standards is compliance with §24-4-103.3(1), C.R.S., which requires the Department to regularly evaluate its rules and determine, among other things, whether the rule has achieved the desired intent and whether more or less regulation is necessary.

The Department's rules regarding assisted living residences (ALRs) have not been comprehensively reviewed and revised since they were initially promulgated in 1985 while the provision of health care in general and residential care in particular has changed significantly. The individuals being served in assisted living residences have more complex healthcare needs than ever before, thus necessitating updated standards to address these needs.

Additionally, the number of assisted living residences in Colorado has risen in the last decade from 500 to over 671. Along with this increase in licenses has come an increase in consumer complaints and care deficiencies found by the Department. Amending the assisted living residence rules will accomplish three primary goals:

1) To better educate, inform and guide facility owners, administrators and staff concerning the care they provide and the residents they serve,

2) To more effectively protect residents and ensure they receive appropriate care while respecting each resident's personal choice and freedom, and

3) To better educate and inform family members and potential consumers regarding the care and services they can expect from a facility, along with the limitations of an assisted living facility compared to a nursing facility.

The Department and many stakeholders agree that it will benefit residents, owners/operators, staff and the community at large to have rules that clearly reflect current industry standards of care along with the Department's specific health and safety expectations.

Increased License-related Fees:

Colorado's ALR industry has experienced rapid growth (82 new residences since FY 15), is serving residents with more complex needs than in the past and is the subject of an increasing amount of complaints (up 140% over the last two years). There are also more ALRs subject to enforcement actions and being investigated for operating without a license. The revenue collected by the ALR initial and renewal licensing fees has not kept pace with the increased workload, and in fact is not sufficient to even fully fund existing appropriations. As a result, the Department's ALR program cannot meet the statutory requirement to survey (inspect) ALRs on a regular basis, and also cannot complete complaint investigations timely. While efforts have been made to increase efficiency, those gains have not been enough to offset the increased need. Through a detailed analysis the Department has identified a need for increased fees to support the regulation of ALRs. The fee increase would be implemented through a phased-in approach.

Specific Statutory Authority

Statutes that require or authorize rulemaking:
Section 25-27-104, C.R.S. (2017).
Section 25-27-107, C.R.S. (2017).
Section 25-27-111, C.R.S. (2017).
Section 25-27-113, C.R.S. (2017).

Is this rulemaking due to a change in state statute?

_____ Yes, the bill number is _____. Rules are ___ authorized ___ required.
___X___No

Does this rulemaking incorporate materials by reference?

___X___ Yes X URL or ___ Sent to State Publications Library
_____ No

Does this rulemaking create or modify fines or fees?

___X____ Yes
_____ No

Does the proposed rule create (or increase) a state mandate on local government?

_X_ No. This rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed. Though the rule does not contain a state mandate, the rule may apply to a local government if the local government has opted to perform an activity, or local government may be engaged as a stakeholder because the rule is important to other local government activities.

___ No. This rulemaking reduces or eliminates a state mandate on local government.

___ Yes. This rule includes a new state mandate or increases the level of service required to comply with an existing state mandate, and local government will not be reimbursed for the costs associated with the new mandate or increase in service.

The state mandate is categorized as:
___ Necessitated by federal law, state law, or a court order
___ Caused by the State's participation in an optional federal program

___ Imposed by the sole discretion of a Department
___ Other: _____

Has an elected official or other representatives of local governments disagreed with this categorization of the mandate? ___ Yes _X_ No

If yes, please explain why there is disagreement in the categorization.

Please elaborate as to why a rule that contains a state mandate on local government is necessary.

Not applicable.

REGULATORY ANALYSIS
Amendments to 6CCR 1011-1 Chapter 7, Assisted Living Residences
April 18, 2018

1. A description of the classes of persons affected by the proposed rule, including the classes that will bear the costs and the classes that will benefit from the proposed rule.

Health and Safety Standards:
Owners, operators, staff and residents of Assisted Living Residences (ALRs) will all be affected by the proposed rule. The owners/operators of ALRs will be the primary group responsible to bear the costs of the rule.

Increased License-related Fees:
The increased fees will be paid by the existing owners of ALRs as well as owners that wish to open new ALRs within Colorado. Whether the increased fee amounts will be passed on to ALR residents in the form of higher monthly fees will be an operational decision within each ALR.

Since the increased fees are necessary to provide a comprehensive regulatory, oversight and enforcement system, the classes that will benefit from the rule include ALR residents and residents' families through assurance that ALRs are providing appropriate services and care in a safe environment. ALR owners and operators also benefit through earlier identification of potential issues because it allows them to make corrections before any residents experience harm.

A. Identify each group of individuals/entities that rely on the rule to maintain their own businesses, agencies or operation, and the size of the group:

Health and Safety Standards:
There are currently approximately 671 licensed assisted living residences that rely on the rule to operate their businesses.

Increased License-related Fees:
Any ALR currently operating within Colorado will need to pay the increased license renewal fees to ensure continued licensing, which is a requirement of continued operations. At the time of the analysis, there were 671 licensed ALRs, but the industry is growing and the number of ALRs has increased by over 80 residences in the past 3 years. Should this growth continue as expected, the size of the impacted group will increase. New ALRs (approximately 30 per year) will pay initial licensing fees as part of the initial licensing application in pursuit of a license to operate within the state. ALRs going through a change in ownership will also pay increased fees. The size of this group fluctuates from year to year but averaged 8 residences per year over the past three years.

B. Identify each group of individuals/entities interested in the outcomes the rule and those identified in #1.A achieve, and if applicable, the size of the group:

Health and Safety Standards:
The groups of individuals/entities interested in the outcomes of the rule and their numbers are as follows:

- ALR residents – (Estimated to be over 20,000 individuals based on the existence of approximately 25,000 licensed ALR beds in Colorado).
- ALR licensees – 671
- Industry organizations – 3
- Consumer advocacy groups – 6
- Fire protection and emergency medical services agencies – 50
- Architectural, design and planning firms – 10
- Other state and local governmental agencies – 3

Increased License-related Fees:
Other than the ALR owners/operators, the groups interested in the outcomes of the fee increase and the resulting enhancement in the Department's ability to periodically inspect ALRs and investigate complaints include:

- ALR residents (Estimated to be over 20,000 individuals based on the existence of approximately 25,000 licensed ALR beds in Colorado).
- Advocates for ALR residents, including residents' families and loved ones, ombudsmen, and advocacy organizations representing issues related to aging.
- Advocacy organizations/associations for the ALR owners/operators.

C. Identify each group of individuals/entities that benefit from, may be harmed by or at-risk because of the rule, and if applicable, the size of the group:

Health and Safety Standards:
All current 20,000- 25,000 residents identified will benefit from the enhanced care and service requirements in the rule, particularly the expanded resident rights criteria.

All 671 licensed ALRs will benefit from the clear language in the revised rule regarding the Department's expectations for the care and service to be delivered to residents. Some ALRs may assert that they will be harmed by the expanded staffing requirements, but the Department believes that any potential harm is outweighed by the consumer benefit.

Additional information regarding specific sections of the proposed rule is contained in the Department's response to the cost benefit analysis requested by the Department of Regulatory Agencies which is incorporated into this rule-making packet. Due to the document's file size, it is being provided as a separate attachment.

Increased License-related Fees:
It is primarily ALR residents that benefit from the increase in fees in that stronger oversight through periodic inspection/surveys and complaint investigations provides greater assurance of a safe ALR environment. (Estimated to be 20,000+ residents).

ALR owners/operators are the group that could potentially be harmed by the fee increase in that it increases their cost of doing business. (Currently 671 residences).

2. To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

A. For those that rely on the rule to maintain their own businesses, agencies or operations:

Health and Safety Standards:

Describe the anticipated favorable and non-favorable non-economic outcomes (short-term and long-term), and if known, the likelihood of the outcomes:

Favorable non-economic outcomes: The new requirement for awake staff to conduct a safety check of consenting residents between 10 pm and 6 am will help to eliminate or significantly reduce the risk of a resident dying or suffering serious bodily injury due to a fall or other incident at night when staff members are not available because they are either off-duty or asleep. The Department has data to support the fact that this proposed rule revision would have saved lives in the past. The Department also has data that over the last several years the incidence and severity of resident neglect, harm and death has increased and is most often tied to a lack of administrative infrastructure and oversight. The new requirement regarding administrator qualifications should attract more experienced personnel and thereby enhance the operation of assisted living residences and the care and service they provide to residents.

Additional information regarding specific sections of the proposed rule is contained in the Department's response to the cost benefit analysis requested by the Department of Regulatory Agencies which is incorporated into this rule-making packet. Due to the document's file size, it is being provided as a separate attachment.

Unfavorable non-economic outcomes: None currently known.

Anticipated financial impact:

Anticipated Costs:	Anticipated Benefits:
Description of costs that must be incurred. • Effective 7/1/2019, individuals who have not previously served as ALR administrators will have to meet enhanced education and/or experience criteria. • For ALRs that have not been complying with statutory requirement to provide 24-hour protective oversight, costs will be incurred by rule that awake staff must conduct safety checks of consenting residents every 4 hours between 8 pm and 6 am. Description of costs that may be incurred. • Reviewing and updating policies as needed to align with new rules. • Physical plant changes after 2019 due to significant building improvements of changes in ownership.	Description of financial benefit. • N/A • See favorable non-economic outcomes listed above. • Improved efficiency resulting in cost savings. • N/A

Cost or cost range. $_____ or __X__ No data available.	Savings or range of savings. $_____ or __X__ No data available.
Dollar amounts that have not been captured and why: • Highly variable. Dependent on current facility staffing pay rates for staff and administrator.	Dollar amounts that have not been captured and why: • Highly variable. Dependent on current facility staffing pay rates for staff and administrator.

Increased License-related fees:

Describe the anticipated favorable and non-favorable non-economic outcomes (short-term and long-term), and if known, the likelihood of the outcomes:

Favorable non-economic outcomes: Paying increased fees provides non-economic benefit to the ALR industry in that the Department will be better able to investigate and seek enforcement against those ALRs that are providing substandard care. This is important for the ALR owners/operators because it increases the public's confidence in the industry as a whole. It also benefits ALRs that remain in compliance because they are assured that they are not being held to a different standard than others in their industry.

Unfavorable non-economic outcomes: None identified.

Anticipated financial impact:

Anticipated Costs:	Anticipated Benefits:
Description of costs that must be incurred. • Phase 1—Fees increased to a level to fully fund existing appropriations. • Phase 2—Fees increased to a level that supports additional surveyors/inspectors. • For both Phase 1 and Phase 2, the increase in the specific fee paid by an ALR depends on factors such as the license-related activity involved (e.g., initial license, renewal, change of ownership), and whether the facility is considered a High Medicaid Utilization facility. Description of costs that may be incurred.	Description of financial benefit. • A certain level of cost-avoidance is achieved because a number of fees were not increased, as the Department analysis showed the existing fees were covering the costs of performing that work. The fees that are not increasing include: ○ Change of address ○ Change of administrator ○ Change of name ○ Initial opening of a secure environment ○ Initial opening of a facility serving a disproportionate share of low income residents ○ Provisional license

• A new fee is proposed that would be an "add-on" to the renewal fee for facilities that have secure units that are separate and distinct from non-secure units. ALRs may incur this fee if they choose to operate such a unit.	
Cost or cost range. The revenue from fees is expected to increase by approximately $1.44 million by the end of the Phase 2 fee increase. The cost to each ALR will depend on factors such as the license-related activity involved (e.g., initial license, renewal, change of ownership), and whether the facility is considered a High Medicaid Utilization facility.	Savings or range of savings. None
Dollar amounts that have not been captured and why: None identified	Dollar amounts that have not been captured and why: None identified

B. <u>For those that are affected by or interested in the outcomes the rule and those identified in #1.A achieve.</u>

Describe the favorable or unfavorable outcomes (short-term and long-term), and if known, the likelihood of the outcomes:

<u>Health and Safety Standards</u>:
Favorable non-economic outcomes: Assisted living residents, their loved ones and the community will benefit in many ways from the rule revision. The Department has added more specificity to the background check requirements for owners, administrators and staff. The Department has expanded the staff training criteria and updated requirements regarding CPR trained staff based upon the unanimous recommendation of a stakeholder subcommittee. A new section has been added regarding emergency preparedness and required emergency equipment. Rule language addressing lift assistance and resident engagement has been significantly updated and a new section has been added regarding fall prevention. The resident rights section has been significantly expanded to recognize residents' ethnic, cultural and religious preference as well as sexual orientation. New food safety standards will protect older and medically fragile residents who are particularly susceptible to food borne illnesses. The Department also attempted to, whenever possible, draft the rule with a person-centered approach that is becoming more common in the industry. The owners, operator and staff of assisted living residences will benefit from the clearer explanation of their duties and responsibilities.

Additional information regarding specific sections of the proposed rule is contained in the Department's response to the cost benefit analysis requested by the Department of Regulatory Agencies which is incorporated into this rule-making packet. Due to the document's file size, it is being provided as a separate attachment.

Unfavorable non-economic outcomes: The Department is not aware of any unfavorable non-economic outcomes.

Any anticipated financial costs monitored by these individuals/entities? Unknown at this time.

Any anticipated financial benefits monitored by these individuals/entities? Unknown at this time.

Increased License-related Fees:
Favorable non-economic outcomes include the timely investigation of complaints and providing assurances that the health, safety and welfare of residents is being protected. Periodic licensure surveys and monitoring of annual ALR self-reporting will also provide a level of assurance that ALRs are operating consistently with the regulations.

It is possible that ALR residents will experience an increase in the rates charged by the ALRs if owners/operators seek to offset licensure fee increases by passing those costs on to residents, which would result in an unfavorable economic outcome for residents in those ALRs.

C. For those that benefit from, are harmed by or are at risk because of the rule, the services provided by individuals identified in #1.A, and if applicable, the stakeholders or partners identified in #1.B.

Health and Safety Standards:
The rule will benefit the residents, their families and advocacy groups by ensuring that all residents are treated with dignity and that their individual health and social needs are recognized and supported. Other benefits are increased staff training to reduce the number of resident falls and limit infection transmission. New criteria regarding food safety standards will limit foodborne illness while preserving a resident's right to personal choice.

The rules will increase the amount of time that staff must spend in training rather than serving residents and, in some instances, the ALR must bear the cost of that additional training. Nevertheless, the Department believes that the benefits of the increased training will far outweigh the ALR's monetary cost for providing such training.

Additional information regarding specific sections of the proposed rule is contained in the Department's response to the cost benefit analysis requested by the Department of Regulatory Agencies which is incorporated into this rule-making packet. Due to the document's file size, it is being provided as a separate attachment.

Increased License-related Fees:

For the residents, their families, and resident advocacy groups, one non-economic benefit of the fee increase is that they will have assurance that the Department is periodically performing routine on-site surveys/inspections to identify and require facilities to correct problems/issues that arise. These issues could relate to quality of care, availability of activities, resident rights, or many other things that drive residents' quality of life. This same group would also now have the comfort that all complaints are investigated in a timely manner, rather than the oftentimes frustrating experience of having complaints linger.

3. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

A. Anticipated CDPHE personal services, operating costs or other expenditures:

Health and Safety Standards:
It is expected that the costs of implementation of the rules will be absorbable within the structure described under the "Increased License-related Fees" section of this question below.

Increased License-related Fees:
Increasing the licensing-related fees paid by ALRs will ensure the Department has the appropriate level of resources to meet its statutory obligations to provide a comprehensive system of ALR regulation, oversight, and enforcement, including periodic on-site surveys of ALRs and timely response to complaints. The needed fee increase is separate from and not due to the changing health, safety, and other operational requirements. The fee increase would be implemented through a phased-in approach.

In Year 1 the fees would be increased by a total of $620,259, adequate to fully fund existing appropriations and pay for existing authorized FTE. In Year 2 fees would be increased an additional $818,019 to support a level of FTE adequate to maintain a comprehensive system of regulation and enforcement, including performing licensure-related surveys/inspections every three years and responding to complaints in a timely manner.

Type of Expenditure	Year 1	Year 2
Personal Services	$ 1,527,409	$ 2,154,420
Operating	$ 34,116	$ 37,000
Other	$ 466,456	$ 654,580
Total	$2,027,981	$2,846,000

Anticipated CDPHE Revenues:

In Phase 1, anticipated cash-fund revenues are expected to be $300,000 from initial license fees and $1,727,981 from license renewal fees. While fees exist for other license-related activities (e.g., change of name, change of address), those amounts are expected to be minimal.

In Phase 2, anticipated cash-fund revenues are expected to be $300,000 from initial license fees and $2,546,000 from license renewal fees. As in Phase 1, while fees will

exist for other license-related activities (e.g., change of name, change of address), those amounts are expected to be minimal.

This rulemaking modifies fees:

Entity Type	# of Entities	Current Fee	Proposed Fee	% increase
ALRs seeking an initial license (one-time fee)	Estimated at 30 per year based on 3-year average	8 beds or less: $6,000 9 beds and more: $7,200	3 - 8 beds: $6,300 9-19 beds: $7,300 20-49 beds: $8,750 50-99 beds: $11,550 100+ beds: $14,750	3-8 beds: 5% 9-19 beds: 2% 20-49 beds: 22% 50-99 beds: 60% 100+ beds: 105%
ALRs seeking a change of ownership (one-time fee)	Estimated at 8 per year based on a 3-year average	First facility: $5,000 Additional facilities: $2,800	Largest facility: 3-19 beds: $6,250 20-49 beds: $7,800 50-99 beds: $10,600 100+ beds: $14,750 Additional facilities: $4,500	First facility: 3-19 beds: 25% 20-49 beds: 56% 50-99 beds: 112% 100+ beds: 195% Additional facilities: 61%
ALRs seeking a renewal license (annual fee)	Estimated 496 based on number of ALRs at time of analysis	$180 base fee plus $47 per licensed bed	Phase 1: $360 base fee plus $67 per licensed bed Phase 2: $360 base fee plus $103 per licensed bed	Phase 1: Varies by size of facility Phase 2: Varies by size of facility
ALRs seeking a renewal license that qualify as a High Medicaid Utilization Facility (HMU) (annual fee)	Estimated 174 based on number of ALRs at time of analysis	$180 base fee plus $19 per licensed bed	Phase 1: $360 base fee plus $23 per licensed bed Phase 2: $360 base fee plus $38 per licensed bed	Phase 1: Varies by size of facility Phase 2: 100%
ALRs seeking a renewal license that have a separate and distinct secure unit (annual fee)	172 ALRs have secure unit, but only those that also have a non-secure unit will be subject to the fee. That number is unknown at	This fee currently does not exist	$350	Percentage increase cannot be calculated since this is a new fee.

	this time but will be a subset of 172.			
ALRs seeking to increase their number of licensed beds (one-time fee)	Unpredictable	$360	$500	39%
A number of fees were not increased, as the analysis identified these fees as being appropriate at their current levels. These fees include: initial license for ALRs serving a disproportionate share of low-income residents, provisional licensure, change of mailing address, change of name, change of administrator, and the fee for opening a secure unit.				

Renewal licensure fees were last increased with an effective date of September 1, 2015. At that time the increase was intended to support FTE specifically to address complaints. The 2015 increase did not take into account other regulatory, survey, or enforcement needs, and that, coupled with growth in the industry has left the Department in a situation where is currently cannot meet its statutory obligations for inspecting ALRs.

Type of Revenue	Year 1	Year 2
Initial Licensure and Change of Ownership Fees	$ 300,000	$300,000
Renewal Licensure Fees	$ 1,727,981	$ 2,546,000
Cash fund reserves (Cash fund balance was $100,000 on July 1, 2017, but as of December 31, 2017 the cash fund balance is $0)	$ 0	$ 0
Total	$2,027,981	$2,846,000

B. Anticipated personal services, operating costs or other expenditures by another state agency: None identified.

Anticipated Revenues for another state agency: None identified.

4. A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

Health and Safety Standards:

Check mark all that apply:
___ Inaction is not an option because the statute requires rules be promulgated.

__The proposed revisions are necessary to comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.

_X_ The proposed revisions appropriately maintain alignment with other states or national standards.

_X_ The proposed revisions implement a Regulatory Efficiency Review (rule review) result or improve public and environmental health practice.

_X_ The proposed revisions implement stakeholder feedback.

_X_ The proposed revisions advance the following CDPHE Strategic Plan priorities:

Goal 1, Implement public health and environmental priorities Goal 2, Increase Efficiency, Effectiveness and Elegance Goal 3, Improve Employee Engagement Goal 4, Promote health equity and environmental justice Goal 5, Prepare and respond to emerging issues, and Comply with statutory mandates and funding obligations

Strategies to support these goals:

___ Substance Abuse (Goal 1)
_X_ Mental Health (Goal 1, 2, 3 and 4)
___ Obesity (Goal 1)
___ Immunization (Goal 1)
___ Air Quality (Goal 1)
___ Water Quality (Goal 1)
___ Data collection and dissemination (Goal 1, 2, 3, 4 and 5)
_X_ Implements quality improvement or a quality improvement project (Goal 1, 2, 3 and 5)
___ Employee Engagement (career growth, recognition, worksite wellness) (Goal 1, 2 and 3)
_X_ Incorporate health equity and environmental justice into decision-making (Goal 1, 3 and 4)
_X_ Establish infrastructure to detect, prepare and respond to emerging issues (Goal 1, 2, 3, 4, and 5)

X Other favorable and unfavorable consequences of inaction: Additional information regarding specific sections of the proposed rule is contained in the Department's response to the cost benefit analysis requested by the Department of Regulatory Agencies which is incorporated into this rule-making packet. Due to the document's file size, it is being provided as a separate attachment.

Increased License-related Fees:

Check mark all that apply:

___ Inaction is not an option because the statute requires rules be promulgated.

_X_ The proposed revisions are necessary to comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.

___ The proposed revisions appropriately maintain alignment with other states or national standards.

_X_ The proposed revisions implement a Regulatory Efficiency Review (rule review) result or improve public and environmental health practice.

_X_ The proposed revisions implement stakeholder feedback.

_X_ The proposed revisions advance the following CDPHE Strategic Plan priorities:

Goal 1, Implement public health and environmental priorities Goal 2, Increase Efficiency, Effectiveness and Elegance Goal 3, Improve Employee Engagement Goal 4, Promote health equity and environmental justice Goal 5, Prepare and respond to emerging issues, and Comply with statutory mandates and funding obligations

Strategies to support these goals:

___ Substance Abuse (Goal 1)
___ Mental Health (Goal 1, 2, 3 and 4)
___ Obesity (Goal 1)
___ Immunization (Goal 1)
___ Air Quality (Goal 1)
___ Water Quality (Goal 1)
___ Data collection and dissemination (Goal 1, 2, 3, 4 and 5)
_X_ Implements quality improvement or a quality improvement project (Goal 1, 2, 3 and 5)

- The proposed fee increase allows the Department to perform periodic on-site surveys (inspections) of licensed ALRs and respond to complaints timely, as well as maintain a comprehensive system of regulation (e.g., occurrence reporting, enforcement activities, investigation of facilities operating without a license). These activities result in identifying problems and implementing corrections in ALR living and care environments, improving facility quality for the health, safety and welfare of ALR residents.

___ Employee Engagement (career growth, recognition, worksite wellness) (Goal 1, 2 and 3)
___ Incorporate health equity and environmental justice into decision-making (Goal 1, 3 and 4)
___ Establish infrastructure to detect, prepare and respond to emerging issues (Goal 1, 2, 3, 4, and 5)

_X_ Other favorable and unfavorable consequences of inaction:

- Without the fee increase, the Department will be unable to address all complaints received.
- Without the fee increase, the Department will be unable to fulfill its statutory obligation to inspect ALRs.
- Without the fee increase, the Department will be unable to meet the regulatory needs of a growing industry that cares for some of Colorado's most vulnerable populations.
- Without the fee increase, ALR owners/operators will experience Departmental delays in processing requests for initial licensure, changes of ownership and approval for increasing number of beds licensed in an ALR.
- Without a fee increase, the Department will be unable to investigate the growing number of ALRs reported to be operating without a license.

5. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

Rulemaking is proposed when it is the least costly method or the only statutorily allowable method for achieving the purpose of the statute. The specific revisions proposed in this rulemaking were developed in conjunction with stakeholders. The benefits, risks and costs of these proposed revisions were compared to the costs and benefits of other options. The proposed revisions provide the most benefit for the least amount of cost, are the minimum necessary or are the most feasible manner to achieve compliance with statute.

Additional information regarding specific sections of the proposed rule is contained in the Department's response to the cost benefit analysis requested by the Department of Regulatory Agencies which is incorporated into this rule-making packet. Due to the document's file size, it is being provided as a separate attachment.

Health and Safety Standards: The Department has determined that there are no less costly or intrusive methods for achieving the purpose of the proposed rule. Section 25-27-104, C.R.S. specifies that the rules address all of the following: location, sanitation, fire safety, adequacy of diet and nutrition, equipment, structure, operation, provision of personal service and protective oversight; personnel practices; administrator and staff qualifications, training and experience; and protection of resident rights.

Increased License-related Fees:
A number of possible fee increases were initially presented to the Assisted Living Advisory Committee, including:

- Increasing fees to allow for an on-site licensure survey (inspection) every year,
- Increasing fees to allow for an on-site licensure survey (inspection) once every 3 years, and
- Increasing fees to fully fund the existing appropriated FTE, which would not support on-site licensure surveys (inspections) at any specific interval.

Based on the stakeholder discussion of these options, an additional option to support on-site licensure surveys (inspections) every other year was prepared and presented to the advisory committee. After consideration of all of these options, the general, but not unanimous, consensus of the advisory committee was to go forward with the fee increase at a level to support an on-site licensure survey every year. This proposal was presented around the state at 6 town hall meetings, and the stakeholder feedback was that annual inspections were too frequent and too costly.

That feedback was presented to the advisory committee, along with additional information from the Department, and the committee then revised its preference to having fees increased to a level that supports initial licensure inspections as currently performed, on-site license renewal inspections every three years, and off-site inspections in the years in which a facility does not receive an on-site inspection.

Therefore, the Department will proceed with a combination of on-site and off-site inspections on an annual basis for all assisted living residents. On-site inspections will occur no less frequently than once every three years and include observations of the

delivery of care, services and activities, evaluation of the environment and setting, and interview with residents.

In every year where an on-site inspection is not conducted, an off-site inspection will take place and will include an evaluation of the ALR's quality management program as required in both Chapters 2 and 7, in addition to evaluation of resident meeting minutes, Ombudsman reports and any recent grievances.

The Department retains the authority, however, to conduct on-site or off-site inspections as frequently as necessary to ensure the health, safety and welfare of the residents.

6. Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.

Health and Safety Standards:
Since ALRs are statutorily prohibited from providing regular 24-hour nursing or medical care, the Department and stakeholders explored alternative rules designed to address the complex medical needs of many individuals currently residing in ALRs. Residents desire to age in place and many ALRs want to provide more extensive care. The Department developed and introduced regulatory language that would allow ALRS the option of providing limited nursing services under certain circumstances. The concept was discussed and reworked several times over the course of several months, but the issues proved too difficult and a consensus could not be reached.

Additional information regarding specific sections of the proposed rule is contained in the Department's response to the cost benefit analysis requested by the Department of Regulatory Agencies which is incorporated into this rule-making packet. Due to the document's file size, it is being provided as a separate attachment.

Increased License-related Fees:
See responses to #4 and #5, above.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

Health and Safety Standards:
Numerous resources were used in the analysis. The Department relied on data from the Compendium of Residential Care and Assisted Living Regulations and Policy, 2017 Edition to evaluate approaches being used in other states regarding ALR staffing and training requirements, administrator qualifications, provisions for dementia care, food service, residency agreements and disclosure requirements. The Department also consulted National Health Statistics Reports from the Centers for Disease Control on the Variation in Residential Care Community Nurse and Aide Staffing Levels, 2014; as well as Long-Term Care Providers and Services Users in the United States: Data from the National Study of Long-Term Care Providers, 2013-2014.

The Department researched the assisted living regulations from 49 other states in an effort to determine how Colorado's proposed regulations matched current regulations in other states. Particular focus was paid to states with similar divisions between the metropolitan and rural areas. The Department also considered material supplied by stakeholders such as Dementia Care Practice, Recommendations for Assisted Living

Residences and Nursing Homes from the Alzheimer's Association and Evidence Supports Action to Prevent Injurious Falls in Older Adults from the Colorado Medical Director's Association.

The Department compared the 2010, 2014 and 2018 editions of the Facility Guidelines Institute with regard to the criteria for Residential Health Care Facilities. The Department also utilized State Health Facts from the Kaiser Family Foundation, and statistics and data collected by the Health Facilities and Emergency Medical Services Department regarding assisted living residence deficiencies and enforcement actions.

Additional information regarding specific sections of the proposed rule is contained in the Department's response to the cost benefit analysis requested by the Department of Regulatory Agencies which is incorporated into this rule-making packet. Due to the document's file size, it is being provided as a separate attachment.

Increased License-related Fees:

The analysis of the revenue levels needed to support the desired level of work combined data from a number of sources, including:

- Appropriated expenditure and FTE levels for the past three fiscal years.
- Actual revenue and expenses for the ALR program for the past three fiscal years.
- Actual ALR personnel cost information for the past three fiscal years.
- Data from the Department's Division of Health Facilities Certification, Licensing, Enforcement & Records (CLER) and Health Facility Quality (HFQ) branches related to number of licenses, complaints, enforcement actions, etc., for the past three fiscal years
- Timekeeping and ASPEN (federal data system) information regarding time required for surveys/inspections, enforcement activities, etc.
- Interviews with ALR program staff and other Department staff to determine work process and process improvements and provide validation of other data gained through other methods.

STAKEHOLDER ENGAGEMENT
Amendments to 6 CCR 1011-1, Ch. 7, Assisted Living Residences
April 18, 2018

State law requires agencies to establish a representative group of participants when considering whether to adopt or modify new and existing rules. This is commonly referred to as a stakeholder group.

Early Stakeholder Engagement:
The following individuals and/or entities were invited to provide input and included in the development of these proposed rules:

Organization	**Representative**
Colorado Health Care Association	*Ann Kokish, Associate Director, Long-Term Care Services
LeadingAge Colorado	* Deborah Lively, Director of Public Policy & Public Affairs Laura Landwirth, President and CEO
Colorado Assisted Living Association	* William Boles, President
Colorado Commission on Aging	* Paulette St. James, Commission Member
Denver Regional Council of Governments	* Shannon Gimbel, Ombudsman Program Manager
Alzheimer's Association	* Amelia Schafer, Vice President of Programs
Consumer representative	* Pat Johnston, family member of memory care resident
Good Samaritan Society	* Julie Lee, Assisted Living Administrator
Haven Assisted Living	* Karen Burley, Director
Assured Assisted Living	* Sheryl Thompson, President and CEO
Myron Stratton Home	* Linda Buendorf, Director of Senior Services
Frasier Meadows Manor Assisted Living	* Kym Hansler, Administrator
Hilltop Community Resources Life Option	* Michaelle Smith, Vice President
Colorado Access, Single Entry Point	* Jun Murai, Supervisor
Jefferson County Public Health	* Pamela Stephens, Regional Emergency Planner
Colorado Department of Health Care Policy and Financing	Cassandra Keller and Caitlin Phillips, Alternative Care Facility Specialists; Heidi Kreuziger, Quality Compliance Specialist, Long Term Services and Supports; Diane Byrne, Brain Injury Waiver Administrator
Colorado Gerontological Society	Eileen Doherty, Executive Director
Colorado Medical Directors Association	Dr. Leslie Eber, President Dr. Gregory Gahm, Past President Dr. Reza Esfahani, Member Dr. Zorin Lesick, Member Dr. Malcom Frasier, Member
None known	Leilani Glaser, RN
Dementia Friendly Communities of Northern Colorado	Cyndy Hunt Luzinski, MS, RN, Executive Director
Edu-Catering: Catering Education for Compliance and Culture Change	Carmen Bowman, Owner
Senior Housing Options	Amy Yount, RN, Quality Management and Staff Development Nurse

	Iva Prinsen, Director of Assisted Living Operations Vennitta Jenkins, Regional Director of Operations
State Fire Prevention and Emergency Medical Services providers	Tim Stover, Fire Marshal, Littleton Fire Rescue Bruce Kral, Fire Marshall, West Metro Fire Protection District Colleen Potton, Community Risk Reduction Specialist, South Metro Fire Rescue Ralph Vickrey, EMS Bureau Chief, Cunningham Fire Protection District Rick Lewis, EMS Bureau Chief, South Metro Fire Rescue Mike Porter, Paramedic, South Metro Fire Rescue Gary Reading, Battalion Chief, Colorado Springs Fire Department
Gardens on Quail Assisted Living & Memory Care	Beverly Moranga, Sara Dent, Memory Care and Assisted Admissions
Belmont Senior Care	Andrea Sanchez, Assistant Administrator
Peakview Assisted Living & Memory Care	Dana Andreski, Administrator
Jaxpointe Memory Care Homes	Russ Udelhofen, Administrator
Helping Hands Home Care	Lori Akisanya, Owner
Serenity House	Michael Zislis, President
OZ Architecture	Jamie Mehlenkamp, AIA, Senior Living Practice Area Leader
HCM Architecture, Design & Planning	Gary Pragger, AIA, Senior Living Designer
Colorado Department of Public Health and Environment	Therese Pilonetti, Division of Environmental Health and Sustainability Daniel Goetz and Jace Driver, Hazardous Materials and Waste Management Division
Colorado Department of Public Safety	Rob Sontag, Division of Fire Prevention and Control

In 1985 when the legislature authorized the Department to license assisted living residences, it also established an advisory committee for the purpose of making recommendations to the Department concerning the regulations promulgated by the Board of Health. Pursuant to statute, the Assisted Living Advisory Committee is composed of ALR representatives, the Colorado Commission on the Aging, local health departments, local boards of health, and consumer and other agencies and organizations providing services to or concerning ALR residents. Advisory committee members involved in the development of the proposed rules are identified with an asterisk in the above stakeholder list.

Beginning in October 2015, the Department in conjunction with the advisory committee conducted 38 task force meetings which were available for the public to attend in person or by toll-free telephone or web conferencing. Details regarding each of those meetings was communicated to every licensed assisted living residence as well as posted on the Department's public blog. Each revised draft was shared in the same manner.

In addition to the monthly committee meetings, two subcommittees were formed to address specific issues. Each subcommittee met several times and involved industry experts as well as committee members. One subcommittee discussed the issue of ALRs providing first aid, CPR, obstructed airway and lift assistance along with staff training requirements. The second

subcommittee discussed how to incorporate into the ALR rules the standards from the Facility Guidelines Institute (FGI) since ALRs have been the only type of health facility licensed by the Department that was not required to follow these guidelines. The recommendations of the two subcommittees were presented to and discussed by the whole committee prior to incorporation into these proposed rules.

The Department then held six town hall style meetings across the State to solicit feedback on the proposed rules. Two of the meetings were in the Denver metropolitan area while the other four were in Grand Junction, Pueblo, Colorado Springs, and Greeley. The Department notified all licensed facilities of those town halls as well as posting details on its website and blog for the general public. The Department also posted a first draft of the rule revisions on its proposed regulations webpage in November and invited all its licensees as well as other interested stakeholders to submit comments and recommendations.

The Department compiled all the comments received at the town halls and in response to its portal messages and website postings and presented those to the Assisted Living Advisory Committee on January 19, 2018. The Committee, the Department and other interested stakeholders spent the entire day discussing every issue raised in order to arrive at the proposed rules that were posted on the Department's draft regulations webpage and presented to the Board in the February 21, 2018 request for rule-making packet.

Since then, the Department has continued to receive and respond to additional stakeholder comments and concerns. Department representatives have participated in at least five additional meetings with various stakeholders. The Department has also responded to 47 requests for cost benefit analysis that were submitted to the Department of Regulatory Agencies.

Stakeholder Group Notification

The stakeholder group was provided notice of the rulemaking hearing and provided a copy of the proposed rules or the internet location where the rules may be viewed. Notice was provided prior to the date the notice of rulemaking was published in the Colorado Register (typically, the 10th of the month following the Request for Rulemaking).

____ Not applicable. This is a Request for Rulemaking Packet. Notification will occur if the Board of Health sets this matter for rulemaking.

__X__ Yes.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

There were a number of major factual and policy issues. The first one involved revision of the ALR administrator qualifications. The Department and a majority of the assisted living advisory committee members believed that the current administrator qualifications were inadequate to prepare an individual for such a complex management role. The committee and the Department proposed new administration qualifications to be effective July 1, 2019, that included various education and/or experience criteria, the least of which was five years of experience providing care for the physically and/or cognitively disabled.

In response to stakeholder concern that those administrator qualifications would unduly limit the supply of potential administrators and create a financial burden for facilities, the Department agreed to modify the previous proposal. The Department now proposes in section 6.3 that an ALR administrator have one year of supervisory experience in the provision of personal services. The Department's proposed administrator training requirements in sections 6.4 through 6.6 remain unchanged.

The second major issue involved the incorporation by reference of the Facility Guidelines Institute Guidelines for the design and construction of assisted living residences. The Board has the authority under § 25-27-104(1), C.R.S., to adopt minimum standards for the **location,** sanitation, **fire safety**, **adequacy of facilities**, adequacy of diet and nutrition, equipment, **structure**, operation, provision of personal services and protective oversight, and personnel practices of assisted living residences within the state of Colorado. (Emphasis added).

The FGI Guidelines provide fundamental, or baseline, requirements for the design and construction of various facility types including ALRs. The Board has previously adopted rules incorporating the FGI Guidelines into other chapters of regulation so that they apply to all other facilities types licensed by the Department, including small residential group homes. The proposed rules regarding compliance with FGI guidelines are prospective and apply in only two distinct situations:

1) When a new facility is applying for an initial ALR license after June 1, 2019, or

2) When a currently licensed ALR undertakes a renovation project on or after December 1, 2019, in which case the Guidelines will apply to only that portion of the building that was renovated.

In response to recent stakeholder concerns, the Department has added language that exempts small residential facilities licensed for 10 beds or less from the FGI Guideline requirements regarding bathroom access and elevator size. The FGI guideline regarding the number of parking spaces for any size facility had previously been modified in section 21.6 but needed clarification so that has now been done.

A third major issue involved the requirement that staff in a non-secure environment perform safety checks of all consenting residents every four hours between 8 PM and 6 AM. In response to stakeholder concerns that requiring sleeping staff to wake up and check on residents at night is financially burdensome, the Department has modified the language in section 8.2 to require that between the hours of 10 PM and 6 AM, staff conduct at least one safety check of consenting residents.

The final major policy issue involved licensing fees. In January 2018, the Department convened two separate meetings with the three industry organizations to seek their input on the license fee structure and attempt to reach a consensus regarding that structure. Unfortunately, a consensus could not be reached so the Department has proposed a new license fee structure that it believes is as equitable as can be achieved given other statutory requirements. More specific information regarding this issue is set forth in other sections of this rulemaking packet. As previously discussed, the proposal was modified to distinguish 3-8 bed facilities and 9-19 bed facilities at the time of initial licensure. The proposed fee for 3-8 bed facilities is $6300; the $7300 fee for 9-19 bed facilities remains unchanged since the request for rulemaking presentation.

Please identify the determinants of health or other health equity and environmental justice considerations, values or outcomes related to this rulemaking.

Overall, after considering the benefits, risks and costs, the proposed rule:

Select all that apply.

X	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.	X	Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.
X	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.		Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.
X	Improves access to food and healthy food options.	X	Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.
X	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.	X	Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.
	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.	X	Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
X	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.	X	Ensures a competent public and environmental health workforce or health care workforce.
	Other:_____		Other:_____

alzheimer's association®

THE BRAINS BEHIND SAVING YOURS.™

March 30, 2018

Randy Kuykendall, Division Director
Health Facilities and Emergency Medical Services Division
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246
Delivered by email to randy.kuykendall@state.co.us

RE: **Comments on revisions to 6 CCR 1011-1 Chapter 07, Assisted Living Residences**

Dear Director Kuykendall,

On behalf of the Alzheimer's Association, I would like to submit these comments related to the Colorado Department of Public Health and Environment's (CDPHE) proposed revisions to 6 CCR 1011-1 Chapter 07, Assisted Living Residences (ALRs). **We strongly support the proposed rule as drafted by the Assisted Living Advisory Committee (ALAC) for the reasons detailed below, and we encourage the Board of Health to adopt it.**

Many People with Dementia Rely on ALRs

Currently, there are 71,000 Coloradans living with Alzheimer's, and that figure is set to rise by nearly 30 percent by 2025. Alzheimer's is the most common form of **dementia, a general term for memory loss and other cognitive abilities serious enough to interfere with daily life**. The disease is progressive, and because there is no treatment or cure, it is fatal. **This is why ALRs are so important to people living with Alzheimer's and other forms of dementia, because many of them will spend time living in an ALR during the course of their journey with this disease.**

This issue is so important to our organization, that we, nationally, supported an effort to create comprehensive dementia care practice standards, which were recently published in *The Gerontologist*, the national journal of the Gerontological Society of America. We believe every ALR caring for people with dementia should be required to follow these recommendations. We are pleased that **the proposed rule mirrors our *Alzheimer's Association Dementia Care Practice Recommendations*** in a number of areas. A summary of those newly published recommendations are attached for your reference.

There is a Problem to be Solved

Many ALRs in our state provide great care to their residents. In fact, these regulations will simply codify standards these facilities already meet and consider normal operating procedure. Our concerns lie with the ALRs that do not meet these standards. We frequently hear stories from families with a loved one who has lived, or is living, in an ALR that does not consider these standards as a minimum, but as something too expensive to achieve. **It is unacceptable to us that minimum care standards are an option, not a requirement, for ALRs in Colorado.** That is what this proposed rule would change.

I have attached comments from Alzheimer's families across our state who have personal experiences with one or more ALR. I hope you take the time to read them, and that you put yourself in the shoes of the family member telling each story about their mother, father, sibling or grandparent living with dementia. These are just a sample of the stories our staff hears regularly about ALRs in Colorado.

The Public Stakeholder Process was Extensive

As you are aware, the proposed rules were drafted by a stakeholder group, the ALAC, made up of consumer, industry and government representatives. **I appreciated the opportunity to serve on this Committee for the full 2**

years and bring the perspective of families struggling with dementia to the discussion. We met at least once a month for 2 years (and some months more frequently) and discussed proposed changes not only issue by issue, but line by line. The result was a **collaborative effort where compromise was achieved, including compromises made by our organization**. At every meeting, there was opportunity for Committee and public comment. In fact, the Committee often asked for input from members of the general public (i.e., non-ALAC members) in attendance. I also appreciate your Department holding a series of public meetings outside of the Denver metro area to solicit additional comments on the proposed rule.

The Alzheimer's Association participated in these meetings in good faith, assuming that all other representatives were doing the same. It is disappointing to us that some members of the ALAC sat silently, or did not attend meetings at all, and waited until the CDPHE Board of Health was preparing to do its work to voice concerns. We are aware that certain industry representatives voiced concerns not only to CDPHE staff, but also to ALR residents. It is distressing to our organization that people with dementia are being needlessly scared into believing that they will be thrown out of their ALRs – their homes – due to these regulations. We should all be working to protect these at-risk adults, not introduce fear and anxiety into their lives. **We do not believe that implementing minimum care standards, such as the ones included in this proposed rule, will lead to the closure of ALRs that are adequately caring for their residents.**

<u>These are Minimum Standards of Care, not Best Practices</u>

The proposed rule outlines minimum standards – a floor, not a ceiling – for care provided at Colorado ALRs. Our preference would be to require best practices, or standards of excellence, for all Colorado ALRs. As I noted before, the ALAC's work involved compromises. The proposed rules cover a wide range of elements. I have detailed below the most important ones to people with dementia and how they compare to our recently published *Alzheimer's Association Dementia Care Practice Recommendations*.

Proposed Rule vs. Alzheimer's Association Dementia Care Practice Recommendations

Element Description	Alzheimer's Association Dementia Care Practice Recommendations	Proposed Rule
Dementia training - staff	Person-centered dementia training for all staff who are likely to interact with persons with dementia. The training should be part of new staff orientations and ongoing training for existing staff.	Requires dementia-related training within 30 days of hire, not on an ongoing basis. *[Section 7, Personnel, 7.9]*
Dementia training – secure unit staff	Our recommendations are not detailed enough to touch on this issue. However, staff members working in a secure unit (i.e., environment) are far more likely to be providing services to residents with dementia and other conditions that result in cognitive impairment. Because of that, we strongly support the requirements listed in the proposed rule as they are written.	Staff who provide services in a secure environment are required to have an additional 8 hours per year of training specific to the population they are serving (i.e., residents with dementia or cognitive impairment). *[Section 25, Secure Environment (25.14)]*. To make the provision of this training as easy as possible, the rule allows for many different ways to receive the training, including through computer-based courses, training videos or distance learning, among others. *[Section 25, Secure Environment (25.14(A)]*.
Pharmacological interventions to manage behavior	1) Encourage the use of nonpharmacological interventions to manage the behavioral and psychological symptoms of dementia before utilizing drugs for that purpose; 2) Identify elements of the social or physical environment that trigger or exacerbate these symptoms for	None of these recommendations are included in the proposed rule.

	each individual resident; and 3) Implement nonpharmacological practices specific to individual residents that are feasible in the care setting.	
Person-centered approach	Person-centered care is the foundation upon which these recommendations are crafted. In every aspect of ALR living, the needs of each resident should be the focus.	This approach is infused throughout the proposed rule.
Resident assessment	Comprehensive, person-centered assessments should be conducted at least every 6 months.	A comprehensive assessment conducted at move-in and updated at least annually and when the residents condition changes. *[Section 12, Resident Care Services, 12.6 & 12.9]*
Diversity and inclusion	Build programs that are sensitive to the unique circumstances of minority, LGBT and other populations, and include multicultural issues within staff trainings.	Residents have "the right to care and services that are not conditioned or limited because of a resident's personal, cultural or ethnic preference." *[Section 13, Residents Rights, 13.1(B)(8)]*
Night time resident safety checks (secure units)	Our recommendations are not detailed enough to touch on this issue. However, we do know that 6 in 10 people with dementia will wander. Wandering away from home or another safe space is dangerous for people with dementia because they can become disoriented, even in familiar places. Because of that, we strongly support the requirements listed in the proposed rule as they are written.	Requires "a sufficient number of trained staff members on duty in the secure environment to ensure each resident's physical… and safety needs are met…" *[Section 25, Secure Environment (25.16)]*. We believe to achieve this basic level of safety in a unit where residents are prone to wander, this also requires that "one trained, awake staff member (is) on duty at all times." *[Section 25, Secure Environment (25.17)]*.

Part of the Alzheimer's Association's mission is "to provide and enhance care and support for all affected" by Alzheimer's and other forms of dementia. However, we can only do so much. We appreciate CDPHE doing its part to achieve that goal by helping to ensure Coloradans living with dementia receive, at a minimum, an appropriate level of care and attention when they can no longer reside in their own homes or with family or friends. I am happy to respond to any questions you or the CDPHE Board of Health has about these comments.

Sincerely,

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Attachments:

- Alzheimer's Association Dementia Care Practice Recommendations published in *The Gerontologist* (Gerontologist, 2018, Vol. 58, No. S1, S1-S9)
- Alzheimer's Association family survey results

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Editorial

Alzheimer's Association Dementia Care Practice Recommendations

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Background and Introduction

Alzheimer's disease is a degenerative brain disease and the most common cause of dementia. Dementia is a syndrome—a group of symptoms—that has a number of causes. The characteristic symptoms include difficulties with memory, language, problem solving, and other cognitive skills that affect a person's ability to perform everyday activities (Alzheimer's Association, 2017).

According to the *Alzheimer's Association 2017 Alzheimer's Disease Facts and Figures*, an estimated 5.5 million Americans are living with Alzheimer's dementia. One in 10 people aged 65 years and older (10%) has Alzheimer's dementia, and almost two-thirds of Americans with Alzheimer's are women. In addition to gender differences, Alzheimer's dementia affects racial and ethnic groups disproportionately. Compared to older white adults, African Americans are about twice as likely to have Alzheimer's or other dementias, and Hispanics are approximately 1.5 times as likely (Alzheimer's Association, 2017).

Almost 60% of older adults with Alzheimer's or other dementias reside in the community, only 25% of who live alone. As their disease progresses, people with Alzheimer's or other dementias generally receive more care from family members, unpaid caregivers, and community-based and residential care providers. Forty-two percent of residents in assisted living communities have Alzheimer's or other dementias (Caffrey et al., 2012; Zimmerman, Sloane, & Reed, 2014), and 61% of nursing home residents have moderate or severe cognitive impairment (Centers for Medicare and Medicaid Services, 2016). Further, by age 80, 75% of people with Alzheimer's dementia are admitted to a nursing home, compared with only 4% of the general population (Arrighi, Neumann, Lieberburg, & Townsend, 2010).

Since its inception, the Alzheimer's Association has been a leader in outlining principles and practices of quality care for individuals living with dementia. Early on, the *Guidelines for Dignity* described goals for quality care, followed by *Key Elements of Dementia Care* and the *Dementia Care Practice Recommendations*, as more evidence became available. In this new iteration, the *Alzheimer's Association Dementia Care Practice Recommendations* outline recommendations for quality care practices based on a comprehensive review of current evidence, best practice, and expert opinion. The Dementia Care Practice Recommendations were developed to better define quality care across all care settings, and throughout the disease course. They are intended for professional care providers who work with individuals living with dementia and their families in residential and community-based care settings.

With the fundamentals of person-centered care as the foundation, the Dementia Care Practice Recommendations (see Figure 1) illustrate the goals of quality dementia care in the following areas:

- Person-centered care
- Detection and diagnosis
- Assessment and care planning
- Medical management
- Information, education, and support
- Ongoing care for behavioral and psychological symptoms of dementia, and support for activities of daily living
- Staffing
- Supportive and therapeutic environments
- Transitions and coordination of services

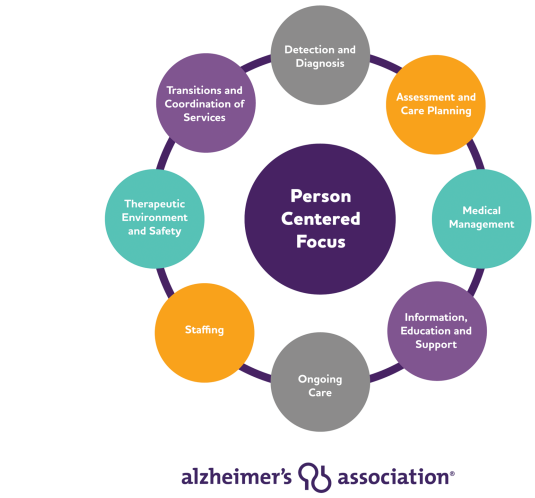

Figure 1. Dementia Care Practice Recommendations.

This article highlights the recommendations from all 10 articles in the Supplement Issue of *The Gerontologist* entitled, *Alzheimer's Association Dementia Care Practice Recommendations*. Each article provides more detail about the specific recommendations, as well as the evidence and expert opinion supporting them. This supplement includes two areas that generally are not included in recommendations for providers in community and residential care settings, although these topics are frequently included in recommendations for physicians and other medical care providers—detection and diagnosis and ongoing medical management. Different from existing recommendations on these two topics, the articles are written for nonphysician care providers and address what these providers can do to help with these important aspects of holistic, person-centered dementia care. Throughout all of the articles, Alzheimer's disease and dementia are used interchangeably. Care partner is used to refer to those people supporting individuals in the early stages of dementia, and caregivers is used to refer to those supporting individuals in the middle and late stages; care provider is used for paid professionals. Lastly, the closing article by Thornhill and Conant (2018) outlines the interplay of policy and practice rounds out the supplement.

The Alzheimer's Association is hopeful that these Recommendations will greatly inform and substantially influence dementia care standards, training, practice, and policy.

Practice Recommendations for Person-Centered Care (Fazio, Pace, Flinner, & Kallmyer, 2018)

1. *Know the person living with dementia*
   The individual living with dementia is more than a diagnosis. It is important to know the unique and complete person, including his/her values, beliefs, interests, abilities, likes, and dislikes—both past and present. This information should inform every interaction and experience.
2. *Recognize and accept the person's reality*
   It is important to see the world from the perspective of the individual living with dementia. Doing so recognizes behavior as a form of communication, thereby promoting effective and empathetic communication that validates feelings and connects with the individual in his/her reality.
3. *Identify and support ongoing opportunities for meaningful engagement*
   Every experience and interaction can be seen as an opportunity for engagement. Engagement should be meaningful to, and purposeful for, the individual living with dementia. It should support interests and preferences, allow for choice and success, and recognize that even when the dementia is most severe, the person can experience joy, comfort, and meaning in life.
4. *Build and nurture authentic, caring relationships*
   Persons living with dementia should be part of relationships that treat them with dignity and respect, and where their individuality is always supported. This type of caring relationship is about being present and concentrating on the interaction, rather than the task. It is about "doing with" rather than "doing for" as part of a supportive and mutually beneficial relationship.
5. *Create and maintain a supportive community for individuals, families, and staff*
   A supportive community allows for comfort and creates opportunities for success. It is a community that values each person and respects individual differences, celebrates accomplishments and occasions, and provides access to and opportunities for autonomy, engagement, and shared experiences.
6. *Evaluate care practices regularly and make appropriate changes*
   Several tools are available to assess person-centered care practices for people living with dementia. It is important to regularly evaluate practices and models, share findings, and make changes to interactions, programs, and practices as needed.

Practice Recommendations for Detection and Diagnosis (Maslow & Fortinsky, 2018)

1. *Make information about brain health and cognitive aging readily available to older adults and their families*
   Within their scope of practice and training, nonphysician care providers who work with older adults and their families in community or residential care settings should either talk with them or refer them to other experts for information about brain health, changes in cognition that commonly occur in aging, and the importance of lifestyle behaviors and other approaches

to maintain brain health. They should suggest print and online sources of additional information as appropriate.

2. *Know the signs and symptoms of cognitive impairment, that signs and symptoms do not constitute a diagnosis of dementia, and that a diagnostic evaluation is essential for diagnosis of dementia*
   All nonphysician care providers who work with older adults in community or residential care settings should be trained to recognize the signs and symptoms of cognitive impairment. They should be trained that signs and symptoms are not sufficient for a diagnosis of dementia and that a diagnostic evaluation must be conducted by a physician who can make the diagnosis.
3. *Listen for concerns about cognition, observe for signs and symptoms of cognitive impairment, and note changes in cognition that occur abruptly or slowly over time*
   Depending on their scope of practice, training, and agency procedures, if any, nonphysician care providers who work with older adults in community or residential care settings should listen for older adults' concerns about dementia and observe for signs and symptoms of cognitive impairment and changes in cognition. As appropriate and in accordance with agency procedures and respect for individuals' privacy, nonphysician care providers should communicate with coworkers about observed signs and symptoms, changes in cognition, and concerns of older adults and family members about the older adult's cognition. Depending on their scope of practice and training, they should encourage the older adult and family to talk with the individual's physician about the signs and symptoms, changes in cognition, and older adult and family concerns.
4. *Develop and maintain routine procedures for detection of cognition and referral for diagnostic evaluation*
   Administrators of organizations that provide services for older adults in community or residential care settings and self-employed care providers should develop and maintain routine procedures for assessment of cognition. They should, at a minimum, maintain an up-to-date list of local memory assessment centers and physicians, including neurologists, geriatricians, and geriatric psychiatrists, who can provide a diagnostic evaluation for older adults who do not have a primary care physician or have a primary care physician who does not provide such evaluations. Ideally, nonphysician care providers and organizations that work with older adults should partner with physicians, health plans, and health care systems to establish effective referral procedures to ensure that older adults with signs and symptoms of cognitive impairment can readily receive a diagnostic evaluation.
5. *Use a brief mental status test to detect cognitive impairment only if*:
   - such testing is within the scope of practice of the nonphysician care provider, and
   - the nonphysician care provider has been trained to use the test; and
   - required consent procedures are known and used; and
   - there is an established procedure for offering a referral for individuals who score below a preset score on the test to a physician for a diagnostic evaluation.
6. *Encourage older adults whose physician has recommended a diagnostic evaluation to follow through on the recommendation*
   Within their scope of practice, training, and agency procedures, if any, nonphysician care providers who work with older adults in community or residential care settings and are aware that an older adult's physician has recommended a diagnostic evaluation should encourage the older adult and family, if appropriate, to follow through on the recommendation. They should talk with the older adult and family about the reasons for and importance of getting a diagnostic evaluation and provide print and online sources of additional information.
7. *Support better understanding of a dementia diagnosis*
   Within their scope of practice, training, and agency procedures, if any, nonphysician care providers who work with older adults in community or residential care settings and are aware that the older adult has received a dementia diagnosis but does not understand the diagnosis (or the older adult's family does not understand the diagnosis) should encourage the older adult and family to talk with the diagnosing physician. The care provider should also offer print and online sources of additional information as appropriate.

Practice Recommendations for Person-Centered Assessment and Care Planning (Molony, Kolanowski, Van Haitsma, & Rooney, 2018)

1. *Perform regular, comprehensive person-centered assessments and timely interim assessments*
   Assessments, conducted at least every 6 months, should prioritize issues that help the person with dementia to live fully. These include assessments of the individual and care partner's relationships and subjective experience and assessment of cognition, behavior, and function, using reliable and valid tools. Assessment is ongoing and dynamic, combining nomothetic (norm-based) and idiographic (individualized) approaches.
2. *Use assessment as an opportunity for information gathering, relationship-building, education, and support*
   Assessment provides an opportunity to promote mutual understanding of dementia and the specific situation of the individual and care partners, and to enhance the quality of the therapeutic partnership. Assessment should reduce fear and stigma and result in referrals to community resources for education, information and

support. Assessment includes an intentional preassessment phase to prepare the assessor to enter the experience of the person living with dementia and their care partner(s).

3. *Approach assessment and care planning with a collaborative, team approach*
   Multidisciplinary assessment and care planning are needed to address the whole-person impact of dementia. The person living with dementia, care partners, and caregivers are integral members of the care planning team. A coordinator should be identified to integrate, document and share relevant information and to avoid redundancy and conflicting advice from multiple providers.
4. *Use documentation and communication systems to facilitate the delivery of person-centered information between all care providers*
   Comprehensive, high-quality assessment is of benefit only if it is documented and shared with care providers for use in planning and evaluating care. Information must be current, accessible, and utilized.
5. *Encourage advance planning to optimize physical, psychosocial, and fiscal wellbeing and to increase awareness of all care options, including palliative care and hospice*
   Early and ongoing discussion of what matters, including values, quality of life and goals for care, are essential for person-centered care. The person living with dementia's preferences and wishes should be honored in all phases of the disease, even when proxy decision making is required. The individual and family should be referred to health care team members to provide ongoing education and support about symptom management and palliative care.

Practice Recommendations for Medical Management (Austrom, Boustani, & LaMantia, 2018)

1. *Take a holistic, person-centered approach to care and embrace a positive approach to the support for persons living with dementia and their caregivers that acknowledges the importance of individuals' ongoing medical care to their well-being and quality of life*
   Nonphysician care providers must adopt a holistic approach to providing care and ongoing support to the person living with dementia and their family caregivers. They should work to reduce existing barriers to coordination of medical and nonmedical care and support. Adopting a positive approach towards care can reduce real or perceived messages of hopelessness and helplessness and replace these with positive messages and an approach that encourages persons living with dementia and their caregivers to seek support and care over the course of the disease.
2. *Seek to understand the role of medical providers in the care of persons living with dementia and the contributions that they make to care*
   Nonmedical care providers and family caregivers should work with medical providers towards developing a shared vision of care to support the person living with dementia.
3. *Know about common comorbidities of aging and dementia and encourage persons living with dementia and their families to talk with the person's physician about how to manage comorbidities at home or in residential care settings*
   Common comorbidities can negatively impact a person living with dementia, and conversely, a diagnosis of dementia can make the treatment and management of comorbid conditions quite challenging. Nonmedical care providers should encourage persons living with dementia and their families to report acute changes in health and function to the person's physician, and to let the physician know about difficulties they encounter in managing acute and chronic comorbidities at home or in a residential care facility.
4. *Encourage persons living with dementia and their families to use nonpharmacologic interventions for common behavioral and psychological symptoms of dementia first*
   Increasing evidence suggests nonpharmacological interventions are effective at managing behavioral and psychological symptoms of dementia. Community care providers should encourage persons with dementia and their families to try these interventions first before considering pharmacological treatments.
5. *Understand and support the use of pharmacological interventions when they are necessary for the person's safety, well-being, and quality of life*
   Although nonpharmacological interventions are preferred, there are times when pharmacological treatment is warranted for behavioral and psychological symptoms. It is important for community care providers to understand that pharmacological treatment can have value for the person living with dementia in certain situations and to help them and their family caregiver to accept such treatment. Community care providers should also understand the general principles for starting and more importantly, ending pharmacological treatments and encourage the person living with dementia and family caregivers to ask their medical providers for regular medication reviews and to consider the discontinuation of medications when appropriate.
6. *Work with the person living with dementia, the family, and the person's physician to create and implement a person-centered plan for possible medical and social crises*
   It is helpful for persons living with dementia and their caregivers to have a plan in place should a medical or

social crisis occur, such as an illness, hospitalization or the death of a caregiver. Having a plan in place will help the person's physician and community care providers provide care and support that reflects the preferences of the person living with dementia and reduce stress for family members and care providers who have to make decisions for the person during a crisis.

7. *Encourage persons living with dementia and their families to start end-of-life care discussions early*
   Persons living with dementia and their caregivers should understand options available for care during the later stages of Alzheimer's disease. Having discussions early with the person's physician and other care providers and communicating the preferences of the person and family across care settings can make the transitions during the progression of dementia more manageable.

Practice Recommendations for Information, Education, and Support for Individuals Living with Dementia and their Caregivers (Whitlatch & Orsulic-Jeras, 2018)

1. *Provide education and support early in the disease to prepare for the future*
   Intervening during the early stages creates opportunities to identify, meet, and, in turn, honor the changing and future care needs and preferences of individuals living with dementia and their family caregivers. Discussing the individual's care values and preferences early in the disease can aid in planning during the moderate and advanced stages, as well as at end of life. Early intervention gives individuals living with dementia a voice in how they are cared for in the future, while giving their caregivers piece of mind when making crucial care-related decisions.
2. *Encourage care partners to work together and plan together*
   In recent years, interventions have been developed that bring together individuals living with dementia and their family caregivers, rather than working with each person separately. This person-centered approach supports, preserves, and validates the individual living with dementia's care values and preferences while acknowledging the concerns, stressors, and needs of the caregiver. By discussing important care-related issues earlier on, the individual with dementia's desires and wishes for their own care will remain an important part of their caregiver's decision-making process as the care situation changes.
3. *Build culturally sensitive programs that are easily adaptable to special populations*
   It is very important to design effective evidence-based programming that is sensitive to the unique circumstances of families living with dementia, such as minority, LGBT, and socially disadvantaged populations. However, many minority or socially disadvantaged families living with dementia do not seek out or accept support from nonfamilial sources. Highlighting multicultural issues when training professionals and providing guidance for reaching out to these special populations will lead to more effective programs that embrace the unique needs of all care partners.
4. *Ensure education, information, and support programs are accessible during times of transition*
   There are many transitional points throughout the disease trajectory that have variable effects on both care partners. For example, transitioning from early to middle to late stage often introduces new symptoms and behaviors that, in turn, increase care partners' questions and concerns about what to expect in the future. Progression through the various stages of dementia also brings about other types of transitions, such as changes in living arrangements or care providers (i.e., from in-home to nursing home care). Providing education, information, and support that honor the individual with dementia's values and preferences during these transitions will be reassuring to caregivers as they make hard choices on behalf of the individual living with dementia.
5. *Use technology to reach more families in need of education, information, and support*
   Supportive interventions and programs that use technology (such as Skype, Facetime, etc.) to reach those in need of services are expectedly on the rise. As technology continues to advance and become more accessible and reliable, delivering programs using electronic devices (computer, table, smart phone) could help reach more families. These programs would be especially useful in rural communities where caregivers and individuals living with dementia are often isolated with little access to supportive services.

Practice Recommendations for Care of Behavioral and Psychological Symptoms of Dementia (BPSD) (Scales, Zimmerman, & Miller, 2018)

1. *Identify characteristics of the social and physical environment that trigger or exacerbate behavioral and psychological symptoms for the person living with dementia*
   Behavioral and psychological symptoms of dementia (BPSDs) result from changes in the brain in relation to characteristics of the social and physical environment; this interplay elicits a response that conveys a reaction, stress, or an unmet need, and affects the quality of life of the person living with dementia. The environmental triggers of BPSDs and responses to them differ for each person, meaning that assessment must be individualized and person-centered.
2. *Implement nonpharmacological practices that are person-centered, evidence-based, and feasible in the care setting*

Antipsychotic and other psychotropic medications are generally not indicated to alleviate BPSDs, and so nonpharmacological practices should be the first-line approach. Practices that have been developed in residential settings and which may also have applicability in community settings include sensory practices, psychosocial practices, and structured care protocols.

3. *Recognize that the investment required to implement nonpharmacological practices differs across care settings*
   Different practices require a different amount of investment in terms of training and implementation, specialized caregiver requirements, and equipment and capital resources. Depending on the investment required, some practices developed in residential settings may be feasible for implementation by caregivers in home-based settings.
4. *Adhere to protocols of administration to ensure that practices are used when and as needed, and sustained in ongoing care*
   Protocols of administration assure that there is a "guideline" for care providers as they strive to alleviate BPSDs. These protocols may evolve over time, responsive to the particular components of the practice that are most effective for the person living with dementia.
5. *Develop systems for evaluating effectiveness of practices and make changes as needed*
   The capacity and needs of persons living with dementia evolve over time, and so practices to alleviate BPSDs also may need to evolve over time. Therefore, it is necessary to routinely assess the effectiveness of the practice and, if necessary, adapt it or implement other evidence-based practices.

Practice Recommendations for Support of Activities of Daily Living (ADLs) (Prizer & Zimmerman, 2018)

1. *Support for ADL function must recognize the activity, the individual's functional ability to perform the activity, and the extent of cognitive impairment*
   Dementia is a progressive disease, accompanied by progressive loss in the ability to independently conduct ADLs. Needs for supportive care increase over time—such as beginning with support needed for dressing, and later toileting, and later eating—and must address both cognitive and functional decline as well as remaining abilities.
2. *Follow person-centered care practices when providing support for all ADL needs*
   Not only are dignity, respect, and choice a common theme across all ADL care, but the manner in which support is provided for functionally-specific ADLs must attend to the individualized abilities, likes, and dislikes of the person living with dementia.
3. *When providing support for dressing, attend to dignity, respect, and choice; the dressing process; and the dressing environment*
   In general, people living with dementia are more able to dress themselves independently if, for example, they are provided selective choice and simple verbal instructions, and if they dress in comfortable, safe areas.
4. *When providing support for toileting, attend to dignity and respect; the toileting process; the toileting environment; and health and biological considerations*
   In general, people living with dementia are more able to be continent if, for example, they are monitored for signs of leakage or incontinence, have regularly scheduled bathroom visits and access to a bathroom that is clearly evident as such, and avoid caffeine and fluids in the evening.
5. *When providing support for eating, attend to dignity, respect and choice; the dining process; the dining environment; health and biological considerations; adaptations and functioning; and food, beverage and appetite*
   In general, people living with dementia are more likely to eat if, for example, they are offered choice, dine with others and in a quiet, relaxing, and homelike atmosphere, maintain oral health, are provided adaptive food and utensils, and offered nutritionally and culturally appropriate foods.

Practice Recommendations for Staffing (Gilster, Boltz, & Dalessandro, 2018)

1. *Provide a thorough orientation and training program for new staff, as well as ongoing training*
   A comprehensive orientation should be provided that includes the organization's vision, mission and values, high performance expectations, and person-centered dementia training. This training is essential for new staff, and should be included in ongoing education for all staff members.
2. *Develop systems for collecting and disseminating person-centered information*
   It is important that all staff know the person living with dementia as an individual. Establish procedures for collecting person-centered information that includes choices, preferences, and life history. It is also essential that an effective process be developed to share this information with all staff.
3. *Encourage communication, teamwork, and interdepartmental/interdisciplinary collaboration*
   An organization should promote staff participation and interdepartmental/ interdisciplinary collaboration through routinely scheduled inservice programs and meetings. Training is most effective when designed to include ongoing education, communication and support. Offering inservices and conducting meetings on

all shifts is important, and will impact attendance, participation and facilitate relationships between staff.

4. *Establish an involved, caring and supportive leadership team*
   Creating a person-centered "community" is not possible without service-oriented leaders, managers and supervisors. It is also vital that the leadership team be vision-driven, open, and flexible. High performing leaders know that staff are the foundation of success, and when staff are valued, recognized, and feel served themselves, they in turn will more likely value and serve others.
5. *Promote and encourage resident, staff, and family relationships*
   Encouraging relationships among persons living with dementia, staff and families is central to person-centered care, and is fostered in part by implementing consistent staff assignment. The involvement of all parties in planning care, activities, education, and social events may cultivate successful relationships as well.
6. *Evaluate systems and progress routinely for continuous improvement*
   It is important that an organization routinely collect and evaluate information on all staff processes, including hiring, orientation, training and satisfaction. Analysis of the data should be used to evaluate the effectiveness of all systems and identify areas for improvement. In addition, leaders should share this information with staff, and act upon the results.

Practice Recommendations for Supportive and Therapeutic Environments (Calkins, 2018)

1. *Create a sense of community within the care environment*
   The care community includes the person receiving care, their family and other chosen care partners, and professional care providers. The environment should support building relationships with others as a result of sharing common attitudes, interests, and the goals of the individuals living with dementia, their caregivers, and other care providers.
2. *Enhance comfort and dignity for everyone in the care community*
   It is important that members of the care community are able to live and work in a state of physical and mental comfort free from pain or restraint. Environments are designed to maintain continuity of self and identity through familiar spaces that support orientation to place, time, and activity.
3. *Support courtesy, concern, and safety within the care community*
   Members of the care community should show politeness and respect in their attitudes and behavior toward each other. Doing so includes creating a supportive environment that does not put unnecessary restrictions on individuals and helps them feel comfortable and secure, while also ensuring their safety. The environment compensates for physical and cognitive changes by maximizing remaining abilities and supporting caregiving activities.
4. *Provide opportunities for choice for all persons in the care community*
   The culture of the care community supports a range of opportunities for all persons to make decisions concerning their personal and professional lives, as well as their health and welfare. The environment can provide opportunities for self-expression and self-determination, reinforcing the individual's continued right to make decisions for him/herself.
5. *Offer opportunities for meaningful engagement to members of the care community*
   Relationships are built on knowing the person, which itself is based on doing things together. An environment that provides multiple, easily accessible opportunities to engage in activities with others supports deeper knowing and the development or maintenance of meaningful relationships.

Practice Recommendations for Transitions in Care (Hirschman & Hodgson, 2018)

1. *Prepare and educate persons living with dementia and their family caregivers about common transitions in care*
   Preparing and educating persons living with dementia and their care partners/caregivers about transitions in care should occur before, during and after transitions. Because family caregivers are integral to the care of individuals living with dementia, it is important to understand their need for information about common transitions, including across care settings, such as home to hospital or skilled nursing facility, nursing home to emergency department; within care settings, such as from an emergency department to an intensive care unit; or from one team of clinicians or care providers to another. For example, tools are publically available from the Alzheimer's Disease Education and Referral Center (ADEAR) and the Alzheimer's Association that can be provided to persons living with dementia and their caregivers to help them prepare for the possibilities of hospitalization and transition to long-term care settings such as nursing homes or assisted living.
2. *Ensure complete and timely communication of information between, across and within settings*
   Individuals living with dementia are frequently transferred across facilities without essential clinical information. Careful attention is essential to ensure a safe "handoff." Finding timely and standardized ways to share medical records and advance care planning forms

between patients, caregivers and providers throughout transitions is needed. Linking electronic health records across care settings also offers this potential. Open communication between providers, across settings, and within organizations or clinical practices is essential (both written and verbal). Assisting persons living with dementia and their caregivers in accessing and sharing information in a person- and family-centered way can help to avoid poor outcomes often associated with transitions in care (e.g., rehospitalizations, emergency department visits, medication errors, and caregiver stress). Information must be clinically meaningful, appropriate in amount; it should be communicated by a method useful to the receiving site of care. Achieving these objectives by using standardized forms or standardized approaches to communicate hand-offs can increase the accuracy of information and minimizes risk of error.

3. *Evaluate the preferences and goals of the person living with dementia along the continuum of transitions in care*
   Revisiting preferences and goals for care, including treatment preferences, advance directives, and social and living situation, while the person living with dementia can participate is essential during transitions in care. If a person living with dementia is unable to participate, including caregivers or others who know the person well is vital. After any hospitalization or other significant change requiring a transition in care or level of care, a review and reassessment of the preferences and goals of the person living with dementia should include an assessment of safety, health needs, and caregiver's ability to manage the needs of the person living with dementia. This requires improved competencies of the entire interprofessional team in conducting goals of care conversation, and more effective processes to ensure appropriate assessments are performed before the decision to move a person with dementia to another setting of care is made.
4. *Create strong interprofessional collaborative team environments to assist persons living with dementia and their care partners/caregivers as they make transitions*
   Creation of a strong interprofessional collaborative team environment to support the person living with dementia throughout transitions in care is crucial. Each member of the team needs to have a basic set of competencies in the fundamentals of caring for individuals living with dementia at all stages and their family caregivers. All of the evidence-based interventions described here were specifically designed to address the challenges for individuals living with dementia and other complex chronic conditions as well as the needs of their family caregivers. For example, in the MIND study case, managers were trained in dementia care management over a 4-week period of time, in another study, Naylor and colleagues (2014) developed a set of web-based education modules designed specifically on how to manage the care needs of older adults living with dementia and their family caregiver as they transition from the hospital to home. Furthermore, this type of work requires continuity of the same clinicians (whenever possible) to support the person living with dementia and their family as they move between providers and across setting. Every member of the health care team must be accountable and responsive to ensure the timely and appropriate transfer of responsibility to the next level or setting of care. Optimally clinicians from the sending site of care should maintain responsibility for individuals with dementia until the caregivers at the receiving site assume clinical responsibility.
5. *Initiate/Use evidence-based models to avoid, delay, or plan transitions in care*
   The seven evidence-based models of care in this review focused on avoiding unnecessary transitions (such as hospitalization, or emergency department visits), delaying or supporting placement in residential care settings (such as nursing homes or assisted living communities). Although many evidence-based models have excluded or limited the inclusion of persons living with dementia, adaptations of these models should be considered whenever possible to improve transitions. Among the interventions that targeted hospitalizations and emergency department visits, it is important to note that these events are often tied to nondementia-related conditions. Furthermore, targeting avoidable hospitalizations or rehospitalization for persons living with dementia has the potential to interrupt poor outcomes more common with this population such as risk of delirium and falls. As evidence-based models of care are adapted and modified to meet the needs of persons living with dementia transitioning between, across and within settings of care it is critical to share the findings from these adapted transitions in care models.

About the Alzheimer's Association

The Alzheimer's Association is the leading voluntary health organization in Alzheimer's care, support, and research. Founded in 1980 by a group of family caregivers and individuals interested in research, the Association includes a home office in Chicago, a public policy office in Washington, D.C., and a presence in communities across the country.

Currently, an estimated 47 million people worldwide are living with dementia. In the United States alone, more than 5 million have Alzheimer's, and over 15 million are serving as their caregivers. The Alzheimer's Association addresses this global epidemic by providing education and support to the millions who face dementia every day, while advancing critical research toward methods of treatment, prevention and, ultimately, a cure.

Funding

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Acknowledgments

These overall recommendations summarize the individual topic recommendations developed by authors of the papers included in the Supplement Issue of *The Gerontologist* entitled, *Alzheimer's Association Dementia Care Practice Recommendations*: Mary Guerriero, Austrom, Marie Boltz, Malaz Boustani, Rachel Conant, Jennifer L. Dalessandro, Sam Fazio, Janice Flinner, Richard H. Fortinsky, Susan D. Gilster, Karen B. Hirschman, Nancy A. Hodgson, Beth A. Kallmyer, Anna Kolanowski, Michael A. LaMantia, Katie Maslow, Stephanie J. Miller, Sheila L. Molony, Silvia Orsulic-Jeras, Douglas Pace, Lindsay P. Prizer, Kate E. Rooney, Kezia Scales, Laura Thorhill, Kimberly Van Haitsma, Carol J. Whitlatch, and Sheryl Zimmerman.

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alzheimer's association®

THE BRAINS BEHIND SAVING YOURS.™

Alzheimer's Association, Colorado Chapter
ALR Survey
(conducted March 2018)

ABOUT THIS DATA

The Alzheimer's Association, Colorado Chapter recently asked the Alzheimer's community in our state to tell us about their experiences with ALRs in Colorado. The responses detailed below are not surprising to us. We have been hearing these stories for years from the families we serve and others across our state.

Our survey questions focused on the following issues:

- Dementia training
- Individual attention
- Behavior changes
- Individualized care
- Emergency situations
- Expectations and responsibilities

We were deliberate in choosing these issues. They are based on: 1) the types of services or care standards that could make the largest positive difference in the lives of people with dementia; and 2) the issues we most often hear about from the families we serve.

A total of 39 people responded to our survey with written comments, and those comments are summarized below. Comments come from people in the following Colorado counties (these are the locations of the survey respondents, not necessarily the ALR residents): Adams, Arapahoe, Boulder, Denver, Douglas, Eagle, El Paso, Gunnison, Jefferson, La Plata, Larimer, Morgan, and Weld.

Other things to note about the comments:

- Not all survey respondents answered every question
- References to specific family members (mom, granddad, etc.) have been replace with "loved one"
- Most respondents had a loved one in an ALR; however, a few respondents were themselves employees of an ALR

The question asked in the survey is highlighted in bold within each section. The bullets represent comments provided by at least one survey respondent. If multiple respondents provided a similar answer, for ease of reading, we have simply added the number of respondents in ( ) after the comment. Additionally, we have added the details when the respondent elaborated, but not all respondents provided more detail than a simple "yes" or "no" answer.

SURVEY RESULTS/COMMENTS

Question #1: Dementia Training

Is (or was) the staff at your loved one's assisted living residence adequately trained to interact with, and care for, someone with Alzheimer's or other form of dementia? If not, please provide an example of how this lack of training impacted your loved one or family.

- Yes (17)
  - The residence even provided dementia training to family members to help them better understand their loved ones' disease.
  - Staff training had an enormously positive impact on my loved one.
- No (21)
  - Staff should be better trained to handle people with dementia.
  - Staff had trouble lifting and transferring my loved one.
  - They gave my loved one psych medication to manage behavior issues.
  - Staff told my loved one to pee in her diaper rather than assisting her request to use the toilet.
  - As a former employee of one of these facilities, I was shocked at how little training there was before I was directly caring for residents with dementia.
  - Family was called to come to the residence to deal with loved ones' behavior issues.
  - Relatives were not allowed to enter unannounced so I was not able to see what the care was like when no one was watching.
  - The aides sometimes responded with agitation, not compassion, which made it more difficult for the residents.

Question #2: Individual Attention

Does (or did) your loved one receive adequate time and attention from the staff at their assisted living residence? If they did not, please provide an example.

- Yes (14)
  - Most of the time they did, but residents didn't seem to have enough help at meal times.
  - Sometimes they did, and other times the staff did not engage with my loved one.
  - When the residents were well, it was fine. When they were ill help was slow to come.
- No (25)
  - Staff left by themselves most of the time.
  - My loved one was in several facilities. They all said they would engage her in activities, but the staff didn't seem to know how, so she would just go back to bed.
  - My loved one couldn't communicate other than with her eyes and body language. There were times she was not dressed properly, not provided assistance with eating, and she lost items that were only found because we intervened. Her hands were not always washed before meals and since she "helped" with her bodily functions, they were usually visibly filthy.
  - My loved one had noticeable dental issues, and the staff didn't say anything. I noticed and arranged for appropriate medical care. When I complained, I was told by staff that they were not a skilled nursing facility.
  - Sometimes my loved one's diapers were not changed for an hour or more.

- My loved one was in a wheel chair and was not allowed to stand or walk (even though he could). Most activities were too far away for someone in a wheel chair to get to.
- My loved one was physically active, and I was assured that staff would be available to take her for walks, but the only time that happened was when family or friends visited her and took her. The staff just sat the residents in front of the TV all day. I could see the physical decline in my loved one because of the inactivity.
- My loved one was allowed to roam, sometimes falling or going into another resident's room. They didn't have enough staff to provide this type of attention.
- My loved one had wounds develop because the staff didn't take time to listen to her complaints and look at them.

Question #3: Behavior Changes (Anxiety and Agitation)

Does (or did) the staff at your loved one's assisted living residence know how to handle the anxiety and agitation that is frequently part of the progression of Alzheimer's or other form of dementia? If not, please provide an example.

- Yes (12)
  - I moved my loved one after an emergency incident, and the new residence's staff was properly trained. She was an entirely different person at this residence. She never had an angry incident after that, and those years were some of the best of her life with this disease.
- No (21)
  - Gave (or wanted to give) my loved one psych medication to manage behavior issues instead of managing the behaviors in other ways.
  - My loved one was in a residence that could not handle her behavior issues. During an outburst, the staff called 9-1-1, then refused to readmit her after the hospital visit. I was forced to find a new home for her.
  - The staff tried, but there was never enough of them and/or they didn't have enough training to handle it.
  - Our family was called to come to the residence and handle our loved one's behavior issues, and the staff had no training on this topic.
  - When our family was about to spend-down and have our loved one on Medicaid, the residence all of the sudden told us they couldn't deal with her behavior anymore and asked our family to provide 24 hour care during certain times to handle it. Then they asked us to find another place for her.
  - I thought the doctor should've kept my loved one on anxiety medication to handle his behavior.

Question #4: Individualized Care

Is (or was) the care provided by your loved one's assisted living residence focused to meet their individual needs? If not, what could the staff change to make it better for your family member?

- Yes (12)
  - I had to play a role to make that happen for my loved one.
  - Yes, but once my loved one had an illness, staff were not equipped to do this.
- No (21)
  - Residents had care plans with activities listed, but they didn't actually do them.

- My loved one preferred gluten free meals, but the staff wouldn't serve that to her because it wasn't on the doctor's order. We later found out she had Celiac disease.
- The staff to resident ratio didn't allow for this type of engagement.
- Staff would line up residents in the hallway to get them ready for showers, which was a privacy issue for my family.
- My loved one was diabetic and there were sugary foods around all the time. She was taken to the hospital 3 times with her blood sugar almost to 500. The place she lives now has locked cabinets, etc. so residents can't access such foods, and the staff is more aware of her diabetes.
- I hired a personal CNA to provide this care for my loved one in his ALR because the staff did not provide this care.

Question #5: Emergency Situations

Has your loved one experienced an emergency situation in their assisted living residence, and if so, was the staff adequately prepared to handle it? If not, please provide an example.

- Yes (15)
  - Even though my loved one died at the hospital of complications from a fall at a residence, I thought the staff handled the situation well.
  - Staff called 9-1-1 to handle these situations, and handled them well.
- No (9)
  - There were 3 or 4 emergency situations with my loved one that went unrecognized by staff. One required a visit to the ER. One required an emergency visit to the dentist. One required a trip to the hospital and a toe amputation. All of them were recognized by me first, and I undertook actions to get my loved one needed medical care.
  - My loved one fell, and it took several minutes for someone to come and help him.
  - No one called me to let me know my loved one had been taken to the ER, even though the ALR had multiple phone numbers to reach me. I was informed when the ER staff called me. Because of the delay, neither me or my sibling were at my loved one's side when she died at the hospital.
  - I noticed bruising on my loved one's face. The staff said they didn't know what happened. She also started losing weight, and the staff kept insisting that she was the same weight as when she arrived. I finally brought her to the ER myself on a Thursday, she passed away on Monday. She had "full blown" colon cancer. The staff never said a word to me about her not feeling well.
  - My loved one was found on the floor of his room after a fall. When I arrived the staff was waiting for permission to call an ambulance. I called one myself.
  - My loved one had several instances. Once we were not notified until hours after the incident.

Question #6: Expectations and Responsibilities

When your loved one moved into their assisted living residence, were you adequately informed about the expectations and responsibilities of the staff and the responsibilities of your family? If not, please provide more detail about the information that wasn't provided at that time.

- Yes (15)
  -
- No (16)

- The "sales pitch" was different from the daily experience for my loved one.
- When ALRs tell families they accept Medicaid, they should be up front about the fact that a Medicaid bed might not be available when their loved one needs one. This is what happened to our family. We were told we had to keep paying out of pocket until a Medicaid bed opened up.
- It doesn't matter what families are told if the high turn-over rate for staff means that good care today might not be so good tomorrow.
- It doesn't matter what the supervisors say if the staff working under them aren't (or are not adequately trained to) carry out those instructions.
- I moved my loved one from one residence to another because the first one would not accept her back after a hospital visit. I just had to hope the new place was better, and it turned out to be.
- The residence my loved one lived in changed hands several times. The service and communication went down-hill.
- We were informed of what the contract specified. However there were many circumstances the contract did not cover, and expectations in these situations were not clear (specifically transfer from regular unit to memory care one).
- I was given a booklet, but it didn't answer the critical questions I was most interested in.

Question #7: What Do You Love

What do (or did) you love about your loved one's assisted living residence? What would you want to make sure every residence in the state of Colorado did for, or provided to, their residents?

** This is provided as a list of items.*

- Staff adequately trained to meet the needs of residents with dementia
- Adequate staffing to meet the needs of residents (including paying the staff adequately)
- Engaging residents in activities
- Keeping my loved one safe while living there
- Staff showing respect, kindness, care and attention to residents – many of these comments were about specific staff members, even though the rest of the respondent's answers detailed complaints about overall staffing and quality of care issues.
- Staff is aware of other chronic conditions
- Having a cheerful, bright and comfortable environment
- Bringing in doctors, etc. for appointments for residents who can't travel easily
- Music and other therapies being available
- Connecting residents to community resources
- Good food

Question #8: Other

Is there anything else you want to tell us about your loved one's time living in an assisted living residence in Colorado?

** This is provided as a list of items.*

- There should be laws requiring comprehensive training, testing and licensing of aides who work with people with dementia.

- There is a problem in Colorado of residence staff neglecting residents, getting fired by their employer, then going to work for another residence/employer. This revolving door in the industry needs to be shut down.
- It is impossible to find placement due to waiting lists (for Medicaid beds).
- There should be unannounced site inspections of these facilities with penalties for violations.
- The expectations on staff were too high for the amount of residents we cared for. Every day I left my job knowing I was not able to provide quality care for all of them. There was no time for socialization or engaging with residents. The focus was taking care of basic needs. This is not a quality of life anyone should be subjected to.
- There is too much staff turnover. Also, the staff is not paid enough, which leads to turnover.
- Families are afraid of complaining sometimes because they are afraid their loved one's care will suffer and/or the agency regulating these facilities won't act to fix the problem(s).
- These facilities should be more affordable.
- Level of care and the facility was significantly different between private pay ALR and Medicaid funded one. Everyone should have the same level of care no matter who funds them.

The Myron Stratton Home

555 Gold Pass Heights • Colorado Springs, Colorado 80906 • 719-579-0930 *tel* • 719-579-0447 *fax*

March 20, 2018

Randy Kuykendall
HFEMSD-C1
4300 Cherry Creek Drive S
Denver, CO 80246

Randy,

As a member of the Assisted Living Advisory committee that met for over two years with carful thought, discussion and a commitment concerning the proposed revision to the ALR Rules (Chapter 7). While not all members agreed on all of the regulations all members came to a consensus that the new regulations will insure the safety and protection of the residents that live in Assisted Living Facilities in Colorado deserve.

The committee consisted of representation from a broad spectrum of organizations, both providers and community members offering support to Colorado residents living in Assisted Living Faculties.

Sincerely,

Linda Buendorf

Linda Buendorf
Director of Senior Services
The Myron Stratton Home
719-540-3111

H. A. Stratton

Founder

The Haven
Assisted Living Facility

A Northwest Colorado Health Community

March 20, 2018

Colorado Department of Public Health & Environment
Randy Kuykendahl, Division Director
Health Facilities and Emergency Medical Services

Dear Randy:
I was contacted earlier this month by someone referred to me by Eileen, Director for the Colorado Gerontological Society. This person inquired as to my comfort with the new rules, wondering if I thought they would be cost prohibitive for small facilities. She knew I directed a small (20 bed) rural facility, therefore contacting me to obtain my support for a cost benefit analysis .

I confirmed, for her, my reason for applying for a position, on the Assisted Living Advisory Committee, was my own concerns that new rules would regulate my facility right out of business.

I defined the process I witnessed the past two years:

- Applications for committee membership were made available to solicit participation from an eclectic group
- All meetings were publicized through venues utilized and recognized by Colorado Assisted Living partners.
- Deborah Lively, LeadingAge Colorado Director of Public Policy and Public Affairs, posted prior to the advisory committee meetings agendas and talking points
- Ms. Lively, post meetings, provided a synopsis of steps taken and decisions made
- All meetings were open
- Small groups were utilized to discuss in depth areas of concern i.e. lift procedures and CPR regulations
- At every meeting I attended in person I saw representation from small facilities in the audience
- The audience was given the opportunity to participate in the discussions. I do not recall any meeting where the audience was excluded from voicing their concerns or opinions
- All meetings had the opportunity to participate by phone
- Assisted living support network groups were represented on the committee
- Multiple stakeholder meetings were held throughout the state, adding another opportunity to voice opinions and concerns
- Draft rules were written to include changes originated at the stakeholder meetings

- All the changes were drafted into a final version with another meeting scheduled, giving yet another opportunity to clarify and refine

I further explained to her, in my opinion, the process implemented by Department staff throughout this endeavor, has been fair, open, extremely thorough, sensitive and responsive to the concerns and ideas of all participants.

When she provided the rules causing her concern I found her to be misinformed, quoting requirements not even drafted in the rules. As for her citing the need for a cost benefit analysis I informed her I believed it to be a stall tactic to undermine the hard work of the committee.

I felt the need to notify you of this phone call and conversation, especially since prompted by the Colorado Gerontological Society. It bothers me that a group, who has had abundant opportunity to contribute, chooses to delay a committed effort to produce a product favorable to all facilities, no matter the size. This was not a simple undertaking. I am pleased to have been a part of the process.

Best regards,

Karen Burley

Karen Burley, Director

Colorado Health Care Association
& Center for Assisted Living

March 14, 2018

Mr. Randy Kuykendall
Director, HFEMS Division
Colorado Department of Public Health & Environment
300 Cherry Creek S Dr.
Denver, CO 80246

Mr. Kuykendall,

Please accept this letter of support for updating the Chapter 7 regulations on behalf of the Colorado Health Care Association and Center for Assisted Living (CHCA/CCAL).

In addition to representing 85% of the state's nursing homes, our Association represents nearly 60 assisted living providers and 4,000 beds of care. Our assisted living members range in size from 6 bed communities to 136 bed communities. CHCA/CCAL provides education, information and advocacy to our membership, all of which is aimed at the provision of high quality care for elderly and disabled Coloradoans.

The Colorado Health Care Association and Center for Assisted Living supports regulation that is fair, stable, efficient, and that does not serve as a barrier to the provision of quality care. As such, the Association has served as an active participant in the Assisted Living Advisory Committee over the course of the last two years. Since the current assisted living regulations were written nearly 20 years ago, much has changed in the world of healthcare. A new set of regulations is needed to meet the modern needs of assisted living residents, and the providers who care for them.

While our membership does not support every tenet of the newly developed regulations, we do support the overall body of work as a reasonable means of regulating assisted living residences in Colorado. We also support the notion of a three-year survey cycle and timely response to complaints. The new regulatory framework will only be effective if the Department is able to survey in a timely fashion.

On behalf of the membership of the Colorado Health Care Association and Center for Assisted Living, I would like to thank the Department for hosting a thorough, participatory, and fully transparent process.

Sincerely,

Doug Farmer
President & CEO

I have been on the ALR Advisory committee for many years and this is the first time we have gone over all of the ALR regulations and rewriting the regulations. It was exciting to go through the regulations and making sure they were updated. It was a long and tedious project but was well worth the time and energy spent on it. I thought the process ran smooth and Lorraine being the mediator throughout the process was a great idea. The committee did an excellent job involving everyone and respecting everyone's input on the committee as well as audience members.

Thank you for involving me in the process. I thoroughly enjoyed the process and hope to be involved in more processes that make a difference to individuals that reside in an ALR.

Jun Murai

CO Access

Supervisor

303-368-3273

Office of the State Long-Term Care Ombudsman

March 15th, 2018

Board of Health
C/O Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246

Dear Board Members:

As State Long-Term Care Ombudsman, I am responsible for serving the 43,000 people who live in assisted living homes and nursing homes across Colorado. The federally mandated work of the program is to serve as a resident-directed advocate and to resolve complaints on their behalf.

The State Long-Term Care Ombudsman Program is also charged with systemic advocacy where there will be impact on the quality of care and quality of life for Coloradans who live with disabilities or problems of aging. We were privileged to participate in a recent stakeholder group that convened for many months. The purpose was to make a comprehensive review and improvement of the licensing regulations. This group was comprised of regulators, many providers, advocates and other groups who interact and transact with the assisted living world.

The resulting document is a well-constructed, consensus-grounded set of proposed regulations which bring our Colorado rules into a better fit with the service provision reality in this increasingly complex world. As we face a more clinically complex resident group, and a growing demographic of older Coloradans, the pressures to perform well fall heavily on providers. But we must bear in mind that the needs of the vulnerable resident are at the very center of the regulatory framework. The role of regulation is to establish a "floor" of assurance for the person made dependent by their age and their condition.

I support the rules, in their entirety, as presented in draft and would ask that you adopt them.
I thank you for your careful consideration,

Anne Meier
State Long-Term Care Ombudsman
Disability Law Colorado
455 Sherman Street, Suite 130
Denver CO 80203

April 4, 2018

Board of Health, A5 - 0100
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246

Dear Board Members,

On behalf of our assisted living members, we are writing to you regarding the revised Standards for Hospitals and Health Facilities: Chapter 7 – Assisted Living Residences (ALRs) that are scheduled for rulemaking on April 18. LeadingAge Colorado represents the full continuum of senior living and care providers in Colorado, including 35 percent of the assisted living beds in the state. Our Director of Public Policy and Public Affairs, Deborah Lively, serves as an appointed member of the Assisted Living Advisory Committee (ALAC).

The re-write of the Chapter 7 rules was an extensive process that took several months to complete. It was a deliberative, and sometimes tedious task that resulted in an update to the regulations that we believe more accurately reflect the standards needed to care for a more medically-complex resident population.

While there remain provisions in the draft final rules that we have concerns about, and which were expressed throughout the process, we do feel these issues were given consideration. We will fully participate with ALAC and Colorado Department of Public Health (CDPHE) staff to develop interpretive guidelines to assist ALRs in complying with the new standards once the rules are approved by the board.

Sincerely,

Laura Landwirth

Laura Landwirth
President & CEO
LeadingAge Colorado

COLORADO
Department of Health Care Policy & Financing

April 5, 2018

Colorado Department of Public Health and Environment
Board of Health
4300 Cherry Creek Drive South
Denver, CO 80246

Dear Board of Health Members,

The Department of Health Care Policy and Financing has been an active member of the Assisted Living Advisory Committee (ALAC) through the duration of the rule revision process. The Department believes the rule revision process has been transparent, inclusive, and amenable to outside comments, questions, and suggestions.

The Department of Health Care Policy and Financing is in full support of the revised Assisted Living Regulations, and firmly believes they will help to ensure the health, safety, and wellbeing of Medicaid residents.

Sincerely,

Colin Laughlin
Office of Community Living Division Director, Benefits and Services Management
Department of Healthcare Policy and Financing

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES

CHAPTER VII - ASSISTED LIVING RESIDENCES

6 CCR 1011-1 Chap 07

Copies of these regulations may be obtained at cost by contacting:

Division Director
Colorado Department of Public Health and Environment
Health Facilities Division
4300 Cherry Creek Drive South
Denver, Colorado 80222-1530
Main switchboard: (303) 692-2800

These chapters of regulation incorporate by reference (as indicated within) material originally published elsewhere. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103 (12.5), C.R.S., the Health Facilities Division of the Colorado Department of Public Health And Environment maintains copies of the incorporated texts in their entirety which shall be available for public inspection during regular business hours at:

Division Director
Colorado Department of Public Health and Environment
Health Facilities Division
4300 Cherry Creek Drive South
Denver, Colorado 80222-1530
Main switchboard: (303) 692-2800

Certified copies of material shall be provided by the division, at cost, upon request. Additionally, any material that has been incorporated by reference after July 1, 1994 may be examined in any state publications depository library. Copies of the incorporated materials have been sent to the state publications depository and distribution center, and are available for interlibrary loan.

1.101 STATUTORY AUTHORITY AND APPLICABILITY

1.101(1) Authority to establish minimum standards through regulation and to administer and enforce such regulations is provided by sections 25-1.5-103, et seq., C.R.S., 25-27-101, and 25-27-104, C.R.S.

1.101(2) Assisted living residences, as defined herein, shall be in compliance with all applicable federal and state statutes and regulations, including but not limited to, the following:

101(2)(a) This Chapter VII.

101(2)(b) 6 CCR 1011-1, Chapter II, pertaining to general licensure requirements.

101(2)(c) 6 CCR 1011-1, Chapter XXIV and Section 25-1.5-301, et seq., C.R.S, pertaining to medication administration.

1.102 DEFINITIONS.

~~For purposes of this chapter, the following definitions shall apply, unless the context requires otherwise:~~

~~1.102(1) "Abuse" means emotional, verbal, physical and sexual abuse, as defined herein.~~

~~1.102(2) "Administrator" means a person who is responsible for the overall operation, and daily administration, management and maintenance of the facility. "Administrator" also refers to "operator" as that term is used in Title 25, Section 27, Part 1.~~

~~1.102(3) "Activities of daily living" include but are not limited to the following:~~

~~102(3)(a) Assisting resident or providing reminders for the following:~~

~~(i) bathing, shaving, dental hygiene, caring for hair;~~

~~(ii) dressing;~~

~~(iii) eating;~~

~~(iv) getting in or out of bed.~~

~~102(3)(b) Making available, either directly or indirectly through the resident agreement, at least the following:~~

~~(i) meals;~~

~~(ii) laundry;~~

~~(iii) cleaning of all common areas, bedrooms, and bathrooms;~~

~~(iv) managing money, as necessary and by agreement;~~

~~(v) making telephone calls;~~

~~(vi) arranging appointments and schedules;~~

~~(vii) shopping;~~

~~(viii) writing letters;~~

~~(ix) recreational and leisure activities.~~

~~1.102(4) "Alternative care facility" means an assisted living residence certified by the Colorado Department of Health Care Policy and Financing to receive Medicaid reimbursement for the services provided by the facility.~~

~~1.102(5) "Assess or assessment" as used herein means recognizing a significant change in the resident's condition. It does not mean making clinical judgments unless the person conducting such assessment is licensed to make such judgments.~~

~~1.102(6) "Assisted living residence" means any of the following:~~

~~102(6)(a) A residential facility that makes available to three or more adults not related to the owner of such facility, either directly or indirectly through a resident agreement with the resident, room and board and at least the following services: personal services; protective oversight; social care due to impaired capacity to live independently; and regular supervision that shall be~~

available on a twenty-four-hour basis, but not to the extent that regular twenty-four hour medical or nursing care is required.

102(6)(b) A residential treatment facility for the mentally ill which is an assisted living residence similar to the definition under Section 1.102 (6)(a), except that the facility is operated and maintained for no more than sixteen (16) mentally ill individuals who are not related to the licensee and are provided treatment commensurate to the individuals' psychiatric needs which has received program approval from the Department of Human Services.

102(6)(c) A Supportive Living Program residence that, in addition to the criteria specified in paragraph (a) above, is certified by the Colorado Department of Health Care Policy and Financing to also provide health maintenance activities, behavioral management and education, independent living skills training and other related services as set forth in the supportive living program regulations at 10 CCR 2505-10, §8.515 (Oct. 1, 2014) which are hereby incorporated by reference.

1.102(7) "Auxiliary aid" means any device used by persons to overcome a physical disability and includes but is not limited to a wheelchair, walker or orthopedic appliance.

1.102(8) "Bedridden" means a resident who:

(a) is unable to ambulate or move about, independently or with the assistance of an auxiliary aid, or

(b) requires assistance in turning and repositioning in bed.

1.102(9) "Care plan" means a written description in lay terminology of the functional capabilities of an individual, the individual's need for personal assistance, and the services to be provided by the facility in order to meet the individual's needs and may also mean a service plan for those facilities which are licensed to provide services specifically for the mentally ill.

1.102(10) "Deficiency" means a violation of regulatory and/or statutory requirements governing assisted living residences, as cited by the Department.

1.102(11) "Deficiency list" means a listing of deficiency citations which contains:

102(11)(a) a statement of the statute or regulation violated; and

102(11)(b) a statement of the findings, with evidence to support the deficiency.

1.102(12) "Department" means the Colorado Department of Public Health and Environment or its designee.

1.102(13) "Discharge" means termination of the resident agreement and the resident's permanent departure from the facility.

1.102(14) "Emergency contact" means one of the individuals identified on the face sheet of the resident record to be contacted in the case of an emergency.

1.102(15) "Emotional abuse" means harassment; threats of punishment, harm, or deprivation directed toward the resident.

1.102(16) "External services" means personal services and protective oversight services provided to a resident by family members or by professionals who are not employees, contractors, or volunteers of the facility. External services providers include, but are not limited to, home health, hospice, private pay caregivers and family members.

~~1.102(17) "Facility" means an assisted living residence.~~

~~1.102(18) "High Medicaid Utilization facility" means an assisted living residence that is certified as an alternative care facility and is eligible for a modified fee schedule.~~

~~1.102(19) "Individualized social supervision" means social care, as defined below.~~

~~1.102(20) "Licensee" means the person or entity to whom a license is issued by the Department pursuant to Section 25-1.5-103 (1) (a), C.R.S., to operate a facility within the definition herein provided. For the purposes of this Chapter VII, the term "licensee" shall be the same as the term "owner."~~

~~1.102(21) "Medical or nursing care" means care provided under the direction of a physician and maintained by on-site nursing personnel.~~

~~1.102(22) "Medication administration" means assisting a resident in the use of medication in accordance with state law.~~

~~1.102(23) "Monitoring" with respect to medications means involvement with a resident's use of medication in accordance with state law.~~

~~1.102(24) "Neglect" means failure to fulfill a caretaking responsibility that leads to physical harm.~~

~~1.102(25) Reserved~~

~~1.102(26) "Ombudsman" means, unless otherwise specified, long term care ombudsman.~~

~~1.102(27) "Owner" means the entity in whose name the license is issued. The entity is responsible for the financial and contractual obligations of the facility. Entity means any individual, corporation, limited liability corporation, firm, partnership, or other legally formed body, however organized. For the purposes of the background check required pursuant to Section 1.104 (3) of the owner, if the owner is an entity other than an individual, one person with legal liability for the facility shall be designated to undergo fingerprinting, in accordance with Department requirements.~~

~~1.102(28) "Personal services" means those services which the administrator and employees of an assisted living residence provide for each resident, including, but not limited to:~~

~~102(28)(a) an environment that is sanitary and safe from physical harm;~~

~~102(28)(b) individualized social supervision;~~

~~102(28)(c) assistance with transportation whether by providing transportation or assisting in making arrangements for the resident to obtain transportation; and~~

~~102(28)(d) assistance with activities of daily living, as herein defined.~~

~~1.102(29) "Physical abuse" means causing physical harm in a situation other than an accident. Physical abuse means behavior, including but not limited to, hitting, slapping, kicking or pinching.~~

~~1.102(30) "Plan of correction" means a written plan to be submitted by facilities to the Department for approval, detailing the measures that shall be taken to correct all cited deficiencies.~~

~~1.102(31) Reserved~~

~~1.102(32) "Protective oversight" means guidance of a resident as required by the needs of the resident or as reasonably requested by the resident including the following:~~

~~102(32)(a) being aware of a resident's general whereabouts, although the resident may travel independently in the community; and~~

~~102(32)(b) monitoring the activities of the resident while on the premises to ensure the resident's health, safety, and well-being, including monitoring the resident's needs and ensuring that the resident receives the services and care necessary to protect the resident's health, safety, and well-being.~~

~~1.102(33) "Resident's legal representative" means one of the following:~~

~~102(33)(a) the legal guardian of the resident, where proof is offered that such guardian has been duly appointed by a court of law, acting within the scope of such guardianship;~~

~~102(33)(b) an individual named as the agent in a power of attorney (POA) that authorizes the individual to act on the resident's behalf, as enumerated in the POA;~~

~~102(33)(c) an individual selected as a proxy decision-maker pursuant to Section 15-18.5-101, C.R.S., et seq., to make medical treatment decisions. For the purposes of this regulation, the proxy decision-maker serves as the resident's legal representative for the purposes of medical treatment decisions only; or~~

~~102(33)(d) a conservator, where proof is offered that such conservator has been duly appointed by a court of law, acting within the scope of such conservatorship.~~

~~1.102(34) "Restraint" means any method or devise used to involuntarily limit freedom of movement, including but not limited to, bodily physical force, mechanical devices or chemicals. Restraint also includes chemical restraint, mechanical restraint, physical restraint and seclusion as defined in 26-20-102, C.R.S. For the purposes of this chapter, restraint also includes voluntary restraints. A secured environment that meets the requirements in Section 1.108 of these regulations shall not be considered a restraint.~~

~~1.102(35) "Restrictive egress alert device" means a device used to prevent the elopement of a resident who is at risk if he or she leaves the facility unsupervised. This includes any device used with residents who have confusion or dementia and is used to prohibit their egress or to immediately redirect them after they exit the facility. Egress alert devices are not considered restrictive when used only to alert staff regarding the ingress and egress of residents, visitors, and others. Restrictive egress alert devices shall not lock any door in a means of egress, including access to a means of egress.~~

~~1.102(36) "Secured environment" means, unless the context requires otherwise, any grounds, building or part thereof, method or device, other than restrictive egress alert devices used consistent with Section 1.104 (5)(m), that prohibits free egress of residents. An environment is secured when the right of any resident thereof to move outside the environment during any hours is limited.~~

~~1.102(37) "Sexual abuse" means non-consensual sexual contact as defined in Section 18-3-401 (4), C.R.S and sexual contact with any person incapable of giving consent. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.~~

~~1.102(38) "Social care" means the organization, planning, coordination, and conducting of a resident's activity program in conjunction with the resident's care plan.~~

~~1.102(39) "Staff" means employees; and contract staff intended to substitute for, or supplement staff who provide resident care services. This does not include individuals providing external services, as defined herein.~~

~~1.102(40) "Therapeutic diet" means a diet ordered by a physician as part of a treatment of disease or clinical condition, or to eliminate, decrease, or increase specific nutrients in the diet. Examples include, but are not limited to: a calorie counted diet, a specific sodium gram diet, and a cardiac diet.~~

~~1.103 DEPARTMENT OVERSIGHT~~

~~1.103(1) *General*~~

~~103(1)(a) Issuing Licenses~~

~~(i) The Department shall issue or renew a license when it is satisfied that the applicant or licensee is in compliance with the requirements set out in these regulations. An initial license, other than a provisional, shall be valid for one year from the date of issuance unless voluntarily relinquished by the facility, revoked, suspended or otherwise sanctioned pursuant to these regulations. A renewal license shall be valid for one year from the prior expiration date unless voluntarily relinquished by the facility, revoked, suspended or otherwise sanctioned pursuant to these regulations.~~

~~(ii) No license shall be issued or renewed by the Department if the owner, applicant, or licensee of the assisted living residence has been convicted of a felony or of a misdemeanor, which felony or misdemeanor involves moral turpitude, as defined by law, or involves conduct that the Department determines could pose a risk to the health, safety, and welfare of residents of the assisted living residence.~~

~~103(1)(b) Provisional Licenses~~

~~(i) The Department may issue a provisional license to an applicant for the purpose of operating an assisted living residence for a period of ninety days if the applicant is temporarily unable to conform to all the minimum standards required under these regulations, except no license shall be issued to an applicant if the operation of the applicant's facility will adversely affect the health, safety, and welfare of the residents of such facility.~~

~~(ii) As a condition of obtaining a provisional license, the applicant shall show proof to the Department that attempts are being made to conform and comply with applicable standards. No provisional license shall be granted prior to the submission of a criminal background check in accordance with 25-27-105 (2.5), C.R.S.~~

~~(iii) A provisional license shall not be renewed.~~

~~103(1)(c) Action Against a License~~

~~(i) General. The Department may suspend, revoke, or not renew the license of any facility which is out of compliance with the requirements of these regulations in conformance with the provisions and procedures specified in article 4 of title 24, C.R.S.~~

~~(ii) Denials. When an application for an original license has been denied by the Department, the Department shall notify the applicant in writing of the denial by mailing a notice to the applicant at the address shown on the application. Any applicant aggrieved by such a denial may pursue the remedy for review provided in article 4 of title 24, C.R.S., by petitioning the Department, within thirty days after receiving such notice.~~

~~1.103(2) *License*~~

~~Unless otherwise specified in this chapter, all licensing and plan review fees paid to the Department shall be deemed non-refundable.~~

~~103(2)(a) High Medicaid Utilization Facilities~~

~~(i) Fee. High Medicaid utilization facilities shall pay a modified license renewal fee as set forth in section 1.103(2)(d) below.~~

~~(ii) Eligible facilities. Facilities identified as high Medicaid utilization are those that have:~~

~~(A) no less than 35 percent of the licensed beds occupied by Medicaid enrollees as indicated by complete and accurate fiscal year claims data; and~~

~~(B) served Medicaid clients and submitted claims data for a minimum of nine (9) months of the relevant fiscal year.~~

~~103(2)(b) Facilities Serving a Disproportionate Share of Low Income Residents~~

~~(i) Fee. Facilities serving a disproportionate share of low-income residents shall pay a reduced initial license fee of $3,000.~~

~~(ii) Eligible facilities. Facilities eligible for the reduced initial license fee shall:~~

~~(A) have qualified for federal or state low income housing assistance;~~

~~(B) plan to serve low income residents with incomes at or below 80 percent of the area median income; and~~

~~(C) submit evidence of such qualification, as required by the Department.~~

~~103(2)(c) Initial License~~

~~(i) The appropriate fee, as set forth below, shall accompany a facility's application for initial license.~~

~~Three to eight licensed beds: $6,000.~~

~~Nine beds or more: $7,200.~~

~~103(2)(d) License Renewal~~

~~(i) For licenses that expire prior to September 1, 2015, the appropriate fee, as set forth below, shall accompany the renewal application:~~

~~(A) $150 per facility plus $30 per bed.~~

~~(B) $150 per facility plus $15 per bed for a high Medicaid utilization facility.~~

~~(ii) For licenses that expire on or after September 1, 2015, the appropriate fee, as set forth below, shall accompany the renewal application:~~

~~(A) $180 per facility plus $47 per bed.~~

~~(B) $180 per facility plus $19 per bed for a high Medicaid utilization facility.~~

~~103(2)(e) Provisional Licensure~~

~~(i) Any facility approved by the Department for a provisional license, shall submit a fee of $1,000 for the provisional licensure period.~~

~~103(2)(f) Other License Fees~~

~~(i) In addition to any other applicable fees, the following fees shall apply to the circumstances described.~~

~~(A) Any facility applying for a change of address, shall submit a fee of $75 with the application.~~

~~(I) For purposes of this subsection, a corporate change of address for multiple facilities shall be considered one change of address.~~

~~(B) Any facility applying for a change of name shall submit a fee of $75 with the application.~~

~~(C) Any facility applying for an increased number of licensed beds shall submit a fee of $360 with the application.~~

~~(D) Any facility applying for a change of administrator shall submit a fee of $500 with the application.~~

~~(E) Any facility seeking to open a secured unit shall submit a fee of $1,600 with the first submission of the applicable building plans.~~

~~(F) Any facility applying for a change of ownership shall submit a fee of $5,000 with the application.~~

~~(I) If the same purchaser buys more than one facility from the same seller in a single business transaction, the change of ownership fee shall be $5,000 for the first facility and $2,800 for each additional facility included in the transaction. The appropriate fee total shall be submitted with the application.~~

~~1.103(3) **Reserved**~~

~~1.103(4) ***Citing Deficiencies***~~

~~103(4)(a) The level of the deficiency shall be based upon the number of sample residents affected and the level of harm, as follows:~~

~~Deficiency level~~	~~Number of Sample~~ [3]	~~Level of Harm~~
~~Level A~~	~~Isolated~~ [4]	~~Potential harm to the resident(s)~~
~~Level B~~	~~Pattern~~ [5]	~~Potential harm to the resident(s)~~
~~Level C~~	~~Isolated~~	~~Actual harm to the resident(s)~~
~~Level D~~	~~Pattern~~	~~Actual harm to the resident(s)~~
~~Level E~~	~~Isolated or Pattern~~	~~Life threatening to the resident(s)~~

~~3 Sample may consist of residents, rooms, staff, etc.~~

~~4 One or a limited number of the sample is affected.~~

~~5 More than a limited number of the sample is affected.~~

103(4)(b) When a Level E deficiency is cited, the facility shall immediately remove the cause of the life-threatening risk and provide evidence, either verbal or written as required by the Department, that the risk has been removed.

1.103(5) ***Plans of Correction (POCs)***

The Department shall require a plan of correction by facilities pursuant to Section 25-27-105 (2), C.R.S.,

103(5)(a) General

(i) The facility shall develop a POC, in the format required by the Department, for every deficiency cited by the Department in the deficiency list.

(ii) The POC shall be typed or printed legibly in ink.

(iii) The date of correction shall be no longer than 30 calendar days from the date of the mailing of the deficiency to the facility, unless otherwise required or approved by the Department.

103(5)(b) Process for Submission and Approval of POC

(i) A facility shall submit a POC to the Department no later than ten (10) working days of the date of the deficiency list letter sent by the Department.

(ii) If an extension of time is needed to complete the POC, the facility shall request an extension in writing from the Department prior to the POC due date. An extension of time may be granted by the Department not to exceed seven (7) calendar days.

(iii) The POC is subject to Department approval.

1.103(6) ***Intermediate Restrictions or Conditions***

The Department may impose intermediate restrictions or conditions on a licensee as provided in Section 25-27-106, C.R.S.

103(6)(a) General. The Department may impose intermediate restrictions or conditions on a licensee that may include at least one of the following:

(i) Retaining a consultant to address corrective measures. The consultant shall not be affiliated with the corporation or the facility on which the intermediate restriction/condition is required; [6]

6 facility may be required to retain a consultant in order to address deficient practice resulting from systemic failure. Systemic failure involves violations regarding a facility system, where such violations resulted or could have resulted in physical or emotional harm to residents. It will be the responsibility of the facility to select the consultant and the consultant's services. An example of a facility system is the facility's medication administration program.

(ii) Monitoring by the Department for a specific period;

(iii) Providing additional training to employees, owners, or operators of the residence;

(iv) Complying with a directed written plan, to correct the violation; or

(v) Paying a civil fine not to exceed two thousand dollars ($2,000) in a calendar year.

103(6)(b) *Imposition of Restrictions/Conditions*

(i) General. Intermediate restrictions or conditions may be imposed when the Department finds the facility has violated statutory or regulatory requirements. The factors that may be considered include, but are not limited to, the following:

(A) level of actual or potential harm to a resident(s);

(B) the number of residents affected;

(C) whether the behaviors leading to the imposition of the restriction are isolated or a pattern;

(D) the licensee's prior history of noncompliance in general, and specifically with reference to the cited deficiencies.

(ii) Optional. Intermediate restrictions or conditions may be imposed for Levels A, B and C deficiencies.

(iii) Mandatory Imposition

(A) A minimum of one intermediate restriction or condition shall be imposed for all cases where the deficiency list includes Levels D or E deficiencies.

(B) For all Level E deficiencies, the Department shall impose a minimum civil fine of $500, not to exceed the cap established by statute; shall require the immediate correction of the circumstances that give rise to the life threatening situation; and may impose other restrictions or conditions as the Department finds necessary.

103(6)(c) *Submission of the Written Plan*

(i) Non-life threatening situations other than fines and Department monitoring. No later than ten (10) working days after the date the notice is received from the Department, unless otherwise extended, the licensee shall submit a written plan, as part of the plan of correction, regarding the implementation of the restriction or condition. This plan shall be subject to Department approval. The plan shall include:

(A) how the restriction or condition will be implemented; and

(B) the timeframe for implementing the restriction or condition.

103(6)(d) *Appealing the Imposition of Intermediate Restrictions/Conditions*. A licensee may appeal the imposition of an intermediate restriction or condition pursuant to procedures established by the Department and as provided by Section 25-27106, C.R.S.

(i) Informal review. Informal review is an administrative review process conducted by the Department that does not include an evidentiary hearing.

(A) A licensee may submit a written request for informal review of the imposition of an intermediate restriction no later than ten (10) working days after the date notice is received from the Department of the restriction or condition. If an extension of time is needed, the facility shall request an extension in writing from the Department prior to the submittal due date. An extension of time may be granted by the Department not to exceed seven (7) calendar days. Informal review may be conducted after the plan of correction has been approved.

(B) Civil fines. For civil fines, the licensee may request in writing that the informal review be conducted in person, which would allow the licensee to orally address the informal reviewer(s).

(ii) Administrative Procedures Act (APA). A licensee may appeal the imposition of an intermediate restriction or condition in accordance with Section 24-4-105, C.R.S. of the APA. A licensee is not required to submit to the Department's informal review before appealing pursuant to the APA.

(iii) *Implementation of Restrictions/Conditions*

(A) Life-threatening situations . The licensee shall implement the restriction or condition immediately upon receiving notice of the restriction or condition.

(iv) Non life-threatening situations. The restriction or condition shall be implemented:

(A) for restriction/conditions other than fines, immediately upon the expiration of the opportunity for appeal or from the date that the Department's decision is upheld after all administrative appeals have been exhausted.

(B) for fines, within 30 calendar days from the date the Department's decision is upheld after all administrative appeals have been exhausted.

1.103(7) ***Facility Reporting Requirements***

103(7)(a) *Occurrences*

(i) Reporting . The facility shall be in compliance with occurrence reporting requirements pursuant to 6 CCR 1011, Chapter II, Section 3.2.

(ii) Facility investigation of occurrences

(A) Occurrences shall be investigated to determine the circumstances of the event and institute appropriate measures to prevent similar future situations.

(B) Documentation regarding investigation, including the appropriate measures to be instituted, shall be made available to the Department, upon request.

(C) A report with the investigation findings will be available for review by the Department within five working days of the occurrence.

(D) Nothing in this Section 1.103 (7)(a) shall be construed to limit or modify any statutory or common law right, privilege, confidentiality or immunity.

103(7)(b) *Mistreatment of Residents/Mishandling of Resident Property.* The declaration required in Section 2.4.3(K), Chapter II of 6 CCR 1011-1, shall also include any action related to the treatment of residents or the handling of their property.

103(7)(c) *Notification Regarding Relocations*. The facility shall notify the Department within 48 hours of the relocation of one or more residents occurs due to any portion of the facility becoming uninhabitable as a result of fire or other disaster.

103(7)(d) *Proof of Fire Suppression or Detection Equipment Testing*. Written proof that such fire suppression or detection equipment has been tested and approved as fully functional and

operational, shall be submitted with the application prior to the issuance of a new license or license renewal.

1.103(8) ***Certification of Administrator Training***

A program of certification shall be approved by the Department if all of the following requirements are met:

103(8)(a) The program or program components are conducted by:

(i) an accredited college, university, or vocational school, or

(ii) an organization, association, corporation, group, or agency with specific expertise in that area; and

(iii) the curriculum includes at least thirty (30) actual hours.

103(8)(b) At least fifteen (15) hours shall comprise a discussion of each the following topics:

(i) resident rights;

(ii) environment and fire safety, including emergency procedures and first-aid;

(iii) assessment skills;

(iv) identifying and dealing with difficult situations and behaviors; and

(v) nutrition.

103(8)(c) The remaining fifteen (15) hours shall provide emphasis on meeting the personal, social and emotional care needs of the resident population served, for example, the elderly, Alzheimers, or the severely and persistently mentally ill.

1.104 ORGANIZATION AND STAFFING

1.104(1) **Owner**

104(1)(a) Regulatory Compliance. The owner shall be responsible for meeting the requirements in these regulations.

104(1)(b) Oversight of Staff. The owner is responsible for assuring that there is adequate training and supervision for staff.

1.104(2) **Administrator**

104(2)(a) Minimum Age Requirement. The administrator shall be at least 21 years of age.

104(2)(b) Minimum Education, Training and Experience Requirements

(i) Any person commencing service as an administrator July 1, 1993, shall meet the minimum education, training, and experience requirements in one of the following ways:

(A) successful completion of a program approved by the Department pursuant to Section 1.103 (6); or

(B) documented previous job related experience or related education equivalent to successful completion of such program. The Department may require additional training to ensure that all the required components of the training curriculum are met.

(ii) Any person already serving as an administrator on July 1, 1993, shall either meet subparagraph (i) above or meet the minimum education, training, and experience requirements in one of the following ways:

(A) successful completion of a program approved by the Department, pursuant to Section 1.103 (4) , if completed within a period of eighteen (18) months following July 1, 1993;

(B) submission of evidence of successful completion of such a program within the five (5) years immediately prior to July 1, 1993; or

(C) previous job related experience equivalent to successful completion of such a program.

(iii) The administrator shall be familiar with all applicable federal and state laws and regulations concerning licensure and certification.

1.104(3) **Personnel**

104(3)(a) General

(i) Communicable diseases

(A) All staff and volunteers, shall be free of communicable disease that can be readily transmitted in the workplace.

(B) All staff shall be required to have a tuberculin skin test prior to direct contact with the residents. In the event of a positive reaction to the skin test, evidence of a chest x-ray and other appropriate follow-up shall be required in accordance with community standards of practice.

(ii) Physical/mental impairment . Any person who is physically or mentally unable to adequately and safely perform duties that are essential functions, may not be approved as a licensee, or employed as staff member, or used as a volunteer.

(iii) Alcohol or substance abuse . The facility shall not employ any person or use a volunteer who is under the influence of a controlled substance, as defined in C.R.S. Sections 18-18-203, 18-18-204, 18-18-205, 18-18-206, and 18-18-207, or who is under the influence of alcohol in the worksite. This does not apply to employees or volunteers using controlled substances under the direction of a physician, and in accordance with their health care provider's instructions.

(iv) Access to policies and procedures . All staff and all volunteers shall have access to the facility's policies, procedure manuals, and other information necessary to perform their duties and to carry out their responsibilities.

104(3)(b) Personnel Files. The facility shall maintain personnel files for staff members as well as for volunteers performing personal services and protective oversight under the auspices of the facility. Files of current employees and volunteers shall be available onsite for Department review.

(i) General . Files shall include documentation required in these Chapter VII regulations, evidencing:

(A) training, including copies of current first aid certification, if applicable;

(B) TB testing, if applicable;

(C) background checks;

(D) date of hire;

(E) If a Qualified Medication Administration Person (QMAP), also:

(I) a copy of the certificate of completion of the medication training course required by these regulations for QMAPs, and

(II) for those QMAPs filling medication reminder boxes, a signed disclosure that they have not had a professional medical, nursing, or pharmacy license revoked.

104(3)(c) Background Checks - Owner and Administrator

(i) The owner and administrator of a facility shall be of good, moral, and responsible character. As part of this determination, the owner and the administrator shall undergo a state fingerprint check with notification of future arrests from a criminal justice agency designated by the Department. The information, upon such request and subject to any restrictions imposed by such agency, shall be forwarded by the criminal justice agency directly to the Department.

(ii) Background checks shall be conducted for all of the following:

(A) owners and administrators for initial licensure, as part of the application process.

(B) existing owners and administrators who have not undergone a state fingerprint check with notification of future arrests.

(C) new owners in a change a ownership, as part of the application process.

(D) new administrators in a change of administrators.

(iii) No license shall be issued or renewed by the Department if the owner of the assisted living facility has been convicted of a felony or of a misdemeanor, which felony or misdemeanor involves moral turpitude, as defined by law, or involves conduct that the Department determines could pose a risk to the health, safety, and welfare of residents of the assisted living residence.

(iv) The owner shall ascertain whether the administrator has been convicted of a felony or a misdemeanor that could pose a risk to the health, safety, and welfare of the residents, when making employment decisions.

(v) Cost of background checks All costs of obtaining a criminal history record pursuant to this requirement shall be borne by the facility, the contract staff agency, or the individual who is the subject of the criminal history record, as appropriate.

104(3)(d) Background Checks - Other Staff and Volunteers

(i) When a background check shall be conducted . The staff who has direct personal contact with the residents of a facility and any volunteer performing personal services or protective oversight, under the auspices of the facility for residents of such facility, shall be of good, moral, and responsible character. In making such a determination, the owner or licensee of a facility shall obtain, prior to such staff or volunteer performing duties, any criminal history record information from a criminal agency, subject to any restrictions imposed by such agency, for any person responsible for the care and welfare or residents of such facility. If the individual is contract staff, the facility shall ensure that a background check has been conducted on such individual within 12 months prior to the date of hire by the facility. The facility shall have documentation of such background checks.

(ii) Use of information by the facility . The facility shall ascertain whether prospective staff or volunteers have been convicted of a felony or a misdemeanor that could pose a risk to the health, safety, and welfare of the residents, when making employment decisions.

(iii) Costs of background checks . All costs of obtaining a criminal history record from a criminal justice agency shall be borne by the facility, the contract staff agency, or the individual who is the subject of the criminal history record, as appropriate.

104(3)(e) Qualifications

(i) General . All staff and all volunteers shall have sufficient skill and ability to perform their respective duties, services, and functions.

(ii) Licensed and certified staff . Licensed or certified staff shall perform duties in accordance with applicable statutes and regulations. Staff and volunteers shall not perform duties that they are not licensed or certified to provide.

(iii) Qualified Medication Administration Persons

(A) To be a qualified medication administration person, an individual shall have completed a medication training course given by a licensed nurse, physician, physician's assistant, or pharmacist, and approved by the Department and/or shall have passed an approved Department competency test for assisting with medications in accordance with 25-1.5-301, et seq. and the regulations promulgated thereto.

(B) Every qualified medication administration staff member who administers medications, whether prescribed or non-prescribed, shall be able to read and understand the information and directions printed or written on the label.

(iv) Current First Aid Certification

(A) There shall be one staff member onsite at all times who has current certification in first aid specific to adults.

(B) The first aid certification shall show that it meets the standards of either the American Red Cross or the American Heart Association.

104(3)(f) Training. The facility shall document the evaluation of previous related experience for volunteers, as applicable, and for staff and that these personnel have all of the training, including on-the-job training, required in this section.

(i) On-the-job training/Evaluation of experience . All staff and all volunteers shall be given on-the-job training or have related experience in the job assigned to them and shall be supervised until they have completed on-the-job training appropriate to their duties and responsibilities or had previous related experience evaluated.

(ii) Training requirements . Staff shall receive the following training, as appropriate. Volunteers providing direct care shall receive training appropriate to their duties and responsibilities.

(A) Prior to providing direct care, the facility shall provide an orientation of the physical plant and adequate training on each of the following topics:

(I) training specific to the particular needs of the populations served (e.g., residents in secured environments, mentally ill, frail elderly, AIDS, Alzheimer's, diabetics, dietary restrictions and bedfast);

(II) resident rights;

(III) first aid and injury response including the procedures for lift assistance;

(IV) the care and services for the current residents;

(V) certified first aid training as necessary to ensure compliance with section 1.104(3)(e)(iv) of this chapter.

(VI) the facility's medication administration program.

(B) Emergency Plan and Evacuation Procedures

(I) Within three (3) days of date of hire or commencement of volunteer service, the facility shall provide adequate training in the emergency plan and evacuation procedures.

(II) Every two (2) months, there shall be a review of all components of the emergency plan, including each individual employee's responsibilities under the plan, with the staff of each shift.

(C) Within one month of the date of hire, the facility shall provide adequate training for staff on each of the following topics:

(I) assessment skills;

(II) infection control;

(III) identifying and dealing with difficult situations and behaviors;

(IV) residents rights, unless previously covered through other training; and

(V) health emergency response, unless previously covered through other training.

1.104(4) **Staffing Requirements**

104(4)(a) Staffing

(i) General . The owner shall employ sufficient staff to ensure the provision of services necessary to meet the needs of the residents.

(ii) Staffing levels . In determining staffing, the facility shall give consideration to factors including but not limited to:

(A) services to meet the residents' needs,

(B) services to be provided under the care plan, and

(C) services to be provided under the resident agreement.

(iii) Minimum Staffing . Each facility shall ensure that at least one staff member who has the qualifications and training listed under Sections 1.104 (3)(e) and (f), and who shall be at least 18 years of age, is present in the facility when one or more residents is present.

104(4)(b) Use of Residents. Residents may participate voluntarily in performing housekeeping duties and other tasks suited to the resident's needs and abilities. However, residents who provide services for the facility on a regular basis, or on an exchange or fee-for-service basis may not be included in the facility's staffing plan in lieu of facility employees except for trained, tested, and supervised residents in those facilities which are licensed to provide services specifically for the mentally ill.

104(4)(c) Use of Volunteers. Volunteers may be utilized in the facility but may not be included in the facility's staffing plan in lieu of facility employees.

1.104(5) Policies and Procedures. Unless otherwise indicated in this Section 1.104 (5), all facilities shall develop, adopt, and follow written policies and procedures that include the requirements listed below and shall comply with all applicable state and federal statutes and regulations. Required disclosures to residents or their legal representatives, as appropriate, regarding the policies and procedures shall be documented in the resident record.

104(5)(a) Admissions. The facility's criteria for admission shall be based upon its ability to meet all the identified care needs of residents. The facility shall consider at least all of the following in making its admission decision: the facility's physical plant, financial resources, and availability of adequately trained staff.

104(5)(b) Emergency Plan and Evacuation Procedures

(i) Emergency plan . The emergency plan shall include planned responses to fire, gas explosion, bomb threat, power outages, and tornado. Such plan shall include provisions for alternate housing in the event evacuation is necessary.

(ii) Disclosure to residents . Within three (3) days of admission, the plan shall be explained to each resident or legal representative, as appropriate.

104(5)(c) Serious Illness, Serious Injury, or Death of the Resident

(i) The policy shall describe the procedures to be followed by the facility in the event of serious illness, serious injury, or death of a resident.

(ii) The policy shall include a requirement that the facility notify an emergency contact when the resident's injury or illness warrants medical treatment or face-to-face medical evaluation. In the case of an emergency room visit or unscheduled hospitalization, a facility must notify an emergency contact immediately, or as soon as practicable.

~~104(5)(d) CPR Directive~~

~~(i) At the time of admission, the facility shall inform residents or their legal representatives regarding the resident's right to receive CPR or have a written CPR directive refusing CPR. At least annually or upon a significant change in health condition, the facility shall review the CPR options with each resident or that resident's legal representative~~

~~(ii) Upon admission and at each subsequent review, the facility and the resident or the resident's legal representative shall sign and date documentation acknowledging that the resident's CPR options were reviewed and understood. Such documentation shall be maintained in each resident's record.~~

~~(iii) The facility shall ensure that staff are aware of or know where to immediately locate each resident's CPR directive.~~

~~104(5)(e) Lift Assistance~~

~~(i) The facility shall describe in writing the procedure for determining when it is appropriate for staff to assist a resident who has fallen and when the local emergency medical responder should be contacted.~~

~~(ii) The facility's lift assistance procedure shall be made available to its local emergency medical responder.~~

~~104(5)(f) Physician Assessment. The facility shall identify when a physician's assessment will be required, based upon at least the following indicators:~~

~~(i) a significant change in the resident's condition;~~

~~(ii) evidence of possible infection (open sores, etc.);~~

~~(iii) injury or accident sustained by the resident which might cause a change in the resident's condition;~~

~~(iv) known exposure of the resident to a communicable disease;~~

~~(v) development of any condition which would have initially precluded admission to the facility.~~

~~104(5)(g) Resident Rights~~

~~(i) General . The policy shall incorporate the provisions under Section 1.106 (1). This policy shall not exclude, take precedence over, or in any way abrogate legal and constitutional rights enjoyed by all adult citizens.~~

~~(ii) Posting . The policy on resident's rights shall be posted in a conspicuous place.~~

~~(iii) Disclosure to residents . Upon admission, the facility shall document the resident or legal representative, as appropriate, has read or had explained the policy on residents' rights.~~

~~104(5)(h) Smoking~~

~~(i) General . The policy shall address residents, staff, volunteers and visitors.~~

~~(ii) Disclosure to residents/staff . Prior to admission or employment, residents and staff shall be informed of any prohibitions.~~

~~104(5)(i) Discharge~~

~~(i) General . The policy shall include all of the following:~~

~~(A) circumstances and conditions under which the facility may require the resident to be involuntarily transferred, discharged or evicted;~~

~~(B) an explanation of the notice requirements;~~

~~(C) a description of the relocation assistance offered by the facility; and~~

~~(D) the right to call advocates, such as the state ombudsman or the designated local ombudsman and the adult protection services of the appropriate county Department of Social Services, for assistance.~~

~~(ii) Disclosure to residents . Upon admission, the facility shall document that the resident or legal representative, as appropriate, has read or had explained the policy on discharge.~~

~~104(5)(j) Management of Resident Funds/Property. The policy shall address the procedures for managing resident funds or property, if the facility provides this service to residents.~~

~~104(5)(k) Internal Grievance Process~~

~~(i) General . The policy shall establish a process for routine and prompt handling of grievances brought by residents and their families. Such policy shall also indicate that residents and their families may contact any of the following agencies and shall provide the telephone number and address of each of the following:~~

~~(A) The state and local Long Term Care Ombudsman;~~

~~(B) The Adult Protection Services of the appropriate county Departments of Social Services;~~

~~(C) The Advocacy Services of the Area's Agency on Aging;~~

~~(D) The Colorado Department of Public Health and Environment; and~~

~~(E) The Colorado Department of Human Services in those cases where the facility is licensed to provide services specifically for the mentally ill.~~

~~(ii) Posting . The internal grievance policy and procedure shall be posted in a conspicuous place.~~

~~(iii) Disclosure to residents . Upon admission, the facility shall document that the resident or the resident's representative, as appropriate, has read or had the policy for the internal grievance process explained.~~

~~104(5)(l) Investigation of Abuse and Neglect Allegations. The facility shall investigate all allegations of abuse and neglect involving residents in accordance with its written policy, which shall include but not be limited to:~~

~~(i) reporting requirements to the appropriate agencies such as the adult protection services of the appropriate county Department of Social Services and to the facility administrator;~~

~~(ii) a requirement that the facility notify an emergency contact about the allegation within 24 hours of the facility becoming aware of the allegation;~~

~~(iii) the process for investigating such allegations;~~

~~(iv) how the facility will document the investigation process to evidence the required reporting and that a thorough investigation was conducted;~~

~~(v) a requirement that the resident shall be protected from potential future abuse and neglect while the investigation is being conducted;~~

~~(vi) a requirement that if the alleged neglect or abuse is verified, the facility shall take appropriate corrective action; and~~

~~(vii) a requirement that a report with the investigation findings will be available for review by the Department not later than five working days of the allegation being lodged with a staff member of the facility.~~

~~104(5)(m) Restrictive Egress Alert Devices Facilities that use restrictive egress alert devices, shall have policy addressing at minimum, the following:~~

~~(i) How the device will be used to protect the resident from elopement, including but not limited to, which door alarms will be triggered by the device.~~

~~(ii) Evidence in the resident's record that the facility has:~~

~~(A) established the legal authority by guardianship, court order, medical durable power of attorney, health care proxy, or other means allowed by Colorado law, for the use of such device;~~

~~(B) conducted an assessment, prior to use, that evaluates the appropriateness of the device and reassessment(s) within 3 calendar days of a significant change in the resident's condition that warrants intervention or different care needs. The assessment and reassessment shall include written findings and their basis. The assessment and reassessment(s) shall be completed by a qualified professional, such as the resident's physician, a social worker, physician's assistant or nurse practitioner. If the qualified professional is a member of the facility staff or has been hired by the facility to conduct the evaluation, the qualified professional shall consult with the resident's physician or other independent person qualified to review the care needs of the resident.~~

~~(iii) How the facility will respond to prevent elopement when an alarm is triggered, including but not limited to:~~

~~(A) the system that will be used to alert staff regarding which door(s) have been breached;~~

~~(B) the staff member(s) responsible for responding to the alarm and for conducting the behavior management intervention; and~~

~~(C) how staff will continue providing protective oversight for other residents while the behavior management intervention, such as redirection, is taking place.~~

~~(iv) How the facility will provide access to a secure outdoor area, consistent with Section 108 (9)(c) (i) and (ii).~~

(v) Monthly testing to ensure that the devices are functioning properly and written evidence of such testing.

1.105 ADMINISTRATIVE FUNCTIONS

1.105(1) **Admissions** *[Eff. 11/01/2008]*

105(1)(a) Who May be Admitted to the Facility. Only residents whose needs can be met by the facility within its licensure category shall be admitted. The facility's ability to meet resident needs shall be based upon a comprehensive pre-admission assessment of the resident's physical, health and social needs; preferences; and capacity for self care.

105(1)(b) Who May Not be Admitted to the Facility. A facility shall not admit or keep any resident requiring a level of care or type of service which the facility does not provide or is unable to provide, and in no event shall a facility admit or keep a resident who:

(i) Is consistently, uncontrollably incontinent unless the resident or staff is capable of preventing such incontinence from becoming a health hazard.

(ii) Is totally bedridden with limited potential for improvement. A facility may keep a resident who becomes bedridden after admission if there is documented evidence of each of the following:

(A) an order by a physician describing the services required to meet the health needs of the resident, including but not limited to, the frequency of assessment and monitoring by the physician or by other licensed medical professionals.

(B) ongoing assessment and monitoring by a licensed or Medicare/Medicaid certified home health agency or hospice service. The assessment and monitoring shall ensure that resident's physical, mental, and psychosocial needs are being met. The frequency of the assessment and monitoring shall be in accordance with resident needs, but shall be conducted no less frequently than weekly.

(C) adequate staffing, with staff who are trained in the provision of caring for bedridden residents, and provision of services to meet the needs of the resident.

(iii) Needs medical or nursing services, as defined herein, on a twenty-four hour basis, except for care provided by a Supportive Living Program residence or by a psychiatric nurse in those facilities which are licensed to provide services specifically for the mentally ill.

(iv) Needs restraints, as defined herein, of any kind except as otherwise provided in 27-65-101, et seq. C.R.S. for those facilities which are licensed to provide services specifically for the mentally ill. The placement of residents in his or her room for the night and the use of time-out, as defined by the facility's written policies and procedures, shall be conducted only as part of a treatment plan developed in consultation with a physician board certified in psychiatry or an advance practice nurse with a specialty in psychiatry. The appropriateness of these provisions in the treatment plan shall be reassessed by either one of these psychiatric clinicians every three months.

(v) Has a communicable disease or infection that is: 1) reportable under 6 CCR 1009 Regulation 1 and 2) potentially transmissible in a facility, unless the resident is receiving medical or drug treatment for the condition and the admission is approved by a physician; or

(vi) Has a substance abuse problem, unless the substance abuse is no longer acute and a physician determines it to be manageable.

1.105(2) **Resident Agreement.** A written agreement shall be executed between the facility and the resident or the resident's legal representative at the time of admission. The parties may amend the agreement provided such amendment is evidenced by the written consent of both parties. No agreement shall be construed to relieve the facility of any requirement or obligation imposed by law or regulation. *[Eff. 11/01/2008]*

105(2)(a) Content. The written agreement shall specify the understanding between the parties regarding, at a minimum the following:

(i) charges, refunds and deposit policies;

(ii) services included in the rates and charges, including optional services for which there will be an additional, specified charge;

(iii) types of services provided by the facility, those services which are not provided, and those which the facility will assist the resident in obtaining;

(iv) the amount of any fee to hold a place for the resident in the facility while the resident is absent from the facility and the circumstances under which it will be charged;

(v) transportation services;

(vi) therapeutic diets;

(vii) whether the facility or the resident will be responsible for providing bed and bath linens, as outlined in Section 110 (3)(a) or furnishings and supplies, as outlined in Section 112(3)(f); and

(viii) a provision that if the facility closes without giving residents thirty days notice of such closure, that security deposits shall be reimbursed.

105(2)(b) Addenda. The written agreement shall have as addenda:

(i) the care plan outlining functional capability and needs; and

(ii) house rules, established pursuant to Section 1.105(4).

105(2)(c) Disclosures. There shall be written evidence that the following have been disclosed, upon admission unless otherwise specified, to the resident or the resident's legal representative, as appropriate:

(i) the facility policies and procedures listed under Section 1.104(5).

(ii) the method for determining staffing levels based on resident needs, including whether or not the facility has awake staff 24 hours a day, the on-site availability of first aid certified staff, and the extent to which certified or licensed health care professionals are available on-site.

(iii) types of daily activities, including examples of such activities, that will be provided for the residents.

(iv) whether or not the facility has automatic fire sprinkler systems.

(v) if the facility uses restrictive egress alert devices, the types of individuals exhibited by persons that need such devices.

1.105(3) ***Management of Resident Funds/Property.*** A facility may enter into a written agreement with the resident or resident's legal representative for the management of a resident's funds or property. However, there shall be no requirement for the facility to handle resident funds or property.

105(3)(a) *Written Agreement.* A resident or the resident's legal representative may authorize the owner to handle the resident's personal funds or property. Such authorization shall be in writing and witnessed and shall specify the financial management services to be performed.

105(3)(b) *Fiduciary Responsibility.* In the event that a written agreement for financial management services is entered into, the facility shall exercise fiduciary responsibility for these funds and property, including, but not limited to, maintaining any funds over the amount of five hundred dollars ($500) in an interest bearing account, separate from the general operating fund of the facility, which interest shall accrue to the resident.

105(3)(c) *Surety Bond.* Facilities which accept responsibility for residents' personal funds shall post a surety bond in an amount sufficient to protect the residents' personal funds.

105(3)(d) *Accounting*

(i) A running account, dated and in ink, shall be maintained of all financial transactions. There shall be at least a quarterly accounting provided to the resident or legal representative itemizing in writing all transactions including at least the following: the date on which any money was received from or disbursed to the resident; any and all deductions for room and board and other expenses; any advancements to the resident; and the balance.

(ii) An account shall begin with the date of the first handling of the personal funds of the resident and shall be kept on file for at least three years following termination of the resident's stay in the facility. Such record shall be available for inspection by the Department.

105(3)(e) *Receipts.* Residents shall receive a receipt for and sign to acknowledge disbursed funds.

1.105(4) ***House Rules .*** The facility shall establish written house rules.

105(4)(a) *Content.* House rules shall list all possible actions which may be taken by the facility if any rule is knowingly violated by a resident. House rules may not violate or contravene any regulation herein, or in any way discourage or hinder a resident's exercise of those rights guaranteed herein. Such rules shall address at least the following:

(i) smoking.

(ii) cooking.

(iii) protection of valuables on premises.

(iv) visitors.

(v) telephone usage including frequency and duration of calls.

(vi) use of common areas, including the use of television, radio, etc.

~~(vii) consumption of alcohol.~~

~~(viii) dress.~~

~~(ix) pets. A facility may keep household pets including dogs, cats, birds, fish, and other animals as permitted by local ordinance, with evidence of compliance with state and local vaccination and inoculation requirements and in accordance with house rules. In no event shall such rules prohibit service or guide animals.~~

~~105(4)(b) *Posting.* The facility shall prominently post written house rules which shall be available at all times to residents.~~

~~105(4)(c) *Disclosure to Residents.* There shall be documentation in the resident's record that a copy of the rules was provided to the resident or the legal representative, as appropriate, prior to admission.~~

~~1.105(5) ***Resident Record*** A confidential record shall be maintained for each resident. Records shall be dated and legibly recorded in ink or in electronic format.~~

~~105(5)(a) *Content of Resident Record.* Resident records shall contain at least, but not be limited to, the following:~~

~~(i)~~ Demographic and medical information

~~(A)~~ Face sheet ~~. The face sheet shall contain the following information:~~

~~(I) resident's full name, including maiden name if applicable;~~

~~(II) resident's sex, date of birth, marital status and social security number, where needed for medicaid or employment purposes;~~

~~(III) date of admission;~~

~~(IV) name, address and telephone number of relatives or legal representative(s), or other person to be notified in an emergency;~~

~~(V) name, address and telephone number of resident's primary physician, and case manager if applicable, and an indication of religious preference, if any, for use in emergency;~~

~~(VI) resident's diagnoses, at the time of admission;~~

~~(VII) current record of the resident's allergies.~~

~~(B) Progress notes of any significant change in physical, behavioral, cognitive and functional condition and action taken by staff to address the resident's changing needs;~~

~~(C) Medication administration record;~~

~~(D) Documentation of on-going services provided by external services providers, such as physical therapy and home health services;~~

~~(E) Advance directives, if applicable;~~

(F) Physician's orders;

(ii) The resident agreement;

(iii) The care plan, as that term is defined herein;

(iv) Resident's most recent former address of residence.

105(5)(b) *Who May Access Resident Records.* Records shall be available for inspection by and release to:

(i) the resident or the resident's legal representative, if so authorized ;

(ii) the resident's attorney of record;

(iii) the state or local Long Term Care ombudsman with the permission of the resident and in accordance with Section 25-1-801, C.R.S.;

(iv) the Department; and

(v) those otherwise authorized by law.

105(5)(c) *Resident Record Storage and Retention*

(i) Records shall be maintained and stored in such a manner as to be protected from loss, damage or unauthorized use.

(ii) Records shall be maintained in the facility or in a central administrative location readily available to facility staff and the department. Records necessary to respond to the current care needs of the resident shall be maintained onsite at the facility.

(iii) Records for discharged residents shall be complete and maintained for a period of three years following the termination of the resident's stay in the facility.

105(5)(d) *Confidentiality.* The confidentiality of the resident record including all medical, psychological and sociological information shall be protected at all times, in accordance with all applicable state and federal laws and regulations.

1.105(6) ***Discharge***

105(6)(a) A resident shall be discharged only for one or more of the following reasons:

(i) When the facility cannot protect the resident from harming him or herself or others.

(ii) When the facility is no longer able to meet the resident's identified needs, based on the facility's discharge policy.

(iii) When a Supportive Living Program resident has met his or her transitional planning goals.

105(6)(b) A resident may be discharged for one or more of the following reasons:

(i) Nonpayment for basic services, including rent, in accordance with the resident agreement; or

(ii) Failure of the resident to comply with the resident agreement which contains notice that discharge may result from violation of the agreement.

105(6)(c) Written notice of discharge shall be provided to the resident or resident's legal representative as follows:

(i) thirty (30) days in advance of discharge for discharge in accordance with Sections 1.105 (6)(a)(ii), 1.105 (6)(b)(i) and 1.105 (6)(b)(ii);

(ii) in cases of medical emergency, or in accordance with Section 1.105 (6)(a)(i), the responsible party shall be notified as soon as possible.

105(6)(d) A copy of the 30 day written notice shall be sent to the state or local ombudsman, within 5 calendar days of the date that it is provided to the resident or the resident's legal representative.

105(6)(e) Discharge shall be coordinated with the resident, the resident's family or resident's legal representative , or the appropriate agency.

1.106 RESIDENT RIGHTS

1.106(1) ***General.*** Residents shall have the following rights:

106(1)(a) The right to be treated with respect and dignity.

106(1)(b) The right to privacy.

106(1)(c) The right not to be isolated or kept apart from other residents.

106(1)(d) The right not to be sexually, verbally, physically or emotionally abused, humiliated, intimidated, or punished.

106(1)(e) The right to be free from neglect.

106(1)(f) The right to live free from involuntary confinement, or financial exploitation and to be free from physical or chemical restraints as defined within these regulations except as otherwise provided in Section 27-10-101, et seq. C.R.S. for those facilities which are licensed to provide services specifically for the mentally ill.

106(1)(g) The right to full use of the facility common areas, in compliance with the documented house rules.

106(1)(h) The right to voice grievances and recommend changes in policies and services.

106(1)(i) The right to communicate privately including but not limited to communicating by mail or telephone with anyone.

106(1)(j) The right to reasonable use of the telephone, in accordance with house rules, which includes access to operator assistance for placing collect telephone calls. At least one telephone accessible to residents utilizing an auxiliary aid shall be available if the facility is occupied by one or more residents utilizing such an aid.

106(1)(k) The right to have visitors, in accordance with house rules, including the right to privacy during such visits.

~~106(1)(l) The right to make visits outside the facility in which case the administrator and the resident shall share responsibility for communicating with respect to scheduling.~~

~~106(1)(m) The right to make decisions and choices regarding their care and treatment, in the management of personal affairs, funds, and property in accordance with their abilities.~~

~~106(1)(n) The right to expect the cooperation of the facility in achieving the maximum degree of benefit from those services which are made available by the facility.~~

~~106(1)(o) The right to exercise choice in attending and participating in religious activities.~~

~~106(1)(p) The right to be reimbursed at an appropriate rate for work performed on the premises for the benefit of the administrator, staff, or other residents, in accordance with the resident's care plan.~~

~~106(1)(q) The right to 30 days written notice of changes in services provided by the facility, including but not limited to changes in charges for any or all services. Exceptions to this notice are:~~

~~(i) changes in the resident's medical acuity that result in a documented decline in condition and that constitute an increase in care necessary to protect the health and safety of the resident; and~~

~~(ii) requests by the resident or the family for additional services to be added to the care plan.~~

~~106(1)(r) The right to have advocates, including members of community organizations whose purposes include rendering assistance to the residents.~~

~~106(1)(s) The right to wear clothing of choice unless otherwise indicated in the resident's care plan and in accordance with reasonable house rules.~~

~~106(1)(t) The right to choose to participate in social activities, in accordance with the care plan.~~

~~106(1)(u) The right to receive services in accordance with the resident agreement and the care plan.~~

~~1.106(2) ***Ombudsman Access.*** A facility shall permit access during reasonable hours to the premises and residents by the State Ombudsman and the designated local long-term care ombudsman in accordance with the federal "Older Americans Act of 1965", pursuant to Section 25-27-104 (2) (d), C.R.S.~~

~~1.106(3) ***Restraints.*** Restraints as defined within these regulations are prohibited except as otherwise provided in 27-65-101, et seq. C.R.S. for those facilities which are licensed to provide services specifically for the mentally ill. The placement of a resident in his or her room for the night or the use of a time-out as defined by the facility's written policies and procedures may only be used in accordance with a treatment plan developed in consultation with and based on a written order by a physician board certified in psychiatry or a psychiatric clinical nurse specialist listed on the advance practice registry. The treatment plan, which shall document that less restrictive measures were unsuccessful, shall be evaluated by a clinician with such credentials every three months.~~

~~1.106(4) ***Mechanisms to Address Resident/Resident Family Concerns***~~

~~106(4)(a) *Internal Grievance Process.* The facility shall implement an internal process for the routine and prompt handling of grievances brought by residents and their families.~~

~~106(4)(b) *Facilities with Less than 17 Beds - House Meetings*~~

~~(i) House meetings shall be held in addition to implementing the internal grievance process pursuant to Subsection (4)(a), above.~~

(ii) In facilities with less than seventeen (17) beds, house meetings shall be held at least quarterly with residents, the appropriate staff, family and friends of residents in order that residents have the opportunity to voice concerns and make recommendations concerning facility policies.

(iii) Written minutes of such meetings shall be maintained for review by residents at any time.

106(4)(c) *Facilities with 17 Beds or More - Residents' Council*

(i) Resident council meetings shall be held in addition to implementing the internal grievance process pursuant to Subsection (4)(a), above.

(ii) In facilities with seventeen (17) or more beds, a residents' council shall be established.

(iii) The residents' council shall have full opportunity to meet without the presence of staff.

(iv) The council shall meet at least monthly with the administrator and a staff representative to voice concerns and make recommendations concerning facility policies. Staff shall respond to these suggestions in writing prior to the next regularly scheduled meeting.

(v) Written minutes of council meetings shall be maintained for review by residents.

1.107 RESIDENT CARE SERVICES

1.107(1) ***General***

107(1)(a) *Facility Census.* The facility shall maintain a current list of residents and their assigned room or apartment.

107(1)(b) *Minimum Services.* The facility shall make available, either directly or indirectly through a resident agreement, the following services, sufficient to meet the needs of the residents:

(i) a physically safe and sanitary environment;

(ii) room and board;

(iii) personal services;

(iv) protective oversight; and

(v) social care.

1.107(2) ***Social and Recreational Activities***

107(2)(a) The facility, in consultation with the residents, shall provide opportunities for social and recreational activities both within and outside the facility and shall coordinate community resources and promote resident participation in activities both in and away from the residence.

107(2)(b) The facility shall encourage resident participation in planning, organizing, and conducting the residents' activity program, taking into consideration the individual interests and wishes of the residents.

107(2)(c) In determining the types of activities offered, the facility shall take into account the physical, social and mental stimulation needs of the residents as well as their personal and religious preferences.

~~1.107(3) ***Care Planning*** he facility shall develop and implement a written care plan for each resident to monitor and oversee the resident's care needs.~~

~~107(3)(a) *Care Plan.* A written care plan for each resident shall be completed at the time of admission and shall include at least the following:~~

~~(i) a comprehensive assessment of the resident's physical health, behavioral, and social needs; preferences; and capacity for self care. The assessment shall include, but not be limited to:~~

~~(A) whether medication is self-administered or whether assistance is required from staff;~~

~~(B) special dietary instructions, if any; and;~~

~~(C) any physical or mental limitations.~~

~~(ii) a description of the services which the facility will provide to meet the needs identified in the comprehensive assessment.~~

~~107(3)(b) *Care Plan Modifications.* The resident may request a modification of the services identified in the care plan at any time.~~

~~107(3)(c) *Reassessments.* The resident shall be reassessed yearly or more frequently, if necessary, to address significant changes in the resident's physical, behavioral, cognitive and functional condition and identify the services that the facility shall provide to address the resident's changing needs. The care plan shall be updated to reflect the results of the reassessment.~~

~~107(3)(d) *External Services.* If the resident is receiving personal care and/or protective oversight services from external services provider(s), the facility shall coordinate and document in the care plan the services that are to be provided by the external services provider(s) as well as the services to be provided by the facility to ensure that the resident needs are met.~~

~~1.107(4) ***Medication***~~

~~107(4)(a) *Personal Medication*~~

~~(i) All personal medication is the property of the resident and no resident shall be required to surrender the right to possess or self-administer any personal medication, except as otherwise specified in the care plan of a resident of a facility which is licensed to provide services specifically for the mentally ill or if a physician or other authorized medical practitioner has determined that the resident lacks the decisional capacity to possess or administer such medication safely.~~

~~(ii) Personal medication shall be returned to the resident or resident's legal representative, upon discharge or death, except that return of medication to the resident may be withheld if specified in the care plan of a resident of a facility which is licensed to provide services specifically for the mentally ill or if a physician or other authorized medical practitioner has determined that the resident lacks the decisional capacity to possess or administer such medication safely. The return of medication shall be documented by the facility.~~

~~(iii) Notwithstanding the provisions of Section 107 (4)(a)(ii), if donated by the resident or the resident's next of kin, the facility may return to a pharmacist unused medications in accordance with state laws, including Section 12-22-133, C.R.S (2005). For purposes of~~

this paragraph, unused medications means prescription medications that are not controlled substances. *[Eff. 01/30/2007]*

107(4)(b) *Misuse of Medication*

(i) Misuse or inappropriate use of known medications for persons who are self-administering shall be reported to the resident's physician or other authorized practitioner.

(ii) No resident shall be allowed to take another's medication nor shall staff be allowed to give one resident's medication to another resident.

(iii) Medication which has a specific expiration date shall not be administered after that date and shall be disposed of appropriately.

107(4)(c) *Labeling*

(i) Medications shall be labeled with the resident's full name and pursuant to Article 22 of Title 12. This does not apply to medications that are self-administered by and in the possession of the resident.

(ii) Any medication container which has a detached, excessively soiled or damaged label, shall be returned to the issuing pharmacy for relabeling or disposed of appropriately.

107(4)(d) *Storage.* All medication shall be stored in a manner that ensures the safety of the residents.

(i) Central location

(A) Medication which is kept in a central location, including refrigerators, shall be kept under lock and shall be stored in separate or compartmentalized packages, containers, or shelves, for each resident in order to prevent intermingling of medication.

(B) Residents shall not have access to medication which is kept in a central location.

(ii) Refrigeration. Medications which require refrigeration shall be stored separately in locked containers in the refrigerator. If medication is stored in a refrigerator dedicated to that purpose, and the refrigerator is in a locked room, then the medications do not need to be stored in locked containers.

(iii) Bulk Quantities. Prescription and over-the-counter medication shall not be kept in stock or bulk quantities, unless such medication is administered by a licensed medical practitioner.

1.107(5) ***Administration of Medication and Treatment***

107(5)(a) *Qualified Medication Administration Staff.* Qualified medication administration staff members may administer or assist the resident in administration of medication.

107(5)(b) *Medication Administration Record*

(i) For residents whose medications are monitored or administered by the facility staff, a current record shall be maintained of the resident's medications including name of drug, dosage, route of administration of medication and directions for administration of medication.

~~(ii) The administration of medication shall be documented at the time of administration.~~

~~107(5)(c) *Written Orders*~~

~~(i) The facility shall only administer medications upon the written order of a licensed physician or other authorized practitioner.~~

~~(ii) If the facility assists the resident with the administration of one or more medications and the resident also self-administers the same or other medication, the written order shall specify that such self-administration is authorized.~~

~~107(5)(d) Telephone Orders~~

~~(i) Only a licensed nurse may accept telephone orders for medication from a physician or other authorized practitioner.~~

~~(ii) All telephone orders shall be evidenced by a written and signed order within fourteen (14) days and documented in resident's record and the facility's medical administration record.~~

~~107(5)(e) *Compliance with Physician Orders*~~

~~(i) This applies to medications and treatment which do not conflict with state law and regulations pertaining to assisted living residences and which are within the scope of services provided by the facility, as outlined in the resident agreement or the house rules.~~

~~(ii) The facility shall be responsible for complying with physician orders, associated with the administration of medication or treatment, unless the resident self-administers such medication or treatment. The facility shall implement a system that:~~

~~(A) Obtains clarification from the physician, as necessary and documents that the physician:~~

~~(I) has been asked whether refusal of the medication or treatment should result in physician notification.~~

~~(II) has been notified, where such notification is appropriate. Documentation of such notification shall be made in the medication administration record or in the progress notes.~~

~~(B) Coordinates care with external providers or accepts responsibility to perform the care using facility staff.~~

~~(C) Trains staff regarding the parameters of the ordered care as appropriate.~~

~~(D) documents delivery of the care, including refusal by the resident of the medication or treatment.~~

~~107(5)(f) *Drugs Used to Affect or Modify Behavior*~~

~~(i) Any drugs used to affect or modify behavior, including psychotropic drugs may not be administered by unlicensed persons as a "PRN" or "as needed" medication, except:~~

(A) in those residential treatment facilities which are licensed to provide services for the mentally ill, or

(B) where a resident understands the purpose of the medication, is capable of requesting the drug of his or her own volition and the facility has documentation from a licensed medical professional that the use of such drug in this manner is appropriate.

107(5)(g) *Oxygen* . Residents may administer oxygen, and staff shall assist with the administration as needed, when prescribed by a physician and if the facility follows appropriate safety requirements regarding oxygen herein.

(i) General

(A) Oxygen tanks shall be secured upright at all times to prevent falling over and secured in a manner to prevent tanks from being dropped or from striking violently against each other.

(B) Tank valves shall be closed except when in use.

(C) Transferring oxygen from one container to another shall be conducted in a well-ventilated room with the door shut. Transfer shall be conducted by a trained staff member or by the resident for whom the oxygen is being transferred, if the resident is capable of performing this task safely. When the transfer is being conducted, no resident, except for a resident conducting such transfer, shall be present in the room. Tanks and other oxygen containers shall not be exposed to electrical sparks, cigarettes or open flames.

(D) Tanks shall not be placed against electrical panels or live electrical cords where the cylinder can become part of an electric circuit.

(ii) Handling

(A) Tanks shall not be rolled on their side or dragged.

(B) Smoking shall be prohibited in rooms where oxygen is used. Rooms in which oxygen is used shall be posted with a conspicuous "No Smoking" sign.

(iii) Storage

(A) Smoking shall be prohibited in rooms where oxygen is stored and such rooms shall be posted with a conspicuous "No Smoking" sign.

(B) Tanks shall not be stored near radiators or other heat sources. If stored outdoors, tanks shall be protected from weather extremes and damp ground to prevent corrosion.

1.108 SECURED ENVIRONMENT

Facilities choosing to operate a secured environment must comply with the regulations contained in this section as well as the other provisions within these regulations.

1.108(1) ***Disclosure to Residents.*** A facility that operates a secured environment shall disclose to the resident and the resident's legal representative, if applicable, prior to the resident's admission to the facility, that the facility operates a secured environment. The disclosure shall include information about

~~the types of resident diagnoses or behaviors that the facility serves and for which staff of the secured environment is trained to provide services.~~

~~1.108(2) ***Resident Rights.*** The resident who believes that he or she has been inappropriately admitted to the secured environment may request the assistance of the facility in contacting the state and local ombudsman and the resident's legal representative. Upon such request the facility shall assist the resident in making such contact.~~

~~1.108(3) ***Who May be Admitted to the Secured Environment***~~

~~108(3)(a) *Needs Can be Met.* Only those residents who need a secured environment placement and whose needs can be met by the facility, as determined by an assessment, may be admitted. Upon completion of the assessment, a resident who has been determined to be a danger to self or others shall not be admitted to the secured environment.~~

~~108(3)(b) *Legal Authority/Voluntary Admission.* A resident shall not be admitted to a secured environment unless legal authority for admitting the resident has been established by guardianship, court order, medical durable power of attorney, health care proxy or other means allowed by Colorado law. However, a resident may voluntarily be admitted or may remain in a secured environment if his or her egress is not restricted.~~

~~108(3)(c) *Mentally Ill.* Facilities that serve residents who are mentally ill shall not admit such residents into a secured environment unless there is no less restrictive alternative and unless they are otherwise in compliance with the requirements of Article 10 of Title 27, Colorado Revised Statutes.~~

~~108(3)(d) *Developmentally Disabled.* Facilities that serve residents with developmental disabilities as defined in Article 10.5 of Title 27, Colorado Revised Statutes shall not admit such residents into a secured environment, unless the facility is in compliance with the requirements of such article.~~

~~1.108(4) ***Secured Environment Assessments and Reassessments***~~

~~108(4)(a) Prior to admission, there shall be an assessment of the resident that evaluates the appropriateness of placement in a secured environment. The assessment shall include written findings and their basis regarding admission to the secured environment and an evaluation of less restrictive alternatives.~~

~~108(4)(b) Reassessments must be completed within 10 days of a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident's stay in the secured environment is still appropriate.~~

~~108(4)(c) The assessment and reassessment shall be completed by a qualified professional such as the resident's physician, a social worker, physician's assistant or nurse practitioner. If the qualified professional is a member of the facility staff or has been hired by the facility to conduct the evaluation, the qualified professional shall consult with the resident's physician or other independent person qualified to review the care needs of resident.~~

~~1.108(5) ***Documentation in the Resident Record.*** The following shall be documented in the resident's record:~~

~~108(5)(a) The legal authority for admission.~~

~~108(5)(b) The assessment.~~

~~108(5)(c) The reassessment(s).~~

~~1.108(6) ***Staffing***~~

~~108(6)(a) The facility shall provide a sufficient number of trained staff members to meet the needs of the residents in the secured environment. In addition to the requirements set forth in Section 1.104 (4)(a) (iii) there shall always be at least one trained staff member in attendance in the secured environment at all times.~~

~~1.108(7) ***Family Council***~~

~~108(7)(a) Facilities with secured environments shall establish a forum for family members of residents in secured environments to voice suggestions, concerns and grievances.~~

~~108(7)(b) The forum shall allow families to meet with the administrator and a staff representative to make recommendations concerning facility policies, grievances, incidents, and other matters of concern to the residents. Staff shall respond to these suggestions in writing prior to the next regularly scheduled meeting.~~

~~108(7)(c) The forum shall be offered at least quarterly and may be held in conjunction with resident house or council meetings. Families shall be given the opportunity to meet with facility staff without residents present, upon request. The forum shall be scheduled at a time that reasonably accommodates family participation and schedules.~~

~~1.108(8) ***Discharge***~~

~~108(8)(a) A facility must give at least 30 days written notice to the resident and the resident's legal representative when moving a resident out of a secured environment, unless the move is made at the request of, or voluntarily by, the person who is legally responsible for the resident or in accordance with the requirements of Section 1.105(6)(b) of these regulations.~~

~~1.108(9) ***Physical Plant Requirements***~~

~~108(9)(a) Reserved~~

~~108(9)(b) *Egress Alert Systems and Devices.* Egress alert systems and devices (such as Wanderguard) shall be arranged to sound a proximity alarm only, and shall not lock any door within a means of egress.~~

~~108(9)(c) *Secure Outdoor Area*~~

~~(i) In addition to the interior common areas required by this regulation, the facility shall provide a safe and secure outdoor area for the use of residents year round.~~

~~(ii) Fencing or other enclosures~~

~~(A) Fencing or other enclosures that prevent elopement and protect the safety and security of the residents shall be installed around secure outdoor areas.~~

~~(B) Where a locked outdoor fence gate restricts access to the public way, all staff must carry gate lock keys on their person at all times while on duty.~~

~~(iii) In facilities establishing a secured environment on or after June 1, 2004, the facility shall ensure that residents are able to access the secure outdoor area independently.~~

1.109 DIETARY AND DINING SERVICES

1.109(1) ***General.*** Reserved.

1.109(2) Food Service Sanitation

109(2)(a) *Facilities with Less than 20 Beds*

(i) Food shall be prepared, handled and stored in a sanitary manner, so that it is free from spoilage, filth, or other contamination, and shall be safe for human consumption.

(ii) Hazardous materials shall not be stored with food supplies.

109(2)(b) *Facilities with 20 Beds or More.* Facilities licensed for 20 beds or more shall comply with the Department's March 1, 2013 regulations on Colorado Retail Food Establishments at 6 CCR 1010-2.

1.109(3) ***Meals and Snacks***

109(3)(a) *Meals*

(i) At least three nutritionally balanced meals in adequate portions, using a variety of foods shall be made available, either directly or indirectly through the resident agreement, at regular times daily.

(ii) In the event the meal provided is unpalatable, a substitute shall be provided.

109(3)(b) *Snacks*

(i) Between meal snacks of nourishing quality shall be available.

1.109(4) ***Menus***

109(4)(a) Menus shall vary daily and shall be adjusted for seasonal changes and holidays.

109(4)(b) Weekly menus shall be available for review by residents in advance of the day of preparation.

109(4)(c) Residents shall be encouraged to participate in planning and in making suggestions as to menus and the facility shall make reasonable efforts to accommodate such suggestions.

1.109(5) ***Food Supply***

109(5)(a) There shall be enough food on hand to prepare three nutritionally balanced meals for three days.

1.109(6) ***Therapeutic Diets.*** A facility may provide therapeutic diets to residents. However, there shall be no requirement that facilities provide this service. If the facility provides therapeutic diets, the following requirements shall apply.

109(6)(a) Therapeutic diets shall be prescribed by a physician.

109(6)(b) If the facility provides therapeutic diets, the facility shall implement a system in order to ensure that the proper diet is provided.

1.109(7) ***Dining Area/Services***

109(7)(a) *Dining Area.* A designated dining area accessible by all residents shall be provided in a separate area or areas capable of comfortably seating all residents.

109(7)(b) *Exclusion from Dining Area*

(i) No resident or group of residents shall be excluded from the designated dining area during meal time unless otherwise indicated in the resident's care plan.

(ii) Meals shall not be routinely served in resident rooms unless otherwise indicated in the resident's care plan.

1.109(8) ***Dishwashing*** Dishwashing shall be conducted in a safe and sanitary manner. A two-compartment sink or a single-compartment sink used in conjunction with a domestic dishwashing machine shall be required. Dish-washing machines shall be used in accordance with manufacturer's instructions .

1.110 LAUNDRY SERVICES

1.110(1) ***Provision of Laundry Services.*** The facility shall make laundry services available in one of the following ways, and in accordance with these regulations:

110(1)(a) providing laundry service for the residents;

110(1)(b) providing access to laundry equipment so that the residents may do their own laundry; or

110(1)(c) by making arrangements with a commercial laundry.

1.110(2) ***Separation of Clean/Soiled Laundry.*** Separate storage for soiled linen and clothing shall be provided.

1.110(3) ***Supply of Clean Bed and Bath Linens***

110(3)(a) Facilities which provide bed and bath linens, shall provide such linens at least weekly or more frequently in accordance with residents' needs. Clean blankets shall also be provided as necessary.

1.111 INTERIOR AND EXTERIOR ENVIRONMENT.

The facility shall provide a clean, sanitary environment, free of hazards to health and safety.

1.111(1) ***Interior Environment*** All interior areas including attics, basements, and garages shall be safely maintained.

111(1)(a) Potential Safety Hazards

(i) Cooking. Cooking shall not be allowed in bedrooms. Residents may have access to an alternative area where minimal food preparation such as heating or reheating food or making hot beverages is allowed. In those facilities which make housing available to residents through apartments rather than resident bedrooms, cooking may be allowed in accordance with house rules. Only residents who are capable of cooking safely shall be allowed to do so. The facility shall document such assessment.

(ii) Electrical Equipment

(A) Extension cords. Extension cords and multiple use electrical sockets in resident rooms shall be limited to one per resident.

(B) Power strips. Power strips are permitted throughout the facility with the following limitations:

(I) The power strip must be provided with overcurrent protection in the form of a circuit breaker or fuse.

(II) The power strip must have a UL (underwriters laboratories) label.

(III) The power strips cannot be linked together when used.

(IV) Extension cords cannot be plugged into the power strip.

(V) Power strips can have no more than six receptacles.

(VI) The use will be restricted to one power strip per resident per bedroom.

(C) Personal appliances. Personal appliances shall be allowed in resident bedrooms only under the following circumstances:

(I) such appliances are not used for cooking;

(II) such appliances do not require use of an extension cord or multiple use electrical sockets;

(III) such appliance is in good repair as evaluated by the administrator; and

(IV) such appliance is used by a resident who the administrator believes to be capable of appropriate and safe use. The facility shall document such assessment.

(D) Electric blanket/Heating pad. In no event shall a heating pad or electric blanket be used in a resident room without either staff supervision or documentation that the administrator believes the resident to be capable of appropriate and safe use.

(iii) Accumulation of refuse. All interior areas including attics, basements, and garages shall be free from accumulations of extraneous materials such as refuse, discarded furniture, and old newspapers.

(iv) Combustibles. Combustibles such as cleaning rags and compounds shall be kept in closed metal containers.

(v) Portable Heaters. Kerosene (fuel fired) heaters shall not be permitted within the facility. Electric or space heaters shall not be permitted within resident bedrooms and may only be used in common areas of the facility if owned, provided, and maintained by the facility.

(vi) Fire resistant wastebaskets . Enclosed areas on the premises where smoking is allowed shall be equipped with fire resistant wastebaskets. In addition, resident rooms occupied by smokers, even when house rules prohibit smoking in resident rooms, shall have fire resistant wastebaskets.

111(1)(b) *Potential Infection/Injury Hazards*

(i) Insect/rodent infestations. The facility shall be maintained free of infestations of insects and rodents and all openings to the outside shall be screened.

(ii) Storage of hazardous substances. Solutions, cleaning compounds and hazardous substances shall be labeled and stored in a safe manner .

111(1)(c) *Heating, Lighting, Ventilation*

(i) Each room in the facility shall be installed with heat, lighting and ventilation sufficient to accommodate its use and the needs of the residents.

(ii) All interior and exterior steps and interior hallways and corridors shall be adequately illuminated.

111(1)(d) *Water*

(i) Potable water. There shall be an adequate supply of safe, potable water available for domestic purposes.

(ii) Hot water.

(A) Hot water shall not measure more than 120 degrees Fahrenheit at taps which are accessible by residents.

(B) There shall be a sufficient supply of hot water during peak usage demands.

111(1)(e) *Telephone*

(i) There shall be a telephone available for regular telephone usage by residents and staff.

1.111(2) ***Exterior Environment***

111(2)(a) Potential Safety Hazards

(i) Maintenance of the grounds. Exterior premises shall be kept free of high weeds and grass, garbage and rubbish. Grounds shall be maintained to prevent hazardous slopes, holes, or other potential hazards.

(ii) Staircases. Exterior staircases of three (3) or more steps and porches shall have handrails. Staircases and porches shall be kept in good repair.

1.112 PHYSICAL PLANT, FURNISHINGS, EQUIPMENT AND SUPPLIES

1.112(1) ***Compliance with State and Local Laws/Codes.*** Facilities shall be in compliance with all applicable:

112(1)(a) Local zoning, housing, fire and sanitary codes and ordinances of the city, city and county, or county where the facility is situated to the extent that such codes are consistent with the federal "Fair Housing Amendment Act of 1988", as amended, 42 U.S.C., sec. 3601, et seq.

112(1)(b) State and local plumbing laws and regulations. Plumbing shall be maintained in good repair, free of the possibility of backflow and backsiphonage, through the use of vacuum breakers and fixed air gaps, in accordance with state and local codes.

112(1)(c) Sewage disposal requirements. Sewage shall be discharged into a public sewer system or disposed of in a manner approved by the local health department, or local laws if no local health department exists, and the Colorado Water Quality Control Commission.

1.112(2) ***Common Areas***

112(2)(a) Common areas sufficient to reasonably accommodate all residents shall be provided.

112(2)(b) All common areas and dining areas shall be accessible to residents utilizing an auxiliary aid without requiring transfer from a wheelchair to walker or from a wheelchair to a regular chair for use in dining area. All doors to those rooms requiring access be at least 32 inches wide.

112(2)(c) A minimum of two entryways shall be provided for access and egress from the building by residents utilizing a wheelchair if the facility is occupied by one or more residents utilizing a wheelchair.

1.112(3) ***Bedrooms and Occupancy Ratios***

112(3)(a) *Bedroom Assignment.* No resident shall be assigned to any room other than a regularly designated bedroom.

112(3)(b) *Occupancy Ratios.* No more than two (2) residents shall occupy a bedroom. However, facilities licensed prior to July 1, 1986 may have up to four (4) residents per room until either a substantial remodeling or a change of ownership occurs.

112(3)(c) *Square Footage Requirements*

(i) On or after June 1, 2004, facilities applying for initial licensure, when such initial license is not a change of ownership, shall have at least 100 square feet for single occupancy bedrooms and 60 square feet per person for double occupancy bedrooms. Bathroom areas and closets shall not be included in the determination of square footage.

(ii) Single occupancy bedrooms shall have at least 100 square feet; double occupancy bedrooms shall have at least 60 square feet per person. However, any facility licensed prior to January 1, 1992 may have bedrooms of not less than 80 square feet for one occupant until either substantial remodeling or a change of ownership occurs. Bathroom areas shall not be included in the determination of square footage.

112(3)(d) *Storage Space.* Each resident shall have storage facilities adequate for clothing and personal articles such as a closet.

112(3)(e) *Windows.* Each bedroom shall have at least one window of eight (8) square feet which shall have opening capability. Any facility licensed prior to January 1, 1992 may have a window of smaller dimensions until either a substantial remodeling or a change of ownership occurs.

112(3)(f) *Furnishings and Supplies*

(i) In facilities which provide furnishings for resident bedrooms pursuant to a resident agreement, each resident bedroom shall be equipped as follows for each resident:

(A) a comfortable, standard-sized bed equipped with a comfortable, clean mattress, mattress protector and pad, and pillow. Rollaway type beds, cots, folding beds or bunk beds shall not be permitted.

(B) a standard-sized chair in good condition.

(C) a towel rack.

1.112(4) ***Bathrooms***

112(4)(a) *Number of Bathrooms Per Resident.* There shall be at least one full bathroom for every six (6) residents. A full bathroom shall consist of at least the following fixtures: toilet, handwashing sink, toilet paper dispenser, mirror, tub or shower, and towel rack. However, any facility licensed to provide services specifically for the mentally ill prior to January 1, 1992 may have one bathroom for every eight (8) residents until either a substantial remodeling or a change of ownership occurs.

112(4)(b) *Bathroom Accessibility*

(i) General. There shall be a bathroom on each floor having resident bedrooms which is accessible without requiring access through an adjacent bedroom.

(ii) Residents using auxiliary aids. In any facility which is occupied by one or more residents utilizing an auxiliary aid, the facility shall provide at least one full bathroom as defined herein with fixtures positioned so as to be fully accessible to any resident utilizing an auxiliary aid.

112(4)(c) *Fixtures*

(i) Non-skid surfaces. Bathtubs and shower floors shall have non-skid surfaces.

(ii) Grab bars. Grab bars shall be properly installed at each tub and shower, and adjacent to each toilet in any facility which is occupied by one or more residents utilizing an auxiliary aid or as otherwise indicated by the needs of the resident population.

(iii) Toilet seats. Toilet seats shall be constructed of non-absorbent material and free of cracks.

112(4)(d) *Supplies*

(i) Individualized supplies. The use of common personal care articles, including soap and towels, is prohibited.

(ii) Toilet paper. Toilet paper in a dispenser shall be available at all times in each bathroom of the facility.

(iii) Liquid soap and paper towels. Liquid soap and paper towels shall be available at all times in the common bathrooms of the facility.

1.113 EMERGENCY EQUIPMENT

113(1) *First Aid.* First aid equipment shall be maintained on the premises in a readily available location and staff shall be instructed in its use.

113(2) *Telephone.* There shall be at least one telephone, not powered by household electrical current, in the facility which may be used by staff, residents, and visitors at all times for use in emergencies. The telephone numbers of police, fire, ambulance [9-1-1, if applicable] and poison control center telephone numbers shall be readily accessible to staff.

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES

CHAPTER 7 - ASSISTED LIVING RESIDENCES

6 CCR 1011-1 Chap 07

Adopted by the Board of Health on _____, 2018.

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SECTION 1 - STATUTORY AUTHORITY AND APPLICABILITY

1.1 AUTHORITY TO ESTABLISH MINIMUM STANDARDS THROUGH REGULATION AND TO ADMINISTER AND ENFORCE SUCH REGULATIONS IS PROVIDED BY §§ 25-1.5-103, 25-27-101, AND 25-27-104, C.R.S.

1.2 ASSISTED LIVING RESIDENCES, AS DEFINED HEREIN, SHALL COMPLY WITH ALL APPLICABLE FEDERAL AND STATE STATUTES AND REGULATIONS INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING:

(A) THIS CHAPTER 7.

(B) 6 CCR 1011-1, CHAPTER 2, PERTAINING TO GENERAL LICENSURE STANDARDS.

(C) 6 CCR 1011-1, CHAPTER 24 AND §§ 25-1.5-301 THROUGH 25-1.5-303 C.R.S, PERTAINING TO MEDICATION ADMINISTRATION.

(D) 6 CCR 1007-2, PART 1, REGULATIONS PERTAINING TO SOLID WASTE DISPOSAL SITES AND FACILITIES, SECTION 13, MEDICAL WASTE.

1.3 THIS REGULATION INCORPORATES BY REFERENCE (AS INDICATED WITHIN) MATERIAL ORIGINALLY PUBLISHED ELSEWHERE. SUCH INCORPORATION, HOWEVER, EXCLUDES LATER AMENDMENTS TO OR EDITIONS OF THE REFERENCED MATERIAL. PURSUANT TO §24-4-103 (12.5), C.R.S., THE HEALTH FACILITIES AND EMERGENCY MEDICAL SERVICES DIVISION OF THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT MAINTAINS COPIES OF THE INCORPORATED TEXTS IN THEIR ENTIRETY WHICH SHALL BE AVAILABLE FOR PUBLIC INSPECTION DURING REGULAR BUSINESS HOURS AT:

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SECTION 2 – DEFINITIONS

FOR PURPOSES OF THIS CHAPTER, THE FOLLOWING DEFINITIONS SHALL APPLY, UNLESS THE CONTEXT REQUIRES OTHERWISE:

“ABUSE” MEANS ANY OF THE FOLLOWING ACTS OR OMISSIONS:

THE NON-ACCIDENTAL INFLICTION OF BODILY INJURY, SERIOUS BODILY INJURY OR DEATH,

CONFINEMENT OR RESTRAINT THAT IS UNREASONABLE UNDER GENERALLY ACCEPTED CARETAKING STANDARDS, OR

SUBJECTION TO SEXUAL CONDUCT OR CONTACT THAT IS CLASSIFIED AS A CRIME.

"ADMINISTRATOR" MEANS A PERSON WHO IS RESPONSIBLE FOR THE OVERALL OPERATION, DAILY ADMINISTRATION, MANAGEMENT AND MAINTENANCE OF THE ASSISTED LIVING RESIDENCE. THE TERM "ADMINISTRATOR" IS SYNONYMOUS WITH "OPERATOR" AS THAT TERM IS USED IN TITLE 25, ARTICLE 27, PART 1.

"ACTIVITIES OF DAILY LIVING (ADLS)" MEANS THOSE PERSONAL FUNCTIONAL ACTIVITIES REQUIRED BY AN INDIVIDUAL FOR CONTINUED WELL-BEING, HEALTH AND SAFETY. AS USED IN THIS CHAPTER 7, ACTIVITIES OF DAILY LIVING INCLUDE, BUT ARE NOT LIMITED TO, ACCOMPANIMENT, EATING, DRESSING, GROOMING, BATHING, PERSONAL HYGIENE (HAIR CARE, NAIL CARE, MOUTH CARE, POSITIONING, SHAVING, SKIN CARE), MOBILITY (AMBULATION, POSITIONING, TRANSFER), ELIMINATION (USING THE TOILET) AND RESPIRATORY CARE.

"ALTERNATIVE CARE FACILITY" MEANS AN ASSISTED LIVING RESIDENCE CERTIFIED BY THE COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING TO RECEIVE MEDICAID REIMBURSEMENT FOR THE SERVICES PROVIDED PURSUANT TO 10 CCR 2505-10, SECTION 8.495.

"APPROPRIATELY SKILLED PROFESSIONAL" MEANS AN INDIVIDUAL THAT HAS THE NECESSARY QUALIFICATIONS AND/OR TRAINING TO PERFORM THE MEDICAL PROCEDURES PRESCRIBED BY A PRACTITIONER. THIS INCLUDES, BUT IS NOT LIMITED TO, REGISTERED NURSE, LICENSED PRACTICAL NURSE, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, RESPIRATORY THERAPIST, AND DIETITIAN.

"ASSISTED LIVING RESIDENCE" OR "ALR" MEANS:

A RESIDENTIAL FACILITY THAT MAKES AVAILABLE TO THREE OR MORE ADULTS NOT RELATED TO THE OWNER OF SUCH FACILITY, EITHER DIRECTLY OR INDIRECTLY THROUGH A RESIDENT AGREEMENT WITH THE RESIDENT, ROOM AND BOARD AND AT LEAST THE FOLLOWING SERVICES: PERSONAL SERVICES; PROTECTIVE OVERSIGHT; SOCIAL CARE DUE TO IMPAIRED CAPACITY TO LIVE INDEPENDENTLY; AND REGULAR SUPERVISION THAT SHALL BE AVAILABLE ON A TWENTY-FOUR-HOUR BASIS, BUT NOT TO THE EXTENT THAT REGULAR TWENTY-FOUR HOUR MEDICAL OR NURSING CARE IS REQUIRED, OR

A SUPPORTIVE LIVING PROGRAM RESIDENCE THAT, IN ADDITION TO THE CRITERIA SPECIFIED IN PARAGRAPH (A) ABOVE, IS CERTIFIED BY THE COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING TO ALSO PROVIDE HEALTH MAINTENANCE ACTIVITIES, BEHAVIORAL MANAGEMENT AND EDUCATION, INDEPENDENT LIVING SKILLS TRAINING AND OTHER RELATED SERVICES AS SET FORTH IN THE SUPPORTIVE LIVING PROGRAM REGULATIONS AT 10 CCR 2505-10, SECTION 8.515.

UNLESS OTHERWISE INDICATED, THE TERM "ASSISTED LIVING RESIDENCE" IS SYNONYMOUS WITH THE TERMS "HEALTH CARE ENTITY," "HEALTH FACILITY," OR "FACILITY" AS USED ELSEWHERE IN 6 CCR 1011-1, STANDARDS FOR HOSPITALS AND HEALTH FACILITIES.

"AT-RISK PERSON" MEANS ANY PERSON WHO IS 70 YEARS OF AGE OR OLDER, OR ANY PERSON WHO IS 18 YEARS OF AGE OR OLDER AND MEETS ONE OR MORE OF THE FOLLOWING CRITERIA:

IS IMPAIRED BY THE LOSS (OR PERMANENT LOSS OF USE) OF A HAND OR FOOT, BLINDNESS OR PERMANENT IMPAIRMENT OF VISION SUFFICIENT TO CONSTITUTE VIRTUAL BLINDNESS;

IS UNABLE TO WALK, SEE, HEAR OR SPEAK;

IS UNABLE TO BREATHE WITHOUT MECHANICAL ASSISTANCE;

IS A PERSON WITH AN INTELLECTUAL AND DEVELOPMENTAL DISABILITY AS DEFINED IN §25.5-10-202, C.R.S.;

IS A PERSON WITH A MENTAL HEALTH DISORDER AS DEFINED IN §27-65-102(11.5), C.R.S.;

IS MENTALLY IMPAIRED AS DEFINED IN §24-34-501(1.3)(b)(II), C.R.S.;

IS BLIND AS DEFINED IN §26-2-103(3), C.R.S.; OR

IS RECEIVING CARE AND TREATMENT FOR A DEVELOPMENTAL DISABILITY UNDER ARTICLE 10.5 OF TITLE 27, C.R.S.

"AUXILIARY AID" MEANS ANY DEVICE USED BY PERSONS TO OVERCOME A PHYSICAL DISABILITY AND INCLUDES BUT IS NOT LIMITED TO A WHEELCHAIR, WALKER OR ORTHOPEDIC APPLIANCE.

"CARE PLAN" MEANS A WRITTEN DESCRIPTION IN LAY TERMINOLOGY OF THE FUNCTIONAL CAPABILITIES OF AN INDIVIDUAL, THE INDIVIDUAL'S NEED FOR PERSONAL ASSISTANCE, SERVICE RECEIVED FROM EXTERNAL PROVIDERS, AND THE SERVICES TO BE PROVIDED BY THE FACILITY IN ORDER TO MEET THE INDIVIDUAL'S NEEDS. IN ORDER TO DELIVER PERSON-CENTERED CARE, THE CARE PLAN SHALL TAKE INTO ACCOUNT THE RESIDENT'S PREFERENCES AND DESIRED OUTCOMES. "CARE PLAN" MAY ALSO MEAN A SERVICE PLAN FOR THOSE FACILITIES WHICH ARE LICENSED TO PROVIDE SERVICES SPECIFICALLY FOR THE MENTALLY ILL.

"CARETAKER NEGLECT" MEANS NEGLECT THAT OCCURS WHEN ADEQUATE FOOD, CLOTHING, SHELTER, PSYCHOLOGICAL CARE, PHYSICAL CARE, MEDICAL CARE, HABILITATION, SUPERVISION OR ANY OTHER SERVICE NECESSARY FOR THE HEALTH OR SAFETY OF AN AT-RISK PERSON IS NOT SECURED FOR THAT PERSON OR IS NOT PROVIDED BY A CARETAKER IN A TIMELY MANNER AND WITH THE DEGREE OF CARE THAT A REASONABLE PERSON IN THE SAME SITUATION WOULD EXERCISE, OR A CARETAKER KNOWINGLY USES HARASSMENT, UNDUE INFLUENCE OR INTIMIDATION TO CREATE A HOSTILE OR FEARFUL ENVIRONMENT FOR AN AT-RISK PERSON.

"CERTIFIED NURSE MEDICATION AIDE (CNA-MED)**"** MEANS A CERTIFIED NURSE AIDE WHO MEETS THE QUALIFICATIONS SPECIFIED IN 3 CCR 716-1, CHAPTER 19 AND WHO IS CURRENTLY CERTIFIED AS A NURSE AIDE WITH MEDICATION AIDE AUTHORITY BY THE STATE BOARD OF NURSING.

"CONTROLLED SUBSTANCE" MEANS ANY MEDICATION THAT IS REGULATED AND CLASSIFIED BY THE CONTROLLED SUBSTANCES ACT AT 21 U.S.C., §812 AS BEING SCHEDULE II THROUGH V.

"DEFICIENCY" MEANS A FAILURE TO FULLY COMPLY WITH ANY STATUTORY AND/OR REGULATORY REQUIREMENTS APPLICABLE TO A LICENSED ASSISTED LIVING RESIDENCE.

"DEFICIENCY LIST" MEANS A LISTING OF DEFICIENCY CITATIONS WHICH CONTAINS A STATEMENT OF THE STATUTE OR REGULATION VIOLATED; AND A STATEMENT OF THE FINDINGS, WITH EVIDENCE TO SUPPORT THE DEFICIENCY.

"DEPARTMENT" MEANS THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT OR ITS DESIGNEE.

"DISPROPORTIONATE SHARE FACILITIES" MEANS FACILITIES THAT SERVE A DISPROPORTIONATE SHARE OF LOW INCOME RESIDENTS AS EVIDENCED BY HAVING QUALIFIED FOR FEDERAL OR STATE LOW INCOME HOUSING ASSISTANCE; PLANNING TO SERVE LOW INCOME RESIDENTS WITH INCOMES AT OR BELOW 80 PERCENT OF THE AREA MEDIAN INCOME; AND SUBMITTING EVIDENCE OF SUCH QUALIFICATION, AS REQUIRED BY THE DEPARTMENT.

"DISCHARGE" MEANS TERMINATION OF THE RESIDENT AGREEMENT AND THE RESIDENT'S PERMANENT DEPARTURE FROM THE FACILITY.

"EGRESS ALERT DEVICE" MEANS A DEVICE THAT IS AFFIXED TO A STRUCTURE OR WORN BY A RESIDENT THAT TRIGGERS A VISUAL OR AUDITORY ALARM WHEN A RESIDENT LEAVES THE BUILDING OR GROUNDS. SUCH DEVICES SHALL ONLY BE USED TO ASSIST STAFF IN REDIRECTING RESIDENTS BACK INTO THE FACILITY WHEN STAFF ARE ALERTED TO A RESIDENT'S DEPARTURE FROM THE FACILITY AS OPPOSED TO RESTRICTING THE FREE MOVEMENT OF RESIDENTS.

"EMERGENCY CONTACT" MEANS ONE OF THE INDIVIDUALS IDENTIFIED ON THE FACE SHEET OF THE RESIDENT RECORD TO BE CONTACTED IN THE CASE OF AN EMERGENCY.

"EXPLOITATION" MEANS AN ACT OR OMISSION COMMITTED BY A PERSON WHO:

USES DECEPTION, HARASSMENT, INTIMIDATION OR UNDUE INFLUENCE TO PERMANENTLY OR TEMPORARILY DEPRIVE AN AT-RISK PERSON OF THE USE, BENEFIT OR POSSESSION OF ANYTHING OF VALUE;

EMPLOYS THE SERVICES OF A THIRD PARTY FOR THE PROFIT OR ADVANTAGE OF THE PERSON OR ANOTHER PERSON TO THE DETRIMENT OF THE AT-RISK PERSON;

FORCES, COMPELS, COERCES OR ENTICES AN AT-RISK PERSON TO PERFORM SERVICES FOR THE PROFIT OR ADVANTAGE OF THE PERSON OR ANOTHER PERSON AGAINST THE WILL OF THE AT-RISK PERSON; OR

MISUSES THE PROPERTY OF AN AT-RISK PERSON IN A MANNER THAT ADVERSELY AFFECTS THE AT-RISK PERSON'S ABILITY TO RECEIVE HEALTH CARE, HEALTH CARE BENEFITS, OR TO PAY BILLS FOR BASIC NEEDS OR OBLIGATIONS.

"EXTERNAL SERVICES" MEANS PERSONAL SERVICES AND PROTECTIVE OVERSIGHT SERVICES PROVIDED TO A RESIDENT BY FAMILY MEMBERS OR HEALTHCARE PROFESSIONALS WHO ARE NOT EMPLOYEES, CONTRACTORS, OR VOLUNTEERS OF THE FACILITY. EXTERNAL SERVICE PROVIDERS INCLUDE, BUT ARE NOT LIMITED TO, HOME HEALTH, HOSPICE, PRIVATE PAY CAREGIVERS AND FAMILY MEMBERS.

"HIGH MEDICAID UTILIZATION FACILITY" MEANS A FACILITY THAT HAS NO LESS THAN 35 PERCENT OF ITS LICENSED BEDS OCCUPIED BY MEDICAID ENROLLEES AS INDICATED BY COMPLETE AND ACCURATE FISCAL YEAR CLAIMS DATA; AND SERVED MEDICAID CLIENTS AND SUBMITTED CLAIMS DATA FOR A MINIMUM OF NINE (9) MONTHS OF THE RELEVANT FISCAL YEAR.

"HOSPICE CARE" MEANS A COMPREHENSIVE SET OF SERVICES IDENTIFIED AND COORDINATED BY AN EXTERNAL SERVICE PROVIDER IN COLLABORATION WITH THE RESIDENT, FAMILY AND ASSISTED LIVING RESIDENCE TO PROVIDE FOR THE PHYSICAL, PSYCHOSOCIAL, SPIRITUAL AND EMOTIONAL NEEDS OF A TERMINALLY ILL RESIDENT AS DELINEATED IN A CARE PLAN. HOSPICE CARE SERVICES SHALL BE AVAILABLE 24 HOURS A DAY, SEVEN DAYS A WEEK PURSUANT TO THE REQUIREMENTS FOR HOSPICE PROVIDERS SET FORTH IN 6 CCR 1011-1, CHAPTER 21, HOSPICES.

"LICENSEE" MEANS THE PERSON OR ENTITY TO WHOM A LICENSE IS ISSUED BY THE DEPARTMENT PURSUANT TO §25-1.5-103 (1) (A), C.R.S., TO OPERATE AN ASSISTED LIVING RESIDENCE WITHIN THE DEFINITION HEREIN PROVIDED. FOR THE PURPOSES OF THIS CHAPTER 7, THE TERM "LICENSEE" IS SYNONYMOUS WITH THE TERM "OWNER."

"MEDICAL WASTE" MEANS WASTE THAT MAY CONTAIN DISEASE CAUSING ORGANISMS OR CHEMICAL THAT PRESENT POTENTIAL HEALTH HAZARDS SUCH AS DISCARDED SURGICAL GLOVES, SHARPS, BLOOD, HUMAN TISSUE, PHARMACEUTICAL WASTE AND LABORATORY WASTE.

"MEDICATION ADMINISTRATION" MEANS ASSISTING A PERSON IN THE INGESTION, APPLICATION, INHALATION, OR, USING UNIVERSAL PRECAUTIONS, RECTAL OR VAGINAL INSERTION OF MEDICATION, INCLUDING PRESCRIPTION DRUGS, ACCORDING TO THE LEGIBLY WRITTEN OR PRINTED DIRECTIONS OF THE ATTENDING PHYSICIAN OR OTHER AUTHORIZED PRACTITIONER OR AS WRITTEN ON THE PRESCRIPTION LABEL AND MAKING A WRITTEN RECORD THEREOF WITH REGARD TO EACH MEDICATION ADMINISTERED, INCLUDING THE TIME AND THE AMOUNT TAKEN.

"MEDICATION ADMINISTRATION" BY A QUALIFIED MEDICATION ADMINISTRATION PERSON DOES NOT INCLUDE JUDGMENT, EVALUATION, OR ASSESSMENTS OR THE INJECTIONS OF MEDICATION (UNLESS OTHERWISE AUTHORIZED BY LAW IN RESPONSE TO AN EMERGENT SITUATION), THE MONITORING OF MEDICATION, OR THE SELF-ADMINISTRATION OF MEDICATION, INCLUDING PRESCRIPTION DRUGS AND INCLUDING THE SELF-INJECTION OF MEDICATION BY THE RESIDENT.

"MEDICATION MONITORING" MEANS:

(A) REMINDING THE RESIDENT TO TAKE MEDICATION(S) AT THE TIME ORDERED BY THE AUTHORIZED PRACTITIONER;

(B) HANDING TO A RESIDENT A CONTAINER OR PACKAGE OF MEDICATION THAT WAS LAWFULLY LABELED PREVIOUSLY BY AN AUTHORIZED PRACTITIONER FOR THE INDIVIDUAL RESIDENT;

(C) VISUAL OBSERVATION OF THE RESIDENT TO ENSURE COMPLIANCE;

(D) MAKING A WRITTEN RECORD OF THE RESIDENT'S COMPLIANCE WITH REGARD TO EACH MEDICATION, INCLUDING THE TIME TAKEN; AND

(E) NOTIFYING THE AUTHORIZED PRACTITIONER IF THE RESIDENT REFUSES OR IS UNABLE TO COMPLY WITH THE PRACTITIONER'S INSTRUCTIONS REGARDING THE MEDICATION.

"MISTREATMENT" MEANS ABUSE, CARETAKER NEGLECT OR EXPLOITATION.

"NURSE" MEANS AN INDIVIDUAL WHO HOLDS A CURRENT UNRESTRICTED LICENSE TO PRACTICE PURSUANT TO ARTICLE 38 OF TITLE 12, C.R.S., AND IS ACTING WITHIN THE SCOPE OF SUCH AUTHORITY.

"NURSING SERVICES" MEANS SUPPORT FOR ACTIVITIES OF DAILY LIVING, THE ADMINISTRATION OF MEDICATIONS AND THE PROVISION OF TREATMENT BY A NURSE IN ACCORDANCE WITH ORDERS FROM THE RESIDENT'S PRACTITIONER.

"OWNER" MEANS THE PERSON OR BUSINESS ENTITY THAT APPLIES FOR ASSISTED LIVING RESIDENCE LICENSURE AND/OR IN WHOSE NAME THE LICENSE IS ISSUED.

"PALLIATIVE CARE" MEANS SPECIALIZED MEDICAL CARE FOR PEOPLE WITH SERIOUS ILLNESSES. THIS TYPE OF CARE IS FOCUSED ON PROVIDING RESIDENTS WITH RELIEF FROM THE SYMPTOMS, PAIN AND STRESS OF SERIOUS ILLNESS, WHATEVER THE DIAGNOSIS. THE GOAL IS TO IMPROVE QUALITY OF LIFE FOR BOTH THE RESIDENT AND THE FAMILY. PALLIATIVE CARE IS PROVIDED BY A TEAM OF PHYSICIANS, NURSES AND OTHER SPECIALISTS WHO WORK WITH A RESIDENT'S OTHER HEALTH CARE PROVIDERS TO PROVIDE AN EXTRA LAYER OF SUPPORT. PALLIATIVE CARE IS APPROPRIATE AT ANY AGE AND AT ANY STAGE IN A SERIOUS ILLNESS AND CAN BE PROVIDED TOGETHER WITH CURATIVE TREATMENT. UNLESS OTHERWISE INDICATED, THE TERM "PALLIATIVE CARE" IS SYNONYMOUS WITH THE TERMS "COMFORT CARE," "SUPPORTIVE CARE," AND SIMILAR DESIGNATIONS.

"PERSONAL CARE WORKER" MEANS AN INDIVIDUAL WHO:

PROVIDES PERSONAL SERVICES FOR ANY RESIDENT, AND

IS NOT ACTING IN HIS OR HER CAPACITY AS A HEALTH CARE PROFESSIONAL UNDER ARTICLES 36, 38, 40.5 OR 41 OF TITLE 12 OF THE COLORADO REVISED STATUTES.

"PERSONAL SERVICES" MEANS THOSE SERVICES THAT AN ASSISTED LIVING RESIDENCE AND ITS STAFF PROVIDE FOR EACH RESIDENT INCLUDING, BUT NOT LIMITED TO:

AN ENVIRONMENT THAT IS SANITARY AND SAFE FROM PHYSICAL HARM,

INDIVIDUALIZED SOCIAL SUPERVISION,

ASSISTANCE WITH TRANSPORTATION, AND

ASSISTANCE WITH ACTIVITIES OF DAILY LIVING.

"PLAN OF CORRECTION" MEANS A WRITTEN PLAN TO BE SUBMITTED BY FACILITIES TO THE DEPARTMENT FOR APPROVAL, DETAILING THE MEASURES THAT SHALL BE TAKEN TO CORRECT ALL CITED DEFICIENCIES.

"PRACTITIONER" MEANS A PHYSICIAN, PHYSICIAN ASSISTANT OR ADVANCE PRACTICE NURSE (I.E., NURSE PRACTITIONER OR CLINICAL NURSE SPECIALIST) WHO HAS A CURRENT, UNRESTRICTED LICENSE TO PRACTICE AND IS ACTING WITHIN THE SCOPE OF SUCH AUTHORITY.

"PRESSURE SORE" (ALSO CALLED PRESSURE ULCER, DECUBITUS ULCER, BED-SORE OR SKIN BREAKDOWN) MEANS AN AREA OF THE SKIN OR UNDERLYING TISSUE (MUSCLE, BONE) THAT IS DAMAGED DUE TO LOSS OF BLOOD FLOW TO THE AREA. SYMPTOMS AND MEDICAL TREATMENT OF PRESSURE SORES ARE BASED UPON THE LEVEL OF SEVERITY OR "STAGE" OF THE PRESSURE SORE.

STAGE 1 AFFECTS ONLY THE UPPER LAYER OF SKIN. SYMPTOMS INCLUDE PAIN, BURNING OR ITCHING AND THE AFFECTED AREA MAY LOOK OR FEEL DIFFERENT FROM THE SURROUNDING SKIN.

STAGE 2 GOES BELOW THE UPPER SURFACE OF THE SKIN. SYMPTOMS INCLUDE PAIN, BROKEN SKIN OR OPEN WOUND THAT IS SWOLLEN, WARM AND/OR RED AND MAY BE OOZING FLUID OR PUS.

STAGE 3 INVOLVES A SORE THAT LOOKS LIKE A CRATER AND MAY HAVE A BAD ODOR. IT MAY SHOW SIGNS OF INFECTION SUCH AS RED EDGES, PUS, ODOR, HEAT AND/OR DRAINAGE.

STAGE 4 IS A DEEP, LARGE SORE. THE SKIN MAY HAVE TURNED BLACK AND SHOW SIGNS OF INFECTION SUCH AS RED EDGES, PUS, ODOR, HEAT AND/OR DRAINAGE. TENDONS, MUSCLES AND BONE MAY BE VISIBLE.

"PROTECTIVE OVERSIGHT" MEANS GUIDANCE OF A RESIDENT AS REQUIRED BY THE NEEDS OF THE RESIDENT OR AS REASONABLY REQUESTED BY THE RESIDENT, INCLUDING THE FOLLOWING:

BEING AWARE OF A RESIDENT'S GENERAL WHEREABOUTS, ALTHOUGH THE RESIDENT MAY TRAVEL INDEPENDENTLY IN THE COMMUNITY; AND

MONITORING THE ACTIVITIES OF THE RESIDENT WHILE ON THE PREMISES TO ENSURE THE RESIDENT'S HEALTH, SAFETY AND WELL-BEING, INCLUDING MONITORING THE RESIDENT'S NEEDS AND ENSURING THAT THE RESIDENT RECEIVES THE SERVICES AND CARE NECESSARY TO PROTECT THE RESIDENT'S HEALTH, SAFETY AND WELL-BEING.

"QUALIFIED MEDICATION ADMINISTRATION PERSON" OR "QMAP" MEANS AN INDIVIDUAL WHO PASSED A COMPETENCY EVALUATION ADMINISTERED BY THE DEPARTMENT BEFORE JULY 1, 2017 OR PASSED A COMPETENCY EVALUATION ADMINISTERED BY AN APPROVED TRAINING ENTITY ON OR AFTER JULY 1, 2017 AND WHOSE NAME APPEARS ON THE DEPARTMENT'S LIST OF PERSONS WHO HAVE PASSED THE REQUISITE COMPETENCY EVALUATION.

"RENOVATION" MEANS ANY CHANGE, ADDITION OR MODIFICATION TO THE EXISTING PHYSICAL PLANT WHICH REQUIRES AN INCREASE IN CAPACITY TO STRUCTURAL, MECHANICAL, OR ELECTRICAL SYSTEMS; THAT ADDS SQUARE FOOTAGE; OR THAT ADDS, REMOVES OR RELOCATES WALLS, WINDOWS OR DOORS.

"RESIDENT'S LEGAL REPRESENTATIVE" MEANS ONE OF THE FOLLOWING:

THE LEGAL GUARDIAN OF THE RESIDENT, WHERE PROOF IS OFFERED THAT SUCH GUARDIAN HAS BEEN DULY APPOINTED BY A COURT OF LAW, ACTING WITHIN THE SCOPE OF SUCH GUARDIANSHIP;

AN INDIVIDUAL NAMED AS THE AGENT IN A POWER OF ATTORNEY (POA) THAT AUTHORIZES THE INDIVIDUAL TO ACT ON THE RESIDENT'S BEHALF, AS ENUMERATED IN THE POA;

AN INDIVIDUAL SELECTED AS A PROXY DECISION-MAKER PURSUANT TO §15-18.5-101, C.R.S., ET SEQ., TO MAKE MEDICAL TREATMENT DECISIONS. FOR THE PURPOSES OF THIS REGULATION, THE PROXY DECISION-MAKER SERVES AS THE RESIDENT'S LEGAL REPRESENTATIVE FOR THE PURPOSES OF MEDICAL TREATMENT DECISIONS ONLY; OR

A CONSERVATOR, WHERE PROOF IS OFFERED THAT SUCH CONSERVATOR HAS BEEN DULY APPOINTED BY A COURT OF LAW, ACTING WITHIN THE SCOPE OF SUCH CONSERVATORSHIP.

"RESTRAINT" MEANS ANY METHOD OR DEVICE USED TO INVOLUNTARILY LIMIT FREEDOM OF MOVEMENT INCLUDING, BUT NOT LIMITED TO, BODILY PHYSICAL FORCE, MECHANICAL DEVICES, CHEMICALS OR CONFINEMENT.

"SECURE-ENVIRONMENT" MEANS ANY GROUNDS, BUILDING OR PART THEREOF, METHOD OR DEVICE THAT PROHIBITS FREE EGRESS OF RESIDENTS. AN ENVIRONMENT IS SECURE WHEN THE RIGHT OF ANY RESIDENT THEREOF TO MOVE OUTSIDE THE ENVIRONMENT DURING ANY HOURS IS LIMITED.

"SELF-ADMINISTRATION" MEANS THE ABILITY OF A RESIDENT TO TAKE MEDICATION INDEPENDENTLY WITHOUT ANY ASSISTANCE FROM ANOTHER PERSON.

"STAFF" MEANS EMPLOYEES AND CONTRACTED INDIVIDUALS INTENDED TO SUBSTITUTE FOR OR SUPPLEMENT EMPLOYEES WHO PROVIDE RESIDENT CARE SERVICES. "STAFF" DOES NOT INCLUDE INDIVIDUALS PROVIDING EXTERNAL SERVICES, AS DEFINED HEREIN.
"THERAPEUTIC DIET" MEANS A DIET ORDERED BY A PRACTITIONER AS PART OF A TREATMENT OF DISEASE OR CLINICAL CONDITION, OR TO ELIMINATE, DECREASE, OR INCREASE SPECIFIC NUTRIENTS IN THE DIET. EXAMPLES INCLUDE, BUT ARE NOT LIMITED TO, A CALORIE COUNTED DIET; A SPECIFIC SODIUM GRAM DIET; AND A CARDIAC DIET.

"TRANSFER" MEANS BEING ABLE TO MOVE FROM ONE BODY POSITION TO ANOTHER. THIS INCLUDES, BUT IS NOT LIMITED TO, MOVING FROM A BED TO A CHAIR OR STANDING UP FROM A CHAIR TO GRASP AN AUXILIARY AID.

SECTION 3 – DEPARTMENT OVERSIGHT

LICENSURE

3.1 APPLICANTS FOR AN INITIAL OR RENEWAL LICENSE SHALL FOLLOW THE LICENSURE PROCEDURES OUTLINED IN 6 CCR 1011-1, CHAPTER 2, PARTS 2.3 THROUGH 2.10.

(A) IN ADDITION, EACH LICENSE RENEWAL APPLICANT SHALL ANNUALLY SUBMIT, IN THE FORM AND MANNER PRESCRIBED BY THE DEPARTMENT, INFORMATION ABOUT THE FACILITY'S OPERATIONS, RESIDENT CARE AND SERVICES.

3.2 THE DEPARTMENT MAY ISSUE A PROVISIONAL LICENSE TO AN APPLICANT FOR THE PURPOSE OF OPERATING AN ASSISTED LIVING RESIDENCE FOR ONE PERIOD OF 90 DAYS IF THE APPLICANT IS TEMPORARILY UNABLE TO CONFORM TO ALL THE MINIMUM STANDARDS REQUIRED UNDER THESE REGULATIONS, EXCEPT NO LICENSE SHALL BE ISSUED TO AN APPLICANT IF THE OPERATION OF THE APPLICANT'S FACILITY WILL ADVERSELY AFFECT THE HEALTH, SAFETY, AND WELFARE OF THE RESIDENTS OF SUCH FACILITY.

(A) AS A CONDITION OF OBTAINING A PROVISIONAL LICENSE, THE APPLICANT SHALL PROVIDE THE DEPARTMENT WITH PROOF THAT IT IS ATTEMPTING TO CONFORM AND COMPLY WITH APPLICABLE STANDARDS. NO PROVISIONAL LICENSE SHALL BE GRANTED PRIOR TO THE SUBMISSION OF A CRIMINAL BACKGROUND CHECK IN ACCORDANCE WITH § 25-27-105 (2.5), C.R.S.

3.3 EACH OWNER OR APPLICANT SHALL REQUEST A BACKGROUND CHECK.

(A) IF AN OWNER OR APPLICANT FOR AN INITIAL ASSISTED LIVING RESIDENCE LICENSE HAS LIVED IN COLORADO FOR MORE THAN THREE YEARS AT THE TIME OF THE INITIAL APPLICATION, SAID INDIVIDUAL SHALL REQUEST FROM THE COLORADO BUREAU OF INVESTIGATION (CBI) A STATE FINGERPRINT-BASED CRIMINAL HISTORY RECORD CHECK WITH NOTIFICATION OF FUTURE ARRESTS.

(B) IF AN OWNER OR APPLICANT FOR AN INITIAL ASSISTED LIVING RESIDENCE LICENSE HAS LIVED IN COLORADO FOR THREE YEARS OR LESS AT THE TIME OF THE INITIAL APPLICATION, SAID INDIVIDUAL SHALL REQUEST A FINGERPRINT-BASED CRIMINAL HISTORY RECORD CHECK GENERATED BY THE FEDERAL BUREAU OF INVESTIGATIONS THROUGH THE CBI.

(C) THE COST OF OBTAINING SUCH INFORMATION SHALL BE BORNE BY THE INDIVIDUAL OR INDIVIDUALS WHO ARE THE SUBJECT OF SUCH CHECK. THE INFORMATION SHALL BE FORWARDED BY THE CBI DIRECTLY TO THE DEPARTMENT.

3.4 NO LICENSE SHALL BE ISSUED OR RENEWED BY THE DEPARTMENT IF AN OWNER, APPLICANT AND/ OR LICENSEE OF THE ASSISTED LIVING RESIDENCE HAS BEEN CONVICTED OF A FELONY OR OF A MISDEMEANOR, WHICH FELONY OR MISDEMEANOR INVOLVES MORAL TURPITUDE OR INVOLVES CONDUCT THAT THE DEPARTMENT DETERMINES COULD POSE A RISK TO THE HEALTH, SAFETY, OR WELFARE OF RESIDENTS OF THE ASSISTED LIVING RESIDENCE.

3.5 AN ASSISTED LIVING RESIDENCE SHALL NOT CARE FOR MORE RESIDENTS THAN THE NUMBER OF BEDS FOR WHICH IT IS CURRENTLY LICENSED.

LICENSE FEES

UNLESS OTHERWISE SPECIFIED, ALL LICENSE FEES PAID TO THE DEPARTMENT SHALL BE NON-REFUNDABLE.

3.6 INITIAL LICENSES

FOR INITIAL LICENSE APPLICATIONS SUBMITTED ON OR AFTER JULY 1, 2018, THE APPLICABLE FEE, AS SET FORTH BELOW, SHALL ACCOMPANY THE LICENSE APPLICATION.

3 TO 8 LICENSED BEDS: $6,300.

9 TO 19 LICENSED BEDS: $7,300.

20 TO 49 LICENSED BEDS: $8,750.

50 TO 99 LICENSED BEDS: $11,550

100 OR MORE LICENSED BEDS: $14,750

QUALIFYING DISPROPORTIONATE SHARE FACILITY: $3,000

3.7 RENEWAL FEES

(A) FOR LICENSES THAT EXPIRE BEFORE JULY 1, 2018, THE APPLICABLE FEE AS SET FORTH BELOW, SHALL ACCOMPANY THE RENEWAL APPLICATION:

$180 PER FACILITY PLUS $47 PER BED.

$180 PER FACILITY PLUS $19 PER BED FOR A HIGH MEDICAID UTILIZATION FACILITY.

(B) FOR LICENSES THAT EXPIRE ON OR AFTER JULY 1, 2018, THE APPLICABLE FEE(S), AS SET FORTH BELOW, SHALL ACCOMPANY THE RENEWAL APPLICATION:

$360 PER FACILITY PLUS $67 PER BED.

$360 PER FACILITY PLUS $23 PER BED FOR A HIGH MEDICAID UTILIZATION FACILITY.

$350 PER SECURE ENVIRONMENT THAT IS SEPARATE AND DISTINCT FROM A NON-SECURE ENVIRONMENT.

(C) FOR LICENSES THAT EXPIRE ON OR AFTER JULY 1, 2019, THE APPLICABLE FEE(S), AS SET FORTH BELOW, SHALL ACCOMPANY THE RENEWAL APPLICATION:

$360 PER FACILITY PLUS $103 PER BED.

$360 PER FACILITY PLUS $38 PER BED FOR A HIGH MEDICAID UTILIZATION FACILITY.

$350 PER SECURE ENVIRONMENT THAT IS SEPARATE AND DISTINCT FROM A NON-SECURE ENVIRONMENT.

3.8 PROVISIONAL LICENSURE. ANY FACILITY APPROVED BY THE DEPARTMENT FOR A PROVISIONAL LICENSE, SHALL SUBMIT A FEE OF $1,000 FOR THE PROVISIONAL LICENSURE PERIOD.

3.9 CHANGE OF OWNERSHIP

(A) THE APPLICABLE FEE, AS SET FORTH BELOW, SHALL ACCOMPANY A FACILITY'S APPLICATION FOR CHANGE OF OWNERSHIP.

THREE TO 19 LICENSED BEDS: $6,250.

20 TO 49 LICENSED BEDS: $7,800.

50 TO 99 LICENSED BEDS: $10,600

100 LICENSED BEDS AND MORE: $13,700

(B) IF THE SAME PURCHASER BUYS MORE THAN ONE FACILITY FROM THE SAME SELLER IN A SINGLE BUSINESS TRANSACTION, THE CHANGE OF OWNERSHIP FEE SHALL BE THE FEE NOTED ABOVE FOR THE LARGEST FACILITY AND $4,500 FOR EACH ADDITIONAL FACILITY INCLUDED IN THE TRANSACTION. THE APPROPRIATE FEE TOTAL SHALL BE SUBMITTED WITH THE APPLICATION.

3.10 OTHER LICENSE FEES

(A) A FACILITY APPLYING FOR A CHANGE OF MAILING ADDRESS, SHALL SUBMIT A FEE OF $75 WITH THE APPLICATION. FOR PURPOSES OF THIS SUBSECTION, A CORPORATE CHANGE OF ADDRESS FOR MULTIPLE FACILITIES SHALL BE CONSIDERED ONE CHANGE OF ADDRESS.

(B) A FACILITY APPLYING FOR A CHANGE OF NAME SHALL SUBMIT A FEE OF $75 WITH THE APPLICATION.

(C) A FACILITY APPLYING FOR AN INCREASED NUMBER OF LICENSED BEDS SHALL SUBMIT A FEE OF $500 WITH THE APPLICATION.

(D) A FACILITY APPLYING FOR A CHANGE OF ADMINISTRATOR SHALL SUBMIT A FEE OF $500 WITH THE APPLICATION.

(E) A FACILITY SEEKING TO OPEN A NEW SECURE ENVIRONMENT SHALL SUBMIT A FEE OF $1,600 WITH THE FIRST SUBMISSION OF THE APPLICABLE BUILDING PLANS.

CITING DEFICIENCIES

3.11 THE LEVEL OF THE DEFICIENCY SHALL BE BASED UPON THE NUMBER OF SAMPLE RESIDENTS AFFECTED AND THE LEVEL OF HARM, AS FOLLOWS:

LEVEL A – ISOLATED POTENTIAL FOR HARM FOR ONE OR MORE RESIDENTS.

LEVEL B – A PATTERN OF POTENTIAL FOR HARM FOR ONE OR MORE RESIDENTS.

LEVEL C – ISOLATED ACTUAL HARM AFFECTING ONE OR MORE RESIDENTS.

LEVEL D – A PATTERN OF ACTUAL HARM AFFECTING ONE OR MORE RESIDENTS.

LEVEL E (IMMEDIATE JEOPARDY) – ACTUAL OR POTENTIAL FOR SERIOUS INJURY OR HARM FOR ONE OR MORE RESIDENTS.

3.12 When a Level E deficiency is cited, the assisted living residence shall immediately remove the cause of the immediate jeopardy risk and provide the Department with written evidence that the risk has been removed.

Plans of Correction

3.13 Pursuant to §25-27-105 (2), C.R.S., an assisted living residence shall submit a written plan detailing the measures that will be taken to correct any deficiencies.

(A) Plans of correction shall be in the format prescribed by the Department and conform with the requirements set forth in 6 CCR 1011-1, Chapter 2, Part 2.11.4,

(B) The Department has the discretion to approve, impose, modify or reject a plan of correction as set forth in 6 CCR 1011-1, Chapter 2, Part 2.11.4.

Intermediate Restrictions or Conditions

3.14 Section 25-27-106, C.R.S., allows the Department to impose intermediate restrictions or conditions on a licensee that may include at least one of the following:

(A) Retaining a consultant to address corrective measures including deficient practice resulting from systemic failure;

(B) Monitoring by the Department for a specific period;

(C) Providing additional training to employees, owners, or operators of the residence;

(D) Complying with a directed written plan, to correct the violation; or

(E) Paying a civil fine not to exceed two thousand dollars ($2,000) in a calendar year.

3.15 Intermediate restrictions or conditions may be imposed for Level A, B and C deficiencies when the Department finds the assisted living residence has violated statutory or regulatory requirements. The factors that may be considered include, but are not limited to, the following:

(A) The level of actual or potential harm to a resident(s),

(B) The number of residents affected,

(C) Whether the conduct leading to the imposition of the restriction are isolated or a pattern, and

(D) The licensee's prior history of noncompliance in general, and specifically with reference to the cited deficiencies.

3.16 For all cases where the deficiency list includes Levels D or E deficiencies, the assisted living residence shall comply with at least one intermediate restriction or condition. In addition, for all level E deficiencies, the assisted living residence shall:

(A) Pay a civil fine of $500, not to exceed $2,000 in a calendar year,

(B) Immediately correct the circumstances that gave rise to the IMMEDIATE JEOPARDY situation, and

(C) COMPLY WITH ANY OTHER RESTRICTIONS OR CONDITIONS REQUIRED BY THE DEPARTMENT.

APPEALING THE IMPOSITION OF INTERMEDIATE RESTRICTIONS/CONDITIONS

3.17 A LICENSEE MAY APPEAL THE IMPOSITION OF AN INTERMEDIATE RESTRICTION OR CONDITION PURSUANT TO PROCEDURES ESTABLISHED BY THE DEPARTMENT AND AS PROVIDED BY §25-27-106, C.R.S.

(A) INFORMAL REVIEW

INFORMAL REVIEW IS AN ADMINISTRATIVE REVIEW PROCESS CONDUCTED BY THE DEPARTMENT THAT DOES NOT INCLUDE AN EVIDENTIARY HEARING.

(1) A LICENSEE MAY SUBMIT A WRITTEN REQUEST FOR INFORMAL REVIEW OF THE IMPOSITION OF AN INTERMEDIATE RESTRICTION NO LATER THAN TEN (10) BUSINESS DAYS AFTER THE DATE NOTICE IS RECEIVED FROM THE DEPARTMENT OF THE RESTRICTION OR CONDITION. IF AN EXTENSION OF TIME IS NEEDED, THE ASSISTED LIVING RESIDENCE SHALL REQUEST AN EXTENSION IN WRITING FROM THE DEPARTMENT PRIOR TO THE SUBMITTAL DUE DATE. AN EXTENSION OF TIME MAY BE GRANTED BY THE DEPARTMENT NOT TO EXCEED SEVEN CALENDAR DAYS. INFORMAL REVIEW MAY BE CONDUCTED AFTER THE PLAN OF CORRECTION HAS BEEN APPROVED.

(2) FOR CIVIL FINES, THE LICENSEE MAY REQUEST IN WRITING THAT THE INFORMAL REVIEW BE CONDUCTED IN PERSON, WHICH WOULD ALLOW THE LICENSEE TO ORALLY ADDRESS THE INFORMAL REVIEWER(S).

(B) FORMAL REVIEW

A LICENSEE MAY APPEAL THE IMPOSITION OF AN INTERMEDIATE RESTRICTION OR CONDITION IN ACCORDANCE WITH THE ADMINISTRATIVE PROCEDURES ACT (APA) AT §24-4-105, C.R.S. A LICENSEE IS NOT REQUIRED TO SUBMIT TO THE DEPARTMENT'S INFORMAL REVIEW BEFORE PURSUING FORMAL REVIEW UNDER THE APA.

(1) FOR LIFE-THREATENING SITUATIONS, THE LICENSEE SHALL IMPLEMENT THE RESTRICTION OR CONDITION IMMEDIATELY UPON RECEIVING NOTICE OF THE RESTRICTION OR CONDITION.

(2) FOR SITUATIONS THAT ARE NOT LIFE-THREATENING, THE RESTRICTION OR CONDITION SHALL BE IMPLEMENTED IN ACCORDANCE WITH THE TYPE OF CONDITION AS SET FORTH BELOW:

(A) FOR RESTRICTION/CONDITIONS OTHER THAN FINES, IMMEDIATELY UPON THE EXPIRATION OF THE OPPORTUNITY FOR APPEAL OR FROM THE DATE THAT THE DEPARTMENT'S DECISION IS UPHELD AFTER ALL ADMINISTRATIVE APPEALS HAVE BEEN EXHAUSTED.

(B) FOR FINES, WITHIN 30 CALENDAR DAYS FROM THE DATE THE DEPARTMENT'S DECISION IS UPHELD AFTER ALL ADMINISTRATIVE APPEALS HAVE BEEN EXHAUSTED.

SUPPORTED LIVING PROGRAM OVERSIGHT

3.18. AN ASSISTED LIVING RESIDENCE THAT IS CERTIFIED TO PARTICIPATE IN THE SUPPORTED LIVING PROGRAM ADMINISTERED BY THE DEPARTMENT OF HEALTHCARE POLICY AND FINANCING SHALL COMPLY WITH BOTH HCPF'S REGULATIONS CONCERNING THAT PROGRAM AND THE APPLICABLE PORTIONS OF THIS CHAPTER. THE DEPARTMENT SHALL COORDINATE WITH HCPF IN REGULATORY INTERPRETATION OF BOTH LICENSE AND CERTIFICATION REQUIREMENTS TO ENSURE THAT THE INTENT OF SIMILAR REGULATIONS IS CONGRUENTLY MET.

SECTION 4 – LICENSEE RESPONSIBILITIES

4.1 THE LICENSEE SHALL ASSUME RESPONSIBILITY FOR ALL SERVICES PROVIDED BY THE ASSISTED LIVING RESIDENCE.

4.2 THE LICENSEE SHALL ENSURE THE PROVISION OF FACILITIES, PERSONNEL AND SERVICES NECESSARY FOR THE WELFARE AND SAFETY OF RESIDENTS.

4.3 THE LICENSEE SHALL ENSURE THAT ALL MARKETING, ADVERTISING AND PROMOTIONAL INFORMATION PUBLISHED OR OTHERWISE DISTRIBUTED BY THE ASSISTED LIVING RESIDENCE ACCURATELY REPRESENTS THE ALR AND THE CARE, TREATMENT AND SERVICES THAT IT PROVIDES.

4.4 THE LICENSEE SHALL ESTABLISH, AND ENSURE THE MAINTENANCE OF, A SYSTEM OF FINANCIAL MANAGEMENT AND ACCOUNTABILITY FOR THE ASSISTED LIVING RESIDENCE.

4.5 THE LICENSEE SHALL APPOINT AN ADMINISTRATOR WHO MEETS THE MINIMUM QUALIFICATIONS SET FORTH IN THIS REGULATION AND DELEGATE TO THAT INDIVIDUAL THE EXECUTIVE AUTHORITY AND RESPONSIBILITY FOR THE ADMINISTRATION OF THE ASSISTED LIVING RESIDENCE.

SECTION 5 - REPORTING REQUIREMENTS

AT RISK PERSONS MANDATORY REPORTING

5.1 ASSISTED LIVING RESIDENCE PERSONNEL ENGAGED IN THE ADMISSION, CARE OR TREATMENT OF AT-RISK PERSONS SHALL REPORT SUSPECTED PHYSICAL OR SEXUAL ABUSE, EXPLOITATION AND/OR CARETAKER NEGLECT TO LAW ENFORCEMENT WITHIN 24 HOURS OF OBSERVATION OR DISCOVERY PURSUANT TO §18-6.5-108, C.R.S.

RESIDENT RELOCATION REPORTING

5.2 THE ASSISTED LIVING RESIDENCE SHALL NOTIFY THE DEPARTMENT WITHIN 48 HOURS IF THE RELOCATION OF ONE OR MORE RESIDENTS OCCURS DUE TO ANY PORTION OF THE ASSISTED LIVING RESIDENCE BECOMING UNINHABITABLE BECAUSE OF FIRE OR OTHER DISASTER.

OCCURRENCE REPORTING

5.3 AN ASSISTED LIVING RESIDENCE SHALL COMPLY WITH ALL OCCURRENCE REPORTING REQUIRED BY STATE LAW AND SHALL FOLLOW THE REPORTING PROCEDURES SET FORTH BELOW:

(A) NOTIFY THE DEPARTMENT OF THE FOLLOWING ITEMS NO LATER THAN THE NEXT BUSINESS DAY AFTER DISCOVERY BY THE ALR:

(1) ANY OCCURRENCE INVOLVING NEGLECT OF A RESIDENT BY FAILURE TO PROVIDE GOODS AND SERVICES NECESSARY TO AVOID THE RESIDENT'S PHYSICAL HARM OR MENTAL ANGUISH;

(2) ANY OCCURRENCE INVOLVING ABUSE OF A RESIDENT BY THE WILLFUL INFLICTION OF INJURY, UNREASONABLE CONFINEMENT, INTIMIDATION OR PUNISHMENT WITH RESULTING PHYSICAL HARM, PAIN OR MENTAL ANGUISH;

(3) ANY OCCURRENCE INVOLVING AN INJURY OF UNKNOWN SOURCE WHERE THE SOURCE OF THE INJURY CANNOT BE EXPLAINED, AND THE INJURY IS SUSPICIOUS BECAUSE OF THE EXTENT OR LOCATION OF THE INJURY; OR

(4) ANY OCCURRENCE INVOLVING MISAPPROPRIATION OF A RESIDENT'S PROPERTY INCLUDING THE DELIBERATE MISPLACEMENT, EXPLOITATION OR WRONGFUL USE OF A RESIDENT'S BELONGINGS OR MONEY WITHOUT THE RESIDENT'S CONSENT.

(B) INVESTIGATE AN OCCURRENCE TO DETERMINE THE CIRCUMSTANCES OF THE EVENT AND INSTITUTE APPROPRIATE MEASURES TO PREVENT SIMILAR FUTURE SITUATIONS.

(1) DOCUMENTATION REGARDING INVESTIGATION, INCLUDING THE APPROPRIATE MEASURES TO BE INSTITUTED, SHALL BE MADE AVAILABLE TO THE DEPARTMENT, UPON REQUEST.

(C) SUBMIT THE ASSISTED LIVING RESIDENCES' FINAL INVESTIGATION REPORT TO THE DEPARTMENT WITHIN FIVE BUSINESS DAYS AFTER THE INITIAL REPORT OF THE OCCURRENCE.

(D) NOTHING IN THIS SECTION 5.3 SHALL BE CONSTRUED TO LIMIT OR MODIFY ANY STATUTORY OR COMMON LAW RIGHT, PRIVILEGE, CONFIDENTIALITY OR IMMUNITY.

SECTION 6 – ADMINISTRATOR

BACKGROUND CHECKS

6.1 IN ORDER TO ENSURE THAT THE ADMINISTRATOR IS OF GOOD, MORAL AND RESPONSIBLE CHARACTER, THE ASSISTED LIVING RESIDENCE SHALL REQUEST A FINGERPRINT-BASED CRIMINAL HISTORY RECORD CHECK WITH NOTIFICATION OF FUTURE ARRESTS FOR EACH PROSPECTIVE ADMINISTRATOR PRIOR TO HIRE.

(A) IF AN ADMINISTRATOR APPLICANT HAS LIVED IN COLORADO FOR MORE THAN THREE YEARS AT THE TIME OF APPLICATION, THE ASSISTED LIVING RESIDENCE SHALL REQUEST THE CRIMINAL HISTORY RECORD CHECK FROM THE COLORADO BUREAU OF INVESTIGATIONS (CBI).

(B) IF AN ADMINISTRATOR APPLICANT HAS LIVED IN COLORADO FOR LESS THAN THREE YEARS AT THE TIME OF APPLICATION, THE ASSISTED LIVING RESIDENCE SHALL REQUEST THE CRIMINAL HISTORY RECORD CHECK FROM THE FEDERAL BUREAU OF INVESTIGATIONS THROUGH THE CBI.

(C) THE COST OF OBTAINING SUCH INFORMATION SHALL BE BORNE BY THE INDIVIDUAL WHO IS THE SUBJECT OF SUCH CHECK. THE INFORMATION SHALL BE FORWARDED BY THE CBI DIRECTLY TO THE DEPARTMENT.

QUALIFICATIONS

6.2 AN ADMINISTRATOR WHO IS RECOGNIZED BY THE DEPARTMENT AS HAVING BEEN AN ASSISTED LIVING RESIDENCE ADMINISTRATOR OF RECORD PRIOR TO JULY 1, 2019, SHALL NOT BE REQUIRED TO MEET THE CRITERIA IN SECTION 6.3.

6.3 EFFECTIVE JULY 1, 2019, EACH NEWLY HIRED ADMINISTRATOR WHO DOES NOT QUALIFY UNDER SECTION 6.2, SHALL BE AT LEAST 21 YEARS OF AGE, POSSESS A HIGH SCHOOL DIPLOMA OR EQUIVALENT AND AT LEAST ONE YEAR OF EXPERIENCE SUPERVISING THE DELIVERY OF PERSONAL CARE SERVICES THAT INCLUDE ACTIVITIES OF DAILY LIVING.

TRAINING

6.4 EACH ADMINISTRATOR SHALL HAVE COMPLETED AN ADMINISTRATOR TRAINING PROGRAM BEFORE ASSUMING AN ADMINISTRATOR POSITION. WRITTEN PROOF REGARDING THE SUCCESSFUL COMPLETION OF SUCH TRAINING PROGRAM SHALL BE MAINTAINED IN THE ADMINISTRATOR'S PERSONNEL FILE.

6.5 EFFECTIVE JANUARY 1, 2019, AN ADMINISTRATOR TRAINING PROGRAM SHALL MEET ALL OF THE FOLLOWING REQUIREMENTS:

(A) THE PROGRAM OR PROGRAM COMPONENTS ARE CONDUCTED BY AN ACCREDITED COLLEGE, UNIVERSITY, OR VOCATIONAL SCHOOL; OR AN ORGANIZATION, ASSOCIATION, CORPORATION, GROUP OR AGENCY WITH SPECIFIC EXPERTISE IN THE PROVISION OF RESIDENTIAL CARE AND SERVICES, AND

(B) THE CURRICULUM INCLUDES AT LEAST 40 ACTUAL HOURS, 20 OF WHICH SHALL FOCUS ON APPLICABLE STATE REGULATIONS. THE REMAINING 20 HOURS SHALL PROVIDE AN OVERVIEW OF THE FOLLOWING TOPICS:

(1) BUSINESS OPERATIONS INCLUDING, BUT NOT LIMITED TO,

(A) BUDGETING,

(B) BUSINESS PLAN/SERVICE MODEL,

(C) INSURANCE,

(D) LABOR LAWS,

(E) MARKETING, MESSAGING AND LIABILITY CONSEQUENCES, AND

(F) RESIDENT AGREEMENT.

(2) DAILY BUSINESS MANAGEMENT INCLUDING, BUT NOT LIMITED TO,

(A) COORDINATION WITH EXTERNAL SERVICE PROVIDERS (I.E., COMMUNITY AND SUPPORT SERVICES INCLUDING CASE MANAGEMENT, REFERRAL AGENCIES, MENTAL HEALTH RESOURCES, OMBUDSMEN, ADULT PROTECTIVE SERVICES, HOSPICE, AND HOME CARE),

(B) ETHICS, AND

(C) GRIEVANCE AND COMPLAINT PROCESS.

(3) PHYSICAL PLANT

(4) RESIDENT CARE INCLUDING, BUT NOT LIMITED TO,

(A) ADMISSION AND DISCHARGE CRITERIA,

(B) BEHAVIOR EXPRESSION MANAGEMENT,

(C) CARE NEEDS ASSESSMENT,

(D) FALL MANAGEMENT,

(E) NUTRITION,

(F) PERSON-CENTERED CARE,

(G) PERSONAL VERSUS SKILLED CARE,

(H) QUALITY MANAGEMENT EDUCATION,

(I) RESIDENT RIGHTS,

(J) SEXUALITY AND AGING,

(K) SECURE ENVIRONMENT, AND

(L) MEDICATION MANAGEMENT.

(5) RESIDENT PSYCHOSOCIAL NEEDS INCLUDING, BUT NOT LIMITED TO,

(A) CULTURAL COMPETENCY (ETHNICITY, RACE, SEXUAL ORIENTATION),

(B) FAMILY INVOLVEMENT AND DYNAMICS,

(C) MENTAL HEALTH CARE (MAINTAINING GOOD MENTAL HEALTH AND RECOGNIZING SYMPTOMS OF POOR MENTAL HEALTH),

(D) PALLIATIVE CARE STANDARDS, AND

(E) RESIDENT ENGAGEMENT.

6.6 COMPETENCY TESTING SHALL BE PERFORMED TO DEMONSTRATE THAT THE INDIVIDUALS TRAINED HAVE A COMPREHENSIVE, EVIDENCE-BASED UNDERSTANDING OF THE REGULATIONS AND TOPICS.

DUTIES

6.7 THE ADMINISTRATOR SHALL BE RESPONSIBLE FOR THE OVERALL OPERATION OF THE ASSISTED LIVING RESIDENCE, INCLUDING, BUT NOT LIMITED TO:

(A) MANAGING THE DAY TO DAY DELIVERY OF SERVICES TO ENSURE RESIDENTS RECEIVE THE CARE THAT IS DESCRIBED IN THE RESIDENT AGREEMENT, THE COMPREHENSIVE RESIDENT ASSESSMENT AND THE RESIDENT CARE PLAN,

(B) ORGANIZING AND DIRECTING THE ASSISTED LIVING RESIDENCE'S ONGOING FUNCTIONS INCLUDING PHYSICAL MAINTENANCE,

(C) ENSURING THAT RESIDENT CARE SERVICES CONFORM TO THE REQUIREMENTS SET FORTH IN SECTION 12 OF THIS CHAPTER,

(D) EMPLOYING, TRAINING AND SUPERVISING QUALIFIED PERSONNEL,

(E) PROVIDING CONTINUING EDUCATION FOR ALL PERSONNEL,

(F) ESTABLISHING AND MAINTAINING A WRITTEN ORGANIZATIONAL CHART TO ENSURE THERE ARE WELL-DEFINED LINES OF RESPONSIBILITY AND ADEQUATE SUPERVISION OF ALL PERSONNEL,

(G) REVIEWING THE MARKETING MATERIALS AND INFORMATION PUBLISHED BY AN ASSISTED LIVING RESIDENCE TO ENSURE CONSISTENCY WITH THE SERVICES ACTUALLY PROVIDED BY THE ALR,

(H) MANAGING THE BUSINESS AND FINANCIAL ASPECTS OF THE ASSISTED LIVING RESIDENCE WHICH INCLUDES WORKING WITH THE LICENSEE TO ENSURE THERE IS AN ADEQUATE BUDGET TO PROVIDE NECESSARY RESIDENT SERVICES,

(I) COMPLETING, MAINTAINING AND SUBMITTING ALL REPORTS AND RECORDS REQUIRED BY THE DEPARTMENT,

(J) COMPLYING WITH ALL APPLICABLE FEDERAL, STATE AND LOCAL LAWS CONCERNING LICENSURE AND CERTIFICATION, AND

(K) APPOINTING AND SUPERVISING A QUALIFIED DESIGNEE WHO IS CAPABLE OF SATISFACTORILY FULFILLING THE ADMINISTRATOR'S DUTIES WHEN THE ADMINISTRATOR IS UNAVAILABLE.

(1) THE NAME AND CONTACT INFORMATION FOR THE ADMINISTRATOR OR QUALIFIED DESIGNEE ON DUTY SHALL ALWAYS BE READILY AVAILABLE TO THE RESIDENTS AND PUBLIC.

(2) THE ADMINISTRATOR OR QUALIFIED DESIGNEE SHALL ALWAYS, WHETHER ON OR OFF SITE, BE READILY ACCESSIBLE TO STAFF.

(3) WHEN A QUALIFIED DESIGNEE IS ACTING AS ADMINISTRATOR IN AN ASSISTED LIVING RESIDENCE THAT IS LICENSED FOR MORE THAN 12 BEDS, THERE SHALL BE AT LEAST ONE OTHER STAFF MEMBER ON DUTY WHOSE PRIMARY RESPONSIBILITY IS THE DAILY CARE OF RESIDENTS.

SECTION 7 – PERSONNEL

BACKGROUND CHECKS

7.1 IN ORDER TO ENSURE THAT STAFF MEMBERS AND VOLUNTEERS ARE OF GOOD, MORAL AND RESPONSIBLE CHARACTER, THE ASSISTED LIVING RESIDENCE SHALL REQUEST, PRIOR TO HIRE, A NAME-BASED CRIMINAL HISTORY RECORD CHECK FOR EACH PROSPECTIVE STAFF MEMBER AND VOLUNTEER PROVIDING ALR SERVICES.

(A) IF THE APPLICANT HAS LIVED IN COLORADO FOR MORE THAN THREE YEARS AT THE TIME OF (B) APPLICATION, THE ASSISTED LIVING RESIDENCE SHALL OBTAIN A NAME-BASED CRIMINAL HISTORY REPORT CONDUCTED BY THE COLORADO BUREAU OF INVESTIGATIONS (CBI).

(B) IF THE APPLICANT HAS LIVED IN COLORADO FOR THREE YEARS OR LESS AT THE TIME OF APPLICATION, THE ASSISTED LIVING RESIDENCE SHALL OBTAIN A NAME-BASED CRIMINAL HISTORY REPORT FOR EACH STATE IN WHICH THE APPLICANT HAS LIVED FOR THE PAST THREE YEARS, CONDUCTED BY THE RESPECTIVE STATES' BUREAUS OF INVESTIGATION OR EQUIVALENT STATE-LEVEL LAW ENFORCEMENT AGENCY OR OTHER NAMED-BASED REPORT AS DETERMINED BY THE DEPARTMENT.

(C) THE COST OF OBTAINING SUCH INFORMATION SHALL BE BORNE BY THE ASSISTED LIVING RESIDENCE, THE CONTRACT STAFFING AGENCY OR THE INDIVIDUAL WHO IS THE SUBJECT OF SUCH CHECK, AS APPROPRIATE.

BACKGROUND CHECK POLICIES AND PROCEDURES

7.2 IF THE ASSISTED LIVING RESIDENCE BECOMES AWARE OF INFORMATION THAT A CURRENT ADMINISTRATOR, STAFF MEMBER OR VOLUNTEER PROVIDING ALR SERVICES COULD POSE A RISK TO THE HEALTH, SAFETY AND WELFARE OF THE RESIDENTS AND/OR THAT SUCH INDIVIDUAL IS NOT OF GOOD, MORAL AND RESPONSIBLE CHARACTER, THE ASSISTED LIVING RESIDENCE SHALL REQUEST AN UPDATED CRIMINAL HISTORY RECORD CHECK FOR SUCH INDIVIDUAL FROM THE CBI AND/OR OTHER RELEVANT LAW ENFORCEMENT AGENCY.

7.3 THE ASSISTED LIVING RESIDENCE SHALL DEVELOP AND IMPLEMENT POLICIES AND PROCEDURES REGARDING THE HIRING OR CONTINUED SERVICE OF ANY ADMINISTRATOR, STAFF MEMBER OR VOLUNTEER PROVIDING ALR SERVICES WHOSE CRIMINAL HISTORY RECORDS DO NOT REVEAL GOOD, MORAL AND RESPONSIBLE CHARACTER OR DEMONSTRATE OTHER CONDUCT THAT COULD POSE A RISK TO THE HEALTH, SAFETY, OR WELFARE OF THE RESIDENTS.

(A) AT A MINIMUM, THE ASSISTED LIVING RESIDENCE SHALL CONSIDER AND ADDRESS THE FOLLOWING ITEMS:

(1) THE HISTORY OF CONVICTIONS, PLEAS OF GUILTY OR NO CONTEST;

(2) THE NATURE AND SERIOUSNESS OF THE CRIME(S);

(3) THE TIME THAT HAS ELAPSED SINCE THE CONVICTIONS;

(4) WHETHER THERE ARE ANY MITIGATING CIRCUMSTANCES; AND

(5) THE NATURE OF THE POSITION TO WHICH THE INDIVIDUAL WILL BE ASSIGNED.

ABILITY TO PERFORM JOB FUNCTIONS

7.4 EACH STAFF MEMBER AND VOLUNTEER PROVIDING ASSISTED LIVING SERVICES SHALL BE PHYSICALLY AND MENTALLY ABLE TO ADEQUATELY AND SAFELY PERFORM ALL FUNCTIONS ESSENTIAL TO RESIDENT CARE.

7.5 THE ASSISTED LIVING RESIDENCE SHALL SELECT DIRECT CARE STAFF BASED ON SUCH FACTORS AS THE ABILITY TO READ, WRITE, CARRY OUT DIRECTIONS, COMMUNICATE AND DEMONSTRATE COMPETENCY TO SAFELY AND EFFECTIVELY PROVIDE CARE AND SERVICES.

7.6 THE ASSISTED LIVING RESIDENCE SHALL ESTABLISH WRITTEN POLICIES CONCERNING PRE-EMPLOYMENT PHYSICAL EVALUATIONS AND EMPLOYEE HEALTH. THOSE POLICIES SHALL INCLUDE, AT A MINIMUM:

(A) TUBERCULIN SKIN TESTING OF EACH STAFF MEMBER AND VOLUNTEER WHO PROVIDE ALR SERVICES PRIOR TO DIRECT CONTACT WITH RESIDENTS; AND

(B) THE IMPOSITION OF WORK RESTRICTIONS ON DIRECT CARE STAFF WHO ARE KNOWN TO BE AFFECTED WITH ANY ILLNESS IN A COMMUNICABLE STAGE. AT A MINIMUM, SUCH STAFF SHALL BE BARRED FROM DIRECT CONTACT WITH RESIDENTS OR RESIDENT FOOD.

7.7 THE ASSISTED LIVING RESIDENCE SHALL HAVE POLICIES AND PROCEDURES RESTRICTING ON-SITE ACCESS BY STAFF OR VOLUNTEERS WITH DRUG OR ALCOHOL USE THAT WOULD ADVERSELY IMPACT THEIR ABILITY TO PROVIDE RESIDENT CARE AND SERVICES.

ORIENTATION

7.8 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT EACH STAFF MEMBER AND VOLUNTEER WHO PROVIDE ALR SERVICES COMPLETE AN INITIAL ORIENTATION BEFORE PROVIDING CARE AND SERVICES TO A RESIDENT. SUCH ORIENTATION SHALL INCLUDE, AT A MINIMUM, ALL OF THE FOLLOWING TOPICS:

(A) THE CARE AND SERVICES PROVIDED BY THE ASSISTED LIVING RESIDENCE INCLUDING PALLIATIVE AND/OR END OF LIFE CARE, IF APPLICABLE,

(B) RESIDENT RIGHTS,

(C) OVERVIEW OF STATE REGULATORY OVERSIGHT APPLICABLE TO THE ASSISTED LIVING RESIDENCE,

(D) HAND HYGIENE AND INFECTION CONTROL,

(E) RECOGNIZING EMERGENCIES, EMERGENCY RESPONSE POLICIES AND PROCEDURES AND RELEVANT EMERGENCY CONTACT NUMBERS,

(F) HOUSE RULES,

(G) PERSON-CENTERED CARE, AND

(H) REPORTING REQUIREMENTS.

STAFF TRAINING

7.9 WITHIN 30 DAYS OF HIRE, THE ASSISTED LIVING RESIDENCE SHALL PROVIDE EACH STAFF MEMBER WITH TRAINING RELEVANT TO THAT STAFF MEMBER'S DUTIES AND RESPONSIBILITIES. THIS TRAINING MAY INCLUDE SELF-STUDY COURSES. IF THE ASSISTED LIVING RESIDENCE USES A VOLUNTEER TO PERFORM ANY STAFF FUNCTIONS, THAT VOLUNTEER SHALL RECEIVE THE SAME TRAINING AS STAFF. THE STAFF TRAINING SHALL INCLUDE, BUT IS NOT LIMITED TO, THE FOLLOWING TOPICS:

(A) ASSIGNMENT OF DUTIES AND RESPONSIBILITIES,

(B) ASSISTED LIVING RESIDENCE POLICIES AND PROCEDURES,

(C) OCCURRENCE REPORTING,

(D) RECOGNIZING BEHAVIORAL EXPRESSION AND MANAGEMENT TECHNIQUES,

(E) HOW TO EFFECTIVELY COMMUNICATE WITH RESIDENTS THAT HAVE HEARING LOSS, LIMITED ENGLISH PROFICIENCY, DEMENTIA, OR OTHER CONDITIONS THAT IMPAIR COMMUNICATION;

(F) EMERGENCY PROCEDURES INCLUDING FIRE RESPONSE, BASIC FIRST AID, AUTOMATED EXTERNAL DEFIBRILLATOR (AED) USE, IF APPLICABLE, PRACTITIONER ASSESSMENT, AND SERIOUS ILLNESS, INJURY AND/OR DEATH OF A RESIDENT;

(G) THE ROLE OF AND COMMUNICATION WITH EXTERNAL SERVICE PROVIDERS,

(H) TRAINING RELATED TO FALL PREVENTION AND WAYS TO MONITOR RESIDENTS FOR SIGNS OF HEIGHTENED FALL POTENTIAL SUCH AS DETERIORATING EYESIGHT, UNSTEADY GAIT, AND INCREASING LIMITATIONS THAT RESTRICT MOBILITY;

(I) WHERE TO IMMEDIATELY LOCATE A RESIDENT'S ADVANCE DIRECTIVE,

(J) MAINTENANCE OF A CLEAN, SAFE AND HEALTHY ENVIRONMENT INCLUDING APPROPRIATE CLEANING TECHNIQUES,

(K) UNDERSTANDING END OF LIFE CARE INCLUDING HOSPICE AND PALLIATIVE CARE,

(L) HOW TO SAFELY PROVIDE LIFT ASSISTANCE, ACCOMPANIMENT AND TRANSPORT OF RESIDENTS; AND

(M) FOOD SAFETY.

PERSONNEL POLICIES

7.10 THE ASSISTED LIVING RESIDENCE SHALL DEVELOP AND MAINTAIN WRITTEN PERSONNEL POLICIES, JOB DESCRIPTIONS AND OTHER REQUIREMENTS REGARDING THE CONDITIONS OF EMPLOYMENT, MANAGEMENT OF STAFF AND RESIDENT CARE TO BE PROVIDED, INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING:

(A) THE ASSISTED LIVING RESIDENCE SHALL PROVIDE A JOB-SPECIFIC ORIENTATION FOR EACH NEW STAFF MEMBER AND VOLUNTEER BEFORE THEY INDEPENDENTLY PROVIDE RESIDENT SERVICES,

(B) ALL STAFF MEMBERS AND VOLUNTEERS WHO PROVIDE ASSISTED LIVING SERVICES SHALL BE INFORMED OF THE PURPOSE AND OBJECTIVES OF THE ASSISTED LIVING RESIDENCE,

(C) ALL STAFF MEMBERS AND VOLUNTEERS WHO PROVIDE ASSISTED LIVING SERVICES SHALL BE GIVEN ACCESS TO THE ALR'S PERSONNEL POLICIES AND THE ALR SHALL PROVIDE EVIDENCE THAT EACH STAFF MEMBER AND VOLUNTEER HAS REVIEWED THEM, AND

(D) ALL STAFF MEMBERS SHALL WEAR NAME TAGS OR OTHER IDENTIFICATION THAT IS VISIBLE TO RESIDENTS AND VISITORS.

(1) THE REQUIREMENT FOR NAME TAGS MAY BE WAIVED IF A MAJORITY OF ATTENDEES AT A REGULARLY SCHEDULED ASSISTED LIVING RESIDENT MEETING AGREE TO DO SO.

(A) THE ASSISTED LIVING RESIDENCE SHALL MAINTAIN DOCUMENTATION SHOWING THAT ALL RESIDENTS AND FAMILY MEMBERS WERE PROVIDED ADVANCE NOTICE REGARDING THE TOPIC AND MEETING DETAILS.

(B) THE DECISION TO WAIVE THE NAME TAG REQUIREMENT SHALL BE RAISED AND REVIEWED AT THE ASSISTED LIVING RESIDENT MEETING AT LEAST ANNUALLY.

PERSONNEL FILES

7.11 THE ASSISTED LIVING RESIDENCE SHALL MAINTAIN A PERSONNEL FILE FOR EACH OF ITS EMPLOYEES AND VOLUNTEERS WHO PROVIDE ALR SERVICES.

7.12 PERSONNEL FILES FOR CURRENT EMPLOYEES AND VOLUNTEERS SHALL BE READILY AVAILABLE ONSITE FOR DEPARTMENT REVIEW.

7.13 EACH PERSONNEL FILE SHALL INCLUDE, BUT NOT BE LIMITED TO, WRITTEN DOCUMENTATION REGARDING THE FOLLOWING ITEMS:

(A) A DESCRIPTION OF THE EMPLOYEE OR VOLUNTEER DUTIES;

(B) DATE OF HIRE OR ACCEPTANCE OF VOLUNTEER SERVICE AND DATE DUTIES COMMENCED;

(C) ORIENTATION AND TRAINING, INCLUDING FIRST AID AND CPR CERTIFICATION, IF APPLICABLE;

(D) VERIFICATION FROM THE DEPARTMENT OF REGULATORY AGENCIES OF AN ACTIVE LICENSE OR CERTIFICATION, IF APPLICABLE;

(E) RESULTS OF BACKGROUND CHECKS AND FOLLOW UP, AS APPLICABLE; AND

(F) TUBERCULIN TEST RESULTS, IF APPLICABLE.

7.14 IF THE EMPLOYEE OR VOLUNTEER IS A QUALIFIED MEDICATION ADMINISTRATION PERSON, THE FOLLOWING SHALL ALSO BE RETAINED IN THE PERSONNEL FILE:

(A) DOCUMENTATION THAT THE INDIVIDUAL'S NAME APPEARS ON THE DEPARTMENT'S LIST OF INDIVIDUALS WHO HAVE SUCCESSFULLY COMPLETED THE MEDICATION ADMINISTRATION COMPETENCY EVALUATION; AND

(B) A SIGNED DISCLOSURE THAT THE INDIVIDUAL HAS NOT HAD A PROFESSIONAL MEDICAL, NURSING, OR PHARMACY LICENSE REVOKED IN THIS OR ANY OTHER STATE FOR REASONS DIRECTLY RELATED TO THE ADMINISTRATION OF MEDICATIONS.

7.15 PERSONNEL FILES SHALL BE RETAINED FOR THREE YEARS FOLLOWING AN EMPLOYEE'S SEPARATION FROM EMPLOYMENT OR A VOLUNTEER'S SEPARATION FROM SERVICE AND INCLUDE THE REASON(S) FOR THE SEPARATION.

PERSONAL CARE WORKER

7.16 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT EACH PERSONAL CARE WORKER ATTENDS THE INITIAL ORIENTATION REQUIRED IN SECTION 7.8. THE ASSISTED LIVING RESIDENCE SHALL ALSO REQUIRE THAT EACH PERSONAL CARE WORKER RECEIVES ADDITIONAL ORIENTATION ON THE FOLLOWING TOPICS BEFORE PROVIDING CARE AND SERVICES TO A RESIDENT.

(A) PERSONAL CARE WORKER DUTIES AND RESPONSIBILITIES;

(B) THE DIFFERENCES BETWEEN PERSONAL SERVICES AND SKILLED CARE; AND

(C) OBSERVATION, REPORTING AND DOCUMENTATION REGARDING A RESIDENT'S CHANGE IN FUNCTIONAL STATUS ALONG WITH THE ASSISTED LIVING RESIDENCE'S RESPONSE REQUIREMENTS.

7.17 ORIENTATION AND TRAINING IS NOT REQUIRED FOR A PERSONAL CARE WORKER WHO IS RETURNING TO AN ASSISTED LIVING RESIDENCE AFTER A BREAK IN SERVICE OF THREE YEARS OR LESS IF THAT INDIVIDUAL MEETS ALL OF THE FOLLOWING CONDITIONS:

(A) THE PERSONAL CARE WORKER COMPLETED THE ASSISTED LIVING RESIDENCE'S REQUIRED ORIENTATION, TRAINING AND COMPETENCY ASSESSMENT AT THE TIME OF INITIAL EMPLOYMENT,

(B) THE PERSONAL CARE WORKER SUCCESSFULLY COMPLETED THE ASSISTED LIVING RESIDENCE'S REQUIRED COMPETENCY ASSESSMENT AT THE TIME OF REHIRE OR REACTIVATION,

(C) THE PERSONAL CARE WORKER DID NOT HAVE PERFORMANCE ISSUES DIRECTLY RELATED TO RESIDENT CARE AND SERVICES IN THE PRIOR ACTIVE PERIOD OF EMPLOYMENT, AND

(D) ALL ORIENTATION, TRAINING AND PERSONNEL ACTION DOCUMENTATION IS RETAINED IN THE PERSONAL CARE WORKER'S PERSONNEL FILE.

7.18 THE ASSISTED LIVING RESIDENCE SHALL DESIGNATE AN ADMINISTRATOR, NURSE OR OTHER CAPABLE INDIVIDUAL TO BE RESPONSIBLE FOR THE OVERSIGHT AND SUPERVISION OF EACH PERSONAL CARE WORKER. SUCH SUPERVISION SHALL INCLUDE, BUT NOT BE LIMITED TO:

(A) BEING ACCESSIBLE TO RESPOND TO PERSONAL CARE WORKER QUESTIONS; AND

(B) EVALUATING EACH PERSONAL CARE WORKER AT LEAST ANNUALLY.

(1) EACH EVALUATION SHALL INCLUDE OBSERVATION OF THE PERSONAL CARE WORKER PERFORMING HIS OR HER ASSIGNED TASKS AND DOCUMENTATION THAT THE WORKER IS COMPETENT IN THE PERFORMANCE OF THOSE TASKS.

7.19 THE ASSISTED LIVING RESIDENCE SHALL ONLY ALLOW A PERSONAL CARE WORKER TO PERFORM TASKS THAT HAVE A CHRONIC, STABLE, PREDICTABLE OUTCOME AND DO NOT REQUIRE ROUTINE NURSE ASSESSMENT.

7.20 THE POTENTIAL DUTIES OF A PERSONAL CARE WORKER RANGE FROM OBSERVATION AND MONITORING OF RESIDENTS TO ENSURE THEIR HEALTH, SAFETY AND WELFARE, TO COMPANIONSHIP AND PERSONAL SERVICES.

7.21 BEFORE A PERSONAL CARE WORKER INDEPENDENTLY PERFORMS PERSONAL SERVICES FOR A RESIDENT, THE SUPERVISOR DESIGNATED BY THE ASSISTED LIVING RESIDENCE SHALL OBSERVE AND DOCUMENT THAT THE WORKER HAS DEMONSTRATED HIS OR HER ABILITY TO COMPETENTLY PERFORM EVERY PERSONAL TASK ASSIGNED. THIS COMPETENCY CHECK SHALL BE REPEATED EACH TIME A WORKER IS ASSIGNED A NEW OR ADDITIONAL PERSONAL CARE TASK THAT HE OR SHE HAS NOT PREVIOUSLY PERFORMED.

7.22 ONLY APPROPRIATELY SKILLED PROFESSIONALS MAY TRAIN PERSONAL CARE WORKERS AND THEIR SUPERVISORS ON SPECIALIZED TECHNIQUES BEYOND GENERAL PERSONAL CARE AND ASSISTANCE WITH ACTIVITIES OF DAILY LIVING AS DEFINED IN THESE RULES. (EXAMPLES INCLUDE, BUT ARE NOT LIMITED TO, TRANSFERS REQUIRING SPECIALIZED EQUIPMENT AND ASSISTANCE WITH THERAPEUTIC DIETS). PERSONAL CARE WORKERS AND THEIR SUPERVISORS SHALL BE EVALUATED FOR COMPETENCY BEFORE THE DELIVERY OF EACH PERSONAL SERVICE REQUIRING A SPECIALIZED TECHNIQUE.

(A) DOCUMENTATION REGARDING COMPETENCY IN SPECIALIZED TECHNIQUES SHALL BE INCLUDED IN THE PERSONNEL FILES OF BOTH PERSONAL CARE WORKERS AND SUPERVISORS.

(B) A REGISTERED NURSE WHO IS EMPLOYED OR CONTRACTED BY THE ASSISTED LIVING RESIDENCE MAY DELEGATE TO A PERSONAL CARE WORKER IN ACCORDANCE WITH THE NURSING PRACTICE ACT IF THE REGISTERED NURSE IS THE SUPERVISING NURSE FOR THE PERSONAL CARE WORKER.

7.23 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT EACH PERSONAL CARE WORKER COMPLIES WITH ALL ASSISTED LIVING RESIDENCE POLICIES AND PROCEDURES AND NOT ALLOW A PERSONAL CARE WORKER TO PERFORM ANY FUNCTIONS WHICH ARE OUTSIDE OF HIS OR HER JOB DESCRIPTION, WRITTEN AGREEMENTS OR A RESIDENT'S CARE PLAN.

SECTION 8 – STAFFING REQUIREMENTS

MINIMUM STAFFING

8.1 WHENEVER ONE OR MORE RESIDENTS ARE PRESENT IN THE ASSISTED LIVING RESIDENCE, THERE SHALL BE AT LEAST ONE STAFF MEMBER PRESENT WHO MEETS THE CRITERIA IN SECTION 8.7 AND IS CAPABLE OF RESPONDING TO AN EMERGENCY.

(A) RESIDENTS SHALL NOT BE TRANSFERRED OFF SITE SOLELY FOR THE CONVENIENCE OF THE ASSISTED LIVING RESIDENCE OR ITS STAFF.

8.2 BETWEEN 10 PM AND 6 AM, STAFF SHALL CONDUCT AT LEAST ONE SAFETY CHECK OF ALL CONSENTING RESIDENTS.

STAFFING LEVELS

8.3 TO DETERMINE APPROPRIATE ROUTINE STAFFING LEVELS, THE ASSISTED LIVING RESIDENCE SHALL CONSIDER, AT A MINIMUM, THE FOLLOWING ITEMS:

(A) THE ACUITY AND NEEDS OF THE RESIDENTS;

(B) THE SERVICES OUTLINED IN THE CARE PLAN; AND

(C) THE SERVICES SET FORTH IN THE RESIDENT AGREEMENT.

8.4 STAFF SHALL BE SUFFICIENT IN NUMBER TO HELP RESIDENTS NEEDING OR POTENTIALLY NEEDING ASSISTANCE, CONSIDERING INDIVIDUAL NEEDS SUCH AS THE RISK OF ACCIDENT, HAZARDS, OR OTHER CHALLENGING EVENTS.

FIRST AID, OBSTRUCTED AIRWAY TECHNIQUE AND CARDIOPULMONARY RESUSCITATION TRAINED STAFF

8.5 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT IT HAS SUFFICIENT STAFF MEMBERS WHO ARE CURRENTLY CERTIFIED IN FIRST AID AND CARDIOPULMONARY RESUSCITATION TO MEET THE REQUIREMENTS OF THIS SECTION.

8.6 EACH ASSISTED LIVING RESIDENCE SHALL HAVE AT LEAST ONE STAFF MEMBER ONSITE AT ALL TIMES WHO HAS CURRENT CERTIFICATION IN FIRST AID FROM A NATIONALLY RECOGNIZED ORGANIZATION SUCH AS THE AMERICAN

RED CROSS, THE AMERICAN HEART ASSOCIATION, NATIONAL SAFETY COUNCIL, OR AMERICAN SAFETY AND HEALTH INSTITUTE. THE CERTIFICATION SHALL EITHER BE IN ADULT FIRST AID OR INCLUDE ADULT FIRST AID.

8.7 EACH ASSISTED LIVING RESIDENCE SHALL HAVE AT LEAST ONE STAFF MEMBER ONSITE AT ALL TIMES WHO HAS CURRENT CERTIFICATION IN CARDIOPULMONARY RESUSCITATION (CPR) AND OBSTRUCTED AIRWAY TECHNIQUES FROM A NATIONALLY RECOGNIZED ORGANIZATION SUCH AS THE AMERICAN RED CROSS, THE AMERICAN HEART ASSOCIATION, THE NATIONAL SAFETY COUNCIL OR THE AMERICAN SAFETY AND HEALTH INSTITUTE. THE CERTIFICATION SHALL EITHER BE IN ADULT CPR OR INCLUDE ADULT CPR.

8.8 EACH ASSISTED LIVING RESIDENCE SHALL PLACE IN A VISIBLE LOCATION A LIST OF ALL STAFF WHO HAVE CURRENT CERTIFICATION IN FIRST AID OR CPR SO THAT THE INFORMATION IS READILY AVAILABLE TO STAFF AT ALL TIMES. THE LIST SHALL BE KEPT UP TO DATE AND INDICATE BY STAFF PERSON WHETHER THE CERTIFICATION IS IN FIRST AID OR CPR OR BOTH.

8.9 EACH ASSISTED LIVING RESIDENCE SHALL REQUIRE THAT ALL STAFF WHO ARE CERTIFIED IN FIRST AID AND/OR OBSTRUCTED AIRWAY TECHNIQUES PROMPTLY PROVIDE THOSE SERVICES IN ACCORDANCE WITH THEIR TRAINING.

8.10 EACH ASSISTED LIVING RESIDENCE SHALL REQUIRE THAT ALL STAFF WHO ARE CERTIFIED IN CPR PROMPTLY PROVIDE THOSE SERVICES IN ACCORDANCE WITH THEIR TRAINING, UNLESS THE AFFECTED RESIDENT HAS A DO NOT RESUSCITATE ORDER.

8.11 EACH ASSISTED LIVING RESIDENCE SHALL REQUIRE THAT STAFF, EVEN IF NOT CERTIFIED IN FIRST AID OR CPR, PROMPTLY RESPOND TO AN EMERGENCY AND FOLLOW THE INSTRUCTIONS OF A 911 EMERGENCY CALL OPERATOR UNTIL A MEDICALLY TRAINED PROVIDER CAN ASSUME CARE.

USE OF VOLUNTEERS AND RESIDENTS

8.12 VOLUNTEERS AND RESIDENTS MAY ASSIST WITH THE PROVISION OF RESIDENT CARE AND SERVICES, BUT THE ASSISTED LIVING RESIDENCE SHALL NOT CONSIDER THE USE OF EITHER VOLUNTEERS OR RESIDENT HELPERS IN DETERMINING THE APPROPRIATE STAFFING LEVEL.

USE OF HOSPICE PROVIDERS

8.13 WHEN LICENSED HOSPICE CARE IS PROVIDED IN AN ASSISTED LIVING RESIDENCE, THERE SHALL BE A WRITTEN AGREEMENT REGARDING THE PROVISION OF THAT CARE BY A HOSPICE PROVIDER. THE WRITTEN AGREEMENT SHALL BE SIGNED BY AUTHORIZED REPRESENTATIVES OF THE HOSPICE AND ASSISTED LIVING RESIDENCE PRIOR TO THE PROVISION OF HOSPICE CARE. THE WRITTEN AGREEMENT SHALL INCLUDE, AT A MINIMUM, THE FOLLOWING:

(A) HOW THE ASSISTED LIVING RESIDENCE AND HOSPICE WILL COORDINATE AND COMMUNICATE WITH EACH OTHER TO ENSURE THAT THE NEEDS OF THE RESIDENT ARE BEING FULLY MET;

(B) A PROVISION THAT THE ASSISTED LIVING RESIDENCE SHALL IMMEDIATELY NOTIFY THE HOSPICE IF:

(1) THERE IS A SIGNIFICANT CHANGE IN THE RESIDENT'S PHYSICAL, MENTAL, SOCIAL OR EMOTIONAL STATUS THAT MAY NECESSITATE A CHANGE TO THE RESIDENT'S CARE PLAN;

(2) THERE IS A NEED TO TRANSFER THE RESIDENT FROM THE ASSISTED LIVING RESIDENCE, IN WHICH CASE THE HOSPICE SHALL COORDINATE ANY NECESSARY CARE RELATED TO THE TERMINAL ILLNESS AND RELATED CONDITIONS; OR

(3) THE RESIDENT DIES.

(C) A PROVISION STATING THAT THE HOSPICE ASSUMES RESPONSIBILITY FOR DETERMINING THE APPROPRIATE COURSE OF HOSPICE CARE, INCLUDING THE DETERMINATION TO CHANGE THE LEVEL OF SERVICES PROVIDED; AND

(D) A PROVISION STATING THAT IT IS THE RESPONSIBILITY OF THE ASSISTED LIVING RESIDENCE TO PROVIDE 24-HOUR ROOM AND BOARD AND THE OTHER SERVICES REQUIRED BY THIS CHAPTER 7.

8.14 IF A HOSPICE PROVIDER FAILS TO PROVIDE SERVICES WHEN THEY ARE NECESSARY, THE ASSISTED LIVING RESIDENCE SHALL FOLLOW THE REQUIREMENTS OF SECTION 12.5 REGARDING A RESIDENT'S SIGNIFICANT CHANGE IN BASELINE STATUS AND REQUEST A PRACTITIONER ASSESSMENT.

CONTRACTED PERSONNEL AND SERVICES

8.15 AN ASSISTED LIVING RESIDENCE THAT USES A SEPARATE AGENCY, ORGANIZATION OR INDIVIDUAL TO PROVIDE SERVICES FOR THE ALR OR RESIDENTS SHALL HAVE A WRITTEN AGREEMENT THAT SETS FORTH THE TERMS OF THE ARRANGEMENT. THE AGREEMENT SHALL SPECIFY, AT A MINIMUM, THE FOLLOWING ITEMS:

(A) THE SPECIFIC SERVICES TO BE PROVIDED;

(B) THE TIME FRAME FOR THE PROVISION OF SUCH SERVICES;

(C) THE CONTRACTOR'S OBLIGATION TO COMPLY WITH ALL APPLICABLE ASSISTED LIVING RESIDENCE POLICIES AND PROCEDURES, INCLUDING PERSONNEL QUALIFICATIONS;

(D) HOW SUCH SERVICES WILL BE COORDINATED AND OVERSEEN BY THE ASSISTED LIVING RESIDENCE; AND

(E) THE PROCEDURE FOR PAYMENT OF SERVICES PROVIDED UNDER THE CONTRACT.

8.16 IF CONTRACT PERSONNEL AND/OR SERVICES ARE USED, THE CONTRACTOR SHALL MEET ALL APPLICABLE REQUIREMENTS OF THESE REGULATIONS.

8.17 NOTWITHSTANDING THE ABOVE CRITERIA, THE ASSISTED LIVING RESIDENCE SHALL RETAIN RESPONSIBILITY FOR OVERSIGHT OF ALL CONTRACTED PERSONNEL AND SERVICES TO ENSURE THE HEALTH, SAFETY AND WELFARE OF THE RESIDENTS.

SECTION 9 – POLICIES AND PROCEDURES

9.1 THE ASSISTED LIVING RESIDENCE SHALL DEVELOP AND AT LEAST ANNUALLY REVIEW, ALL POLICIES AND PROCEDURES. AT A MINIMUM, THE ASSISTED LIVING RESIDENCE SHALL HAVE POLICIES AND PROCEDURES THAT ADDRESS THE FOLLOWING ITEMS:

(A) ADMISSION AND DISCHARGE CRITERIA IN ACCORDANCE WITH SECTIONS 11 AND 25, IF APPLICABLE;

(B) RESIDENT RIGHTS;

(C) GRIEVANCE PROCEDURE AND COMPLAINT RESOLUTION;

(D) INVESTIGATION OF ABUSE, NEGLECT AND EXPLOITATION ALLEGATIONS;

(E) HOUSE RULES;

(F) EMERGENCY PREPAREDNESS;

(G) FALL MANAGEMENT;

(H) PROVISION OF LIFT ASSISTANCE, FIRST AID, OBSTRUCTED AIRWAY TECHNIQUE, AND CARDIOPULMONARY RESUSCITATION;

(I) UNANTICIPATED ILLNESS, INJURY, SIGNIFICANT CHANGE OF STATUS FROM BASELINE OR DEATH OF RESIDENT;

(J) INFECTION CONTROL;

(K) PRACTITIONER ASSESSMENT;

(L) HEALTH INFORMATION MANAGEMENT;

(M) PERSONNEL;

(N) STAFF TRAINING;

(O) ENVIRONMENTAL PEST CONTROL;

(P) MEDICATION ERRORS AND MEDICATION DESTRUCTION AND DISPOSAL;

(Q) MANAGEMENT OF RESIDENT FUNDS, IF APPLICABLE;

(R) POLICIES AND PROCEDURES RELATED TO SECURE ENVIRONMENT, IF APPLICABLE; AND

(S) PROVISION OF PALLIATIVE CARE IN ACCORDANCE WITH 6 CCR 1011-1, CHAPTER 2, PART 3.3.1, IF APPLICABLE.

SECTION 10 – EMERGENCY PREPAREDNESS

EMERGENCY POLICIES AND PROCEDURES

10.1 THE ASSISTED LIVING RESIDENCE SHALL HAVE READILY AVAILABLE A ROSTER OF CURRENT RESIDENTS, THEIR ROOM ASSIGNMENTS AND EMERGENCY CONTACT INFORMATION ALONG WITH A FACILITY DIAGRAM SHOWING ROOM LOCATIONS.

10.2 THE ASSISTED LIVING RESIDENCE SHALL COMPLETE A RISK ASSESSMENT OF ALL HAZARDS AND PREPAREDNESS MEASURES TO ADDRESS NATURAL AND HUMAN-CAUSED CRISES INCLUDING, BUT NOT LIMITED TO, FIRE(S), GAS EXPLOSION, POWER OUTAGES, TORNADO, FLOODING AND THREATENED OR ACTUAL ACTS OF VIOLENCE.

10.3 THE ASSISTED LIVING RESIDENCE SHALL DEVELOP AND FOLLOW WRITTEN POLICIES AND PROCEDURES TO ENSURE THE CONTINUATION OF NECESSARY CARE TO ALL RESIDENTS FOR AT LEAST 72 HOURS IMMEDIATELY FOLLOWING ANY EMERGENCY INCLUDING, BUT NOT LIMITED TO, A LONG-TERM POWER FAILURE.

10.4 EMERGENCY POLICIES AND PROCEDURES SHALL BE TAILORED TO THE GEOGRAPHIC LOCATION OF THE ASSISTED LIVING RESIDENCE; TYPES OF RESIDENTS SERVED; AND UNIQUE RISKS AND CIRCUMSTANCES IDENTIFIED BY THE ASSISTED LIVING RESIDENCE.

10.5 EACH ASSISTED LIVING RESIDENCE SHALL IDENTIFY ITS HIGHEST POTENTIAL RISK AND HOLD ROUTINE DRILLS TO FACILITATE STAFF AND RESIDENT RESPONSE TO THAT RISK. THERE SHALL BE WRITTEN DOCUMENTATION OF SUCH DRILLS.

10.6 EACH ASSISTED LIVING RESIDENCE'S EMERGENCY POLICIES SHALL ADDRESS, AT A MINIMUM, ALL OF THE FOLLOWING ITEMS:

(A) WRITTEN INSTRUCTIONS FOR EACH IDENTIFIED RISK THAT INCLUDES PERSONS TO BE NOTIFIED AND STEPS TO BE TAKEN. THE INSTRUCTIONS SHALL BE READILY AVAILABLE 24 HOURS A DAY IN MORE THAN ONE LOCATION WITH ALL STAFF AWARE OF THE LOCATIONS.

(B) A SCHEMATIC PLAN OF THE BUILDING OR PORTIONS THEREOF PLACED VISIBLY IN A CENTRAL LOCATION AND THROUGHOUT THE BUILDING, AS NEEDED, SHOWING EVACUATION ROUTES, SMOKE STOP AND FIRE DOORS, EXIT DOORS, AND THE LOCATION OF FIRE EXTINGUISHERS AND FIRE ALARM BOXES.

(C) WHEN TO EVACUATE THE PREMISES AND THE PROCEDURE FOR DOING SO.

(D) A PRE-DETERMINED MEANS OF COMMUNICATING WITH RESIDENTS, FAMILIES, STAFF AND OTHER PROVIDERS.

(E) A PLAN THAT ENSURES THE AVAILABILITY OF, OR ACCESS TO, EMERGENCY POWER FOR ESSENTIAL FUNCTIONS AND ALL RESIDENT-REQUIRED MEDICAL DEVICES OR AUXILIARY AIDS.

(F) STORAGE AND PRESERVATION OF MEDICATIONS.

(G) ASSIGNMENT OF SPECIFIC TASKS AND RESPONSIBILITIES TO THE STAFF MEMBERS ON EACH SHIFT INCLUDING USE OF A TRIAGE SYSTEM TO ASSESS THE NEEDS OF THE MOST VULNERABLE RESIDENTS FIRST.

(H) PROTECTION AND TRANSFER OF HEALTH INFORMATION AS NEEDED TO MEET THE CARE NEEDS OF RESIDENTS.

(I) IN THE EVENT RELOCATION OF RESIDENTS BECOMES NECESSARY, WRITTEN AGREEMENTS WITH OTHER HEALTH FACILITIES AND/OR COMMUNITY AGENCIES.

EMERGENCY EQUIPMENT

10.7 FIRST AID EQUIPMENT SHALL BE MAINTAINED ON THE PREMISES IN A READILY AVAILABLE LOCATION AND STAFF SHALL BE INSTRUCTED IN ITS USE AND LOCATION.

10.8 THE ASSISTED LIVING RESIDENCE SHALL HAVE ENOUGH FIRST AID KITS TO ENABLE STAFF TO IMMEDIATELY RESPOND TO EMERGENCIES. EACH FIRST AID KIT SHALL BE CHECKED REGULARLY TO ENSURE THAT IT IS FULLY STOCKED AND THAT ANY EXPIRATION DATE IS NOT EXCEEDED.

10.9 EACH KIT SHALL INCLUDE, AT A MINIMUM, THE FOLLOWING ITEMS:

(A) LATEX FREE DISPOSABLE GLOVES,

(B) SCISSORS,

(C) ADHESIVE BANDAGES,

(D) BANDAGE TAPE,

(E) STERILE GAUZE PADS,

(F) FLEXIBLE ROLLER GAUZE,

(G) TRIANGULAR BANDAGES WITH SAFETY PINS,

(H) A NOTE PAD WITH A PEN OR PENCIL,

(I) A CPR BARRIER DEVICE OR MASK, AND

(J) SOAP OR WATERLESS HAND SANITIZER.

10.10 IF THE ASSISTED LIVING RESIDENCE HAS AN AUTOMATED EXTERNAL DEFIBRILLATOR (AED), STAFF SHALL BE TRAINED IN ITS USE AND IT SHALL BE MAINTAINED IN ACCORDANCE WITH THE MANUFACTURER'S SPECIFICATIONS.

10.11 THERE SHALL BE AT LEAST ONE TELEPHONE, NOT POWERED BY HOUSEHOLD ELECTRICAL CURRENT, IN THE ASSISTED LIVING RESIDENCE AVAILABLE FOR IMMEDIATE EMERGENCY USE BY STAFF, RESIDENTS, AND VISITORS. CONTACT INFORMATION FOR POLICE, FIRE, AMBULANCE [9-1-1, IF APPLICABLE] AND POISON CONTROL CENTER SHALL BE READILY ACCESSIBLE TO STAFF.

10.12 ASSISTED LIVING RESIDENCES SHALL HAVE A BATTERY OR GENERATOR-POWERED ALTERNATIVE LIGHTING SYSTEM AVAILABLE IN THE EVENT OF A POWER FAILURE.

SECTION 11 – RESIDENT ADMISSION AND DISCHARGE

MOVE-IN CRITERIA

11.1 THE ASSISTED LIVING RESIDENCE SHALL ACCEPT ONLY THOSE PERSONS WHOSE NEEDS CAN BE FULLY MET BY THE EXISTING STAFF, PHYSICAL ENVIRONMENT AND SERVICES ALREADY BEING PROVIDED. THE ASSISTED LIVING RESIDENCE'S ABILITY TO MEET RESIDENT NEEDS SHALL BE BASED UPON A COMPREHENSIVE PRE-ADMISSION ASSESSMENT OF A RESIDENT'S PHYSICAL, MENTAL AND SOCIAL NEEDS; CULTURAL, RELIGIOUS AND ACTIVITY NEEDS; PREFERENCES; AND CAPACITY FOR SELF-CARE.

MOVE-IN RESTRICTIONS

11.2 AN ASSISTED LIVING RESIDENCE SHALL NOT ALLOW TO MOVE-IN ANY PERSON WHO:

(A) NEEDS REGULAR 24-HOUR MEDICAL OR NURSING CARE,

(B) IS INCAPABLE OF SELF-ADMINISTRATION OF MEDICATION AND THE ASSISTED LIVING RESIDENCE DOES NOT HAVE STAFF WHO ARE EITHER LICENSED OR QUALIFIED UNDER 6 CCR 1011-1, CHAPTER 24 TO ADMINISTER MEDICATIONS,

(C) HAS AN ACUTE PHYSICAL ILLNESS WHICH CANNOT BE MANAGED THROUGH MEDICATION OR PRESCRIBED THERAPY,

(D) HAS PHYSICAL LIMITATIONS THAT RESTRICT MOBILITY UNLESS COMPENSATED FOR BY AVAILABLE AUXILIARY AIDS OR INTERMITTENT STAFF ASSISTANCE,

(E) HAS INCONTINENCE ISSUES THAT CANNOT BE MANAGED BY THE RESIDENT OR STAFF,

(F) IS PROFOUNDLY DISORIENTED TO TIME, PERSON AND PLACE WITH SAFETY CONCERNS THAT REQUIRE A SECURE ENVIRONMENT AND THE ASSISTED LIVING RESIDENCE DOES NOT PROVIDE A SECURE ENVIRONMENT,

(G) HAS A STAGE 3 OR 4 PRESSURE SORE AND DOES NOT MEET THE CRITERIA IN SECTION 12.4,

(H) HAS A HISTORY OF CONDUCT THAT HAS BEEN DISCLOSED TO THE ASSISTED LIVING RESIDENCE THAT WOULD POSE A DANGER TO THE RESIDENT OR OTHERS UNLESS THE ALR REASONABLY BELIEVES THAT THE CONDUCT CAN BE MANAGED THROUGH THERAPEUTIC APPROACHES, OR

(I) NEEDS RESTRAINTS, AS DEFINED HEREIN, OF ANY KIND EXCEPT AS STATUTORILY ALLOWED FOR ASSISTED LIVING RESIDENCES WHICH ARE CERTIFIED TO PROVIDE SERVICES SPECIFICALLY FOR THE MENTALLY ILL.

(1) ASSISTED LIVING RESIDENCES CERTIFIED TO PROVIDE SERVICES FOR THE MENTALLY ILL SHALL HAVE POLICIES, PROCEDURES AND APPROPRIATE STAFF TRAINING REGARDING THE USE OF

RESTRAINT AND MAINTAIN CURRENT DOCUMENTATION TO SHOW THAT LESS RESTRICTIVE MEASURES WERE AND CONTINUE TO BE UNSUCCESSFUL.

RESIDENT AGREEMENT

11.3 AT THE TIME THE RESIDENT MOVES IN, THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT THE RESIDENT AND/OR THE RESIDENT'S LEGAL REPRESENTATIVE HAS RECEIVED A COPY OF THE WRITTEN RESIDENT AGREEMENT AND AGREED TO THE TERMS SET FORTH THEREIN. THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT THE AGREEMENT IS SIGNED AND DATED BY BOTH PARTIES.

11.4 THE TERMS OF A RESIDENT AGREEMENT SHALL NOT ALTER, OR BE CONSTRUED TO RELIEVE THE ASSISTED LIVING RESIDENCE OF COMPLIANCE WITH, ANY REQUIREMENT OR OBLIGATION UNDER RELEVANT FEDERAL, STATE OR LOCAL LAW AND REGULATION.

11.5 THE ASSISTED LIVING RESIDENCE SHALL REVIEW ITS RESIDENT AGREEMENTS ANNUALLY AND UPDATE OR AMEND THEM AS NECESSARY. AMENDMENTS TO THE RESIDENT AGREEMENT SHALL ALSO BE SIGNED AND DATED BY BOTH PARTIES.

(A) WHEN A CHANGE OF OWNERSHIP OCCURS, THE NEW OWNER SHALL EITHER ACKNOWLEDGE AND AGREE TO THE TERMS OF EACH EXISTING RESIDENT AGREEMENT OR ESTABLISH A NEW AGREEMENT WITH EACH RESIDENT.

11.6 THE WRITTEN RESIDENT AGREEMENT SHALL SPECIFY THE UNDERSTANDING BETWEEN THE PARTIES CONCERNING, AT A MINIMUM, THE FOLLOWING ITEMS:

(A) ASSISTED LIVING RESIDENCE CHARGES, REFUNDS AND DEPOSIT POLICIES;

(B) THE GENERAL TYPE OF SERVICES AND ACTIVITIES PROVIDED AND NOT PROVIDED BY THE ASSISTED LIVING RESIDENCE AND THOSE WHICH THE ASSISTED LIVING RESIDENCE WILL ASSIST THE RESIDENT IN OBTAINING;

(C) A LIST OF SPECIFIC ASSISTED LIVING RESIDENCE SERVICES INCLUDED FOR THE AGREED UPON RATES AND CHARGES, ALONG WITH A LIST OF ALL AVAILABLE OPTIONAL SERVICES AND THE SPECIFIED CHARGE FOR EACH;

(D) THE AMOUNT OF ANY FEE TO HOLD A PLACE FOR THE RESIDENT IN THE ASSISTED LIVING RESIDENCE WHILE THE RESIDENT IS ABSENT FROM THE ASSISTED LIVING RESIDENCE AND THE CIRCUMSTANCES UNDER WHICH IT WILL BE CHARGED;

(E) RESPONSIBILITY FOR PROVIDING AND MAINTAINING BED LINENS, BATH AND HYGIENE SUPPLIES, ROOM FURNISHINGS, COMMUNICATION DEVICES AND AUXILIARY AIDS; AND

(F) A GUARANTEE THAT ANY SECURITY DEPOSIT WILL BE FULLY REIMBURSED IF THE ASSISTED LIVING RESIDENCE CLOSES WITHOUT GIVING RESIDENT(S) WRITTEN NOTICE AT LEAST 30 CALENDAR DAYS BEFORE SUCH CLOSURE.

WRITTEN DISCLOSURE OF INFORMATION

11.7 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT WHEN A NEW RESIDENT MOVES IN, HE OR SHE IS PROVIDED WITH, AND ACKNOWLEDGES RECEIPT OF, THE FOLLOWING INFORMATION:

(A) HOW TO OBTAIN ACCESS TO THE ASSISTED LIVING RESIDENCE POLICIES AND PROCEDURES LISTED UNDER SECTION 9.1,

(B) THE RESIDENT'S RIGHT TO RECEIVE CARDIOPULMONARY RESUSCITATION (CPR) OR HAVE A WRITTEN ADVANCE DIRECTIVE REFUSING CPR,

(C) MINIMUM STAFFING LEVELS, WHETHER THE ASSISTED LIVING RESIDENCE HAS AWAKE STAFF 24 HOURS A DAY AND THE EXTENT TO WHICH CERTIFIED OR LICENSED HEALTH CARE PROFESSIONALS ARE AVAILABLE ON-SITE,

(D) WHETHER THE ASSISTED LIVING RESIDENCE HAS AN AUTOMATIC FIRE SPRINKLER SYSTEM,

(E) WHETHER THE ASSISTED LIVING RESIDENCE USES EGRESS ALERT DEVICES, INCLUDING DETAILS ABOUT WHEN AND WHERE THEY ARE USED,

(F) WHETHER THE ASSISTED LIVING RESIDENCE HAS RESIDENT LOCATION MONITORING DEVICES (SUCH AS VIDEO SURVEILLANCE), WHEN AND WHERE THEY ARE USED, AND HOW THE ASSISTED LIVING RESIDENCE DETERMINES THAT A RESIDENT REQUIRES MONITORING,

(G) WHETHER THE ASSISTED LIVING RESIDENCE OPERATES A SECURE ENVIRONMENT AND WHAT THAT MEANS,

(H) THE RESIDENT'S INDIVIDUALIZED CARE PLAN THAT ADDRESSES HIS OR HER FUNCTIONAL CAPABILITY AND NEEDS,

(I) SMOKING PROHIBITIONS AND/OR DESIGNATED AREAS FOR SMOKING,

(J) THE READILY AVAILABLE ON-SITE LOCATION OF THE ASSISTED LIVING RESIDENCE'S MOST RECENT INSPECTION REPORT, AND

(K) UPON REQUEST, A COPY OF THE MOST RECENT VERSION OF THESE CHAPTER 7 RULES.

MANAGEMENT OF RESIDENT FUNDS/PROPERTY

11.8 AN ASSISTED LIVING RESIDENCE SHALL NOT ASSUME POWER OF ATTORNEY OR GUARDIANSHIP OVER A RESIDENT UNLESS BY COURT ORDER, NOR SHALL AN ASSISTED LIVING RESIDENCE REQUIRE A RESIDENT TO EXECUTE OR ASSIGN A LOAN, ADVANCE, FINANCIAL INTEREST, MORTGAGE OR OTHER PROPERTY IN EXCHANGE FOR FUTURE SERVICES.

11.9 AN ASSISTED LIVING RESIDENCE SHALL NOT BE REQUIRED TO HANDLE RESIDENT FUNDS OR PROPERTY.

11.10 AN ASSISTED LIVING RESIDENCE THAT CHOOSES TO HANDLE RESIDENT FUNDS OR PROPERTY, SHALL HAVE A POLICY REGARDING THE MANAGEMENT OF SUCH FUNDS AND SHALL COMPLY WITH THE FOLLOWING CRITERIA:

(A) THERE SHALL BE A WRITTEN AUTHORIZATION THAT SPECIFIES THE TERMS AND DURATION OF THE FINANCIAL MANAGEMENT SERVICES TO BE PERFORMED BY THE ASSISTED LIVING RESIDENCE. SUCH AUTHORIZATION SHALL BE SIGNED BY THE RESIDENT OR RESIDENT'S LEGAL REPRESENTATIVE AND NOTARIZED.

(B) UPON ENTERING INTO AN AGREEMENT WITH A RESIDENT FOR FINANCIAL MANAGEMENT SERVICES, THE ASSISTED LIVING RESIDENCE SHALL EXERCISE FIDUCIARY RESPONSIBILITY FOR THESE FUNDS AND PROPERTY, INCLUDING, BUT NOT LIMITED TO, MAINTAINING ANY FUNDS OVER THE AMOUNT OF FIVE HUNDRED DOLLARS ($500) IN AN INTEREST-BEARING ACCOUNT, SEPARATE FROM THE GENERAL OPERATING FUND OF THE ALR, WHICH INTEREST SHALL ACCRUE TO THE RESIDENT.

(C) THE ASSISTED LIVING RESIDENCE SHALL POST A SURETY BOND IN AN AMOUNT SUFFICIENT TO PROTECT THE RESIDENTS' PERSONAL FUNDS.

(D) THE ASSISTED LIVING RESIDENCE SHALL MAINTAIN A CONTINUOUS, DATED RECORD OF ALL FINANCIAL TRANSACTIONS. THE RECORD SHALL BEGIN WITH THE DATE OF THE FIRST HANDLING OF THE PERSONAL FUNDS OF THE RESIDENT AND SHALL BE KEPT ON FILE FOR AT LEAST THREE YEARS FOLLOWING TERMINATION OF THE RESIDENT'S STAY IN THE ASSISTED LIVING RESIDENCE. SUCH RECORD SHALL BE AVAILABLE FOR INSPECTION BY THE DEPARTMENT.

(E) THE ASSISTED LIVING RESIDENCE SHALL PROVIDE THE RESIDENT OR LEGAL REPRESENTATIVE A RECEIPT EACH TIME FUNDS ARE DISBURSED ALONG WITH A QUARTERLY REPORT IDENTIFYING THE BEGINNING AND ENDING ACCOUNT BALANCE ALONG WITH A DESCRIPTION OF EACH AND EVERY TRANSACTION SINCE THE LAST REPORT.

DISCHARGE

11.11 THE ASSISTED LIVING RESIDENCE SHALL ARRANGE TO DISCHARGE ANY RESIDENT WHO:

(A) HAS AN ACUTE PHYSICAL ILLNESS WHICH CANNOT BE MANAGED THROUGH MEDICATION OR PRESCRIBED THERAPY,

(B) HAS PHYSICAL LIMITATIONS THAT RESTRICT MOBILITY, AND WHICH CANNOT BE COMPENSATED FOR BY AVAILABLE AUXILIARY AIDS OR INTERMITTENT STAFF ASSISTANCE,

(C) HAS INCONTINENCE ISSUES THAT CANNOT BE MANAGED BY THE RESIDENT OR STAFF,

(D) HAS A STAGE 3 OR STAGE 4 PRESSURE SORE AND DOES NOT MEET THE CRITERIA IN SECTION 12.4,

(E) IS PROFOUNDLY DISORIENTED TO TIME, PERSON AND PLACE WITH SAFETY CONCERNS THAT REQUIRE A SECURE ENVIRONMENT AND THE ASSISTED LIVING RESIDENCE DOES NOT PROVIDE A SECURE ENVIRONMENT,

(F) EXHIBITS CONDUCT THAT POSES A DANGER TO SELF OR OTHERS AND THE ASSISTED LIVING RESIDENCE IS UNABLE TO SUFFICIENTLY ADDRESS THOSE ISSUES THROUGH THERAPEUTIC APPROACH, AND/OR

(G) NEEDS MORE SERVICES THAN CAN BE ROUTINELY PROVIDED BY THE ASSISTED LIVING RESIDENCE OR AN EXTERNAL SERVICE PROVIDER.

11.12 THE ASSISTED LIVING RESIDENCE MAY ALSO DISCHARGE A RESIDENT FOR:

(A) NONPAYMENT OF BASIC SERVICES IN ACCORDANCE WITH THE RESIDENT AGREEMENT; OR

(B) THE RESIDENT'S FAILURE TO COMPLY WITH A VALID, SIGNED RESIDENT AGREEMENT.

11.13 WHERE A RESIDENT HAS DEMONSTRATED THAT HE OR SHE HAS BECOME A DANGER TO SELF OR OTHERS, THE ASSISTED LIVING RESIDENCE SHALL PROMPTLY IMPLEMENT THE FOLLOWING PROCESS PENDING DISCHARGE:

(A) TAKE ALL APPROPRIATE MEASURES NECESSARY TO PROTECT OTHER RESIDENTS;

(B) REASSESS THE RESIDENT TO BE DISCHARGED AND REVISE HIS OR HER CARE PLAN TO IDENTIFY THE RESIDENT'S CURRENT NEEDS AND WHAT SERVICES THE ASSISTED LIVING RESIDENCE WILL PROVIDE TO MEET THOSE NEEDS; AND

(C) ENSURE ALL STAFF ARE AWARE OF ANY NEW DIRECTIVES PLACED IN THE CARE PLAN AND ARE PROPERLY TRAINED TO PROVIDE SUPERVISION AND ACTIONS CONSISTENT WITH THE CARE PLAN.

11.14 THE ASSISTED LIVING RESIDENCE SHALL COORDINATE A VOLUNTARY OR INVOLUNTARY DISCHARGE WITH THE RESIDENT, THE RESIDENT'S LEGAL REPRESENTATIVE AND/OR THE APPROPRIATE AGENCY. PRIOR TO DISCHARGING A RESIDENT BECAUSE OF INCREASED CARE NEEDS, THE ASSISTED LIVING RESIDENCE SHALL MAKE DOCUMENTED EFFORTS TO MEET THOSE NEEDS THROUGH OTHER MEANS.

11.15 IN THE EVENT A RESIDENT IS TRANSFERRED TO ANOTHER HEALTH CARE ENTITY FOR ADDITIONAL CARE, THE ASSISTED LIVING RESIDENCE SHALL ARRANGE TO EVALUATE THE RESIDENT PRIOR TO RE-ADMISSION OR DISCHARGE THE RESIDENT IN ACCORDANCE WITH THE DISCHARGE PROCEDURES SPECIFIED BELOW.

11.16 THE ASSISTED LIVING RESIDENCE SHALL PROVIDE WRITTEN NOTICE OF ANY DISCHARGE TO THE RESIDENT OR LEGAL REPRESENTATIVE 30 CALENDAR DAYS IN ADVANCE OF DISCHARGE EXCEPT IN CASES OF IMMINENT PHYSICAL HARM TO OR BY THE RESIDENT OR MEDICAL EMERGENCY, WHEREUPON THE ASSISTED LIVING RESIDENCE SHALL NOTIFY THE LEGAL REPRESENTATIVE AS SOON AS POSSIBLE.

11.17 A COPY OF ANY INVOLUNTARY DISCHARGE NOTICE SHALL BE SENT TO THE STATE AND/OR LOCAL LONG-TERM CARE OMBUDSMAN, WITHIN FIVE (5) CALENDAR DAYS OF THE DATE THAT IT IS PROVIDED TO THE RESIDENT OR THE RESIDENT'S LEGAL REPRESENTATIVE.

SECTION 12 - RESIDENT CARE SERVICES

MINIMUM SERVICES

12.1 THE ASSISTED LIVING RESIDENCE SHALL MAKE AVAILABLE, EITHER DIRECTLY OR INDIRECTLY THROUGH A RESIDENT AGREEMENT, THE FOLLOWING SERVICES, SUFFICIENT TO MEET THE NEEDS OF THE RESIDENTS:

(A) A PHYSICALLY SAFE AND SANITARY ENVIRONMENT INCLUDING, BUT NOT LIMITED TO, MEASURES TO REDUCE THE RISK OF POTENTIAL HAZARDS IN THE PHYSICAL ENVIRONMENT RELATED TO THE UNIQUE CHARACTERISTICS OF THE POPULATION;

(B) ROOM AND BOARD;

(C) PERSONAL SERVICES INCLUDING, BUT NOT LIMITED TO, A SYSTEM FOR IDENTIFYING AND REPORTING RESIDENT CONCERNS THAT REQUIRE EITHER AN IMMEDIATE INDIVIDUALIZED APPROACH OR ON-GOING MONITORING AND POSSIBLE RE-ASSESSMENT;

(D) PROTECTIVE OVERSIGHT INCLUDING, BUT NOT LIMITED TO, TAKING APPROPRIATE MEASURES WHEN CONFRONTED WITH AN UNANTICIPATED SITUATION OR EVENT INVOLVING ONE OR MORE RESIDENTS AND THE IDENTIFICATION OF URGENT ISSUES OR CONCERNS THAT REQUIRE AN IMMEDIATE INDIVIDUALIZED APPROACH; AND

(E) SOCIAL CARE AND RESIDENT ENGAGEMENT.

NURSING SERVICES

12.2 NURSES MAY PROVIDE NURSING SERVICES TO SUPPORT THE PERSONAL SERVICES PROVIDED TO RESIDENTS OF THE ASSISTED LIVING RESIDENCE, EXCEPT THAT SUCH SERVICES SHALL NOT RISE TO THE LEVEL THAT REQUIRES RESIDENT DISCHARGE AS DESCRIBED IN SECTION 11.11 OR BECOMES REGULAR 24-HOUR MEDICAL OR NURSING CARE.

(A) OTHER STAFF MAY ASSIST WITH NURSING SERVICES IF THEY ARE TRAINED AND EVALUATED FOR COMPETENCY PRIOR TO ASSIGNMENT.

(B) STAFF ASSISTING WITH NURSING SERVICES SHALL BE SUPERVISED BY A NURSE.

(C) ONLY STAFF EMPLOYED OR CONTRACTED BY THE ASSISTED LIVING RESIDENCE SHALL PROVIDE OR ASSIST WITH NURSING SERVICES ON BEHALF OF THE ASSISTED LIVING RESIDENCE.

12.3 THE FOLLOWING OCCASIONALLY REQUIRED SERVICES MAY ONLY BE PROVIDED BY AN EXTERNAL SERVICE PROVIDER OR THE NURSE OF THE ASSISTED LIVING RESIDENCE:

(A) SYRINGE OR TUBE FEEDING,

(B) INTRAVENOUS MEDICATION,

(C) CATHETER CARE THAT INVOLVES CHANGING THE CATHETER, IRRIGATION OF THE CATHETER AND/OR TOTAL ASSISTANCE WITH CATHETER,

(D) OSTOMY CARE WHERE THE OSTOMY SITE IS NEW OR UNSTABLE, AND

(E) CARE FOR A STAGE 1 OR STAGE 2 PRESSURE SORE IF THE CONDITION IS STABLE AND RESOLVING.

12.4 AN ASSISTED LIVING RESIDENCE SHALL NOT ADMIT OR KEEP A RESIDENT WITH A STAGE 3 OR STAGE 4 PRESSURE SORE UNLESS THE RESIDENT HAS A TERMINAL CONDITION AND IS RECEIVING CONTINUING CARE FROM AN EXTERNAL SERVICE PROVIDER.

PRACTITIONER ASSESSMENT

12.5 THE ASSISTED LIVING RESIDENCE SHALL HAVE A POLICY AND PROCEDURE REGARDING WHEN A PRACTITIONER'S ASSESSMENT OF A RESIDENT IS APPROPRIATE. AT A MINIMUM, THE ASSISTED LIVING RESIDENCE SHALL CONTACT THE RESIDENT'S PRIMARY PRACTITIONER WHEN ANY OF THE FOLLOWING CIRCUMSTANCES OCCUR AND FOLLOW THE PRACTITIONER'S RECOMMENDATION REGARDING FURTHER ACTION.

(A) THE RESIDENT EXPERIENCES A SIGNIFICANT CHANGE IN THEIR BASELINE STATUS,

(B) THE RESIDENT HAS PHYSICAL SIGNS OF POSSIBLE INFECTION (OPEN SORES, ETC.),

(C) THE RESIDENT SUSTAINS AN INJURY OR ACCIDENT,

(D) THE RESIDENT HAS KNOWN EXPOSURE TO A COMMUNICABLE DISEASE, AND/OR

(E) THE RESIDENT DEVELOPS ANY CONDITION WHICH WOULD HAVE INITIALLY PRECLUDED ADMISSION TO THE ASSISTED LIVING RESIDENCE.

COMPREHENSIVE RESIDENT ASSESSMENT

12.6 AT THE TIME A NEW RESIDENT MOVES IN, THE ASSISTED LIVING RESIDENCE SHALL COMPLETE A COMPREHENSIVE ASSESSMENT THAT REFLECTS INFORMATION REQUESTED AND RECEIVED FROM THE RESIDENT, THE RESIDENT'S REPRESENTATIVE IF REQUESTED BY THE RESIDENT, AND A PRACTITIONER. INFORMATION FROM THE COMPREHENSIVE ASSESSMENT SHALL BE USED TO ESTABLISH AN INDIVIDUALIZED CARE PLAN.

12.7 THE COMPREHENSIVE ASSESSMENT SHALL INCLUDE ALL THE FOLLOWING ITEMS:

(A) INFORMATION FROM THE COMPREHENSIVE PRE-ADMISSION ASSESSMENT DESCRIBED IN SECTION 11.1,

(B) INFORMATION REGARDING THE RESIDENT'S OVERALL HEALTH AND PHYSICAL FUNCTIONING ABILITY,

(C) INFORMATION REGARDING THE RESIDENT'S ADVANCE DIRECTIVES,

(D) COMMUNICATION ABILITY AND ANY SPECIFIC NEEDS TO FACILITATE EFFECTIVE COMMUNICATION,

(E) CURRENT DIAGNOSES AND ANY KNOWN OR ANTICIPATED NEED OR IMPACT RELATED TO THE DIAGNOSES,

(F) FOOD AND DINING PREFERENCES, UNIQUE NEEDS AND RESTRICTIONS,

(G) INDIVIDUAL BATHROOM ROUTINES, SLEEP AND AWAKE PATTERNS,

(H) REACTIONS TO THE ENVIRONMENT AND OTHERS, INCLUDING CHANGES THAT MAY OCCUR AT CERTAIN TIMES OR IN CERTAIN CIRCUMSTANCES,

(I) ROUTINES AND INTERESTS,

(J) HISTORY AND CIRCUMSTANCES OF RECENT FALLS AND ANY KNOWN APPROACHES TO PREVENT FUTURE FALLS,

(K) SAFETY AWARENESS,

(L) TYPES OF PHYSICAL, MENTAL AND SOCIAL SUPPORT REQUIRED; AND

(M) PERSONAL BACKGROUND, INCLUDING INFORMATION REGARDING ANY OTHER INDIVIDUALS WHO ARE SUPPORTIVE OF THE RESIDENT, CULTURAL PREFERENCES AND SPIRITUAL NEEDS.

12.8 THE COMPREHENSIVE ASSESSMENT SHALL BE DOCUMENTED IN WRITING AND KEPT IN THE RESIDENT'S HEALTH INFORMATION RECORD.

12.9 THE COMPREHENSIVE ASSESSMENT SHALL BE UPDATED FOR EACH RESIDENT AT LEAST ANNUALLY AND WHENEVER THE RESIDENT'S CONDITION CHANGES FROM BASELINE STATUS.

RESIDENT CARE PLAN

12.10 EACH RESIDENT CARE PLAN SHALL:

(A) BE DEVELOPED WITH INPUT FROM THE RESIDENT AND THE RESIDENT REPRESENTATIVE,

(B) REFLECT THE MOST CURRENT ASSESSMENT INFORMATION,

(C) PROMOTE RESIDENT CHOICE, MOBILITY, INDEPENDENCE AND SAFETY,

(D) DETAIL SPECIFIC PERSONAL SERVICE NEEDS AND PREFERENCES ALONG WITH THE STAFF TASKS NECESSARY TO MEET THOSE NEEDS,

(E) IDENTIFY ALL EXTERNAL SERVICE PROVIDERS ALONG WITH CARE COORDINATION ARRANGEMENTS, AND

(F) IDENTIFY FORMAL, PLANNED, AND INFORMAL SPONTANEOUS ENGAGEMENT OPPORTUNITIES THAT MATCH THE RESIDENT'S PERSONAL CHOICES AND NEEDS.

CARE COORDINATION

12.11 THE ASSISTED LIVING RESIDENCE SHALL BE RESPONSIBLE FOR THE COORDINATION OF RESIDENT CARE SERVICES WITH KNOWN EXTERNAL SERVICE PROVIDERS.

12.12 THE ASSISTED LIVING RESIDENCE SHALL NOTIFY THE RESIDENT'S REPRESENTATIVE WHENEVER THE RESIDENT EXPERIENCES A SIGNIFICANT CHANGE FROM BASELINE STATUS.

RESTRAINT

12.13 AN ASSISTED LIVING RESIDENCE SHALL NOT USE RESTRAINTS OF ANY KIND OR DEPRIVE A RESIDENT OF HIS OR HER LIBERTY FOR PURPOSES OF CARE OR SAFETY EXCEPT AS ALLOWED BY SECTION 11.2(H), SECTION 25, OR AS SET FORTH BELOW.

12.14 A DEVICE THAT FACILITATES A RESIDENT'S WELL-BEING AND/OR INDEPENDENCE MAY BE USED ONLY IF ALL OF THE FOLLOWING CRITERIA ARE MET:

(A) THE RESIDENT HAS THE FUNCTIONAL ABILITY TO ALTER HIS OR HER POSITION;

(B) THE RESIDENT IS ABLE TO REMOVE THE DEVICE TO ALLOW FOR NORMAL MOVEMENT;

(C) THE DEVICE IMPROVES THE RESIDENT'S PHYSICAL OR EMOTIONAL STATE AND ALLOWS THE RESIDENT TO PARTICIPATE IN ACTIVITIES THAT WOULD OTHERWISE BE DIFFICULT OR IMPOSSIBLE; AND

(D) THERE IS AN ORDER FROM A PRACTITIONER FOR ITS USE.

(1) THERE SHALL ALSO BE INTERDISCIPLINARY DOCUMENTATION FROM BOTH THE PRACTITIONER AND A THERAPIST DESCRIBING THE BENEFITS AND HAZARDS ASSOCIATED WITH THE DEVICE AND INFORMATION ON ITS APPROPRIATE USE.

(2) A RESIDENT'S CONTINUED USE OF SUCH DEVICE SHALL BE RE-EVALUATED BY BOTH THERAPIST AND PRACTITIONER AT LEAST ANNUALLY OR WHENEVER THE RESIDENT EXPERIENCES A SIGNIFICANT CHANGE IN STATUS.

(3) DOCUMENTATION OF COMPLIANCE WITH THIS SUBSECTION (D) SHALL BE RETAINED IN THE RESIDENT'S CARE PLAN.

FALL MANAGEMENT PROGRAM

12.15 THE ASSISTED LIVING RESIDENCE SHALL DEVELOP POLICIES AND PROCEDURES TO ESTABLISH A FALL MANAGEMENT PROGRAM. THE PROGRAM SHALL INCLUDE THE FOLLOWING:

(A) PROVIDING FALL MANAGEMENT EDUCATION AND MATERIALS TO RESIDENTS AND FAMILY MEMBERS;

(B) DETAILING IN EACH RESIDENT'S CARE PLAN THE INDIVIDUALIZED APPROACH NECESSARY TO ADDRESS FALL RISK RELATED TO DEFICITS IN STRENGTH, BALANCE AND EYESIGHT, OR EFFECTS OF MEDICATION AS IDENTIFIED DURING THE COMPREHENSIVE RESIDENT ASSESSMENT;

(C) PROVIDING RESIDENT ENGAGEMENT ACTIVITIES TO IMPROVE STRENGTH AND BALANCE AS SPECIFIED IN SECTION 12.22(C);

(D) ROUTINELY INSPECTING AND MAINTAINING A SAFE EXTERIOR AND INTERIOR ENVIRONMENT AS SPECIFIED IN SECTIONS 21 AND 22; AND

(E) PROVIDING STAFF TRAINING RELATED TO FALL PREVENTION AS SPECIFIED IN SECTION 7.9(H).

LIFT ASSISTANCE

12.16 EACH ASSISTED LIVING RESIDENCE SHALL DIRECT STAFF TO ASSIST RESIDENTS WHO HAVE FALLEN OR ARE OTHERWISE UNABLE TO INDEPENDENTLY GET UP OFF THE FLOOR. THE ASSISTED LIVING RESIDENCE'S POLICY ON STAFF PROVIDING LIFT ASSISTANCE SHALL BE MADE AVAILABLE TO ITS LOCAL EMERGENCY MEDICAL RESPONDER.

12.17 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT IT HAS TRAINED STAFF AVAILABLE TO EVALUATE RESIDENTS WHO HAVE FALLEN OR ARE OTHERWISE UNABLE TO INDEPENDENTLY GET UP OFF THE FLOOR AND

PROVIDE LIFT ASSISTANCE WHEN DETERMINED APPROPRIATE INSTEAD OF RELYING ON EMERGENCY MEDICAL RESPONDERS.

(A) EACH SITUATION SHALL BE EVALUATED TO DETERMINE IF THE RESIDENT CAN BE ASSISTED IN A SAFE MANNER SUCH AS WHEN THE RESIDENT HAS NO PAIN AND/OR THERE IS NO CHANGE FROM BASELINE, THE RESIDENT'S MENTAL STATUS IS UNCHANGED FROM BASELINE, AND THERE IS NO OR MINOR BLEEDING.

(B) ONCE THE SITUATION HAS BEEN EVALUATED, ASSISTED LIVING RESIDENCE POLICY SHALL REQUIRE STAFF TO TAKE THE FOLLOWING ACTIONS:

(1) PHYSICALLY PERFORM THE LIFT ASSISTANCE USING TECHNIQUES PROVIDED IN STAFF TRAINING AND MONITOR THE RESIDENT, OR

(2) NOT LIFT AND CALL 9-1-1 WHEN THE RESIDENT IS UNCONSCIOUS, THE RESIDENT'S PHYSICAL OR MENTAL STATUS HAS DECLINED FROM BASELINE, THE RESIDENT EXPERIENCES AN INCREASE IN PAIN WHEN LIFTING IS ATTEMPTED, THE RESIDENT WANTS 9-1-1 CALLED, AND/OR THE RESIDENT EITHER CAN'T ASSIST IN ANY WAY OR REFUSES TO ASSIST BECAUSE OF PAIN, INJURY, OR OTHER PHYSICAL COMPLICATIONS.

(C) THE ASSISTED LIVING RESIDENCE SHALL PROMPTLY NOTIFY THE RESIDENT'S PRACTITIONER, FAMILY AND/OR LEGAL REPRESENTATIVE OF THE OCCURRENCE OF EITHER CIRCUMSTANCE IDENTIFIED IN SECTION 12.17(B)(1) OR (2), ALONG WITH INFORMATION REGARDING THE ALR'S RESPONSE.

12.18 THE ASSISTED LIVING RESIDENCE'S POLICY SHALL ALSO REQUIRE DOCUMENTATION OF THE ACTION TAKEN BY STAFF AND ONGOING EFFORTS TO PREVENT A REOCCURRENCE OF THE SITUATION IN THE FUTURE.

RESIDENT ENGAGEMENT

12.19 THE ASSISTED LIVING RESIDENCE SHALL ENCOURAGE RESIDENTS TO MAINTAIN AND DEVELOP THEIR FULLEST POTENTIAL FOR INDEPENDENT LIVING THROUGH INDIVIDUAL AND GROUP ENGAGEMENT OPPORTUNITIES.

12.20 THE ASSISTED LIVING RESIDENCE SHALL PROVIDE ALL RESIDENTS WITH REGULAR OPPORTUNITIES TO PARTICIPATE IN STRUCTURED ENGAGEMENT AND SHALL SUPPORT THE PURSUIT OF EACH RESIDENT'S INTERESTS.

12.21 IF REQUESTED, THE ASSISTED LIVING RESIDENCE SHALL ASSIST A RESIDENT WITH IDENTIFYING AND ACCESSING OUTSIDE SERVICES AND COMMUNITY EVENTS.

12.22 EXAMPLES OF RESIDENT ENGAGEMENT INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING:

(A) INDIVIDUAL OR GROUP CONVERSATION, RECREATION, ART, CRAFTS, MUSIC AND PET CARE;

(B) USE OF DAILY LIVING SKILLS THAT FOSTER AND MAINTAIN A SENSE OF PURPOSE AND SIGNIFICANCE;

(C) PHYSICAL PURSUITS SUCH AS GAMES, SPORTS AND EXERCISE THAT DEVELOP AND MAINTAIN STRENGTH, COORDINATION AND RANGE OF MOTION;

(D) EDUCATIONAL OPPORTUNITIES SUCH AS SPECIAL CLASSES OR COMMUNITY EVENTS;

(E) CULTIVATION OF PERSONAL INTERESTS AND PURSUITS; AND

(F) ENCOURAGING ENGAGEMENT WITH OTHERS.

12.23 THE ASSISTED LIVING RESIDENCE SHALL ENCOURAGE RESIDENTS TO CONTRIBUTE TO THE PLANNING, PREPARATION, CONDUCT, CLEAN-UP AND CRITIQUE OF ANY STRUCTURED ENGAGEMENT OFFERING.

12.24 THE ASSISTED LIVING RESIDENCE SHALL EVALUATE ITS RESIDENT ENGAGEMENT PROGRAM AT LEAST EVERY THREE MONTHS TO ASCERTAIN WHETHER THE OPPORTUNITIES OFFERED TO RESIDENTS ARE RELEVANT AND WELL-RECEIVED AND/OR IF CHANGES ARE APPROPRIATE IN RESPONSE TO RESIDENT FEED-BACK.

12.25 THE ASSISTED LIVING RESIDENCE SHALL, WHENEVER FEASIBLE, COORDINATE WITH LOCAL AGENCIES AND VOLUNTEER ORGANIZATIONS TO PROMOTE RESIDENT PARTICIPATION IN COMMUNITY CENTERED ACTIVITIES INCLUDING, BUT NOT LIMITED TO:

(A) PUBLIC SERVICE ENDEAVORS;

(B) COMMUNITY EVENTS SUCH AS CONCERTS, EXHIBITS AND PLAYS;

(C) COMMUNITY ORGANIZED GROUP ENGAGEMENT SUCH AS SENIOR CITIZEN GROUPS, SPORTS LEAGUES AND SERVICE CLUBS; AND

(D) ATTENDANCE AT THE PLACE OF WORSHIP OF THE RESIDENT'S CHOICE.

12.26 EACH ASSISTED LIVING RESIDENCE SHALL PLACE NOTICES OF PLANNED RESIDENT ENGAGEMENT OFFERINGS IN A CENTRAL LOCATION READILY ACCESSIBLE TO RESIDENTS, RELATIVES AND THE PUBLIC. COPIES SHALL BE RETAINED FOR AT LEAST SIX MONTHS.

RESIDENT ENGAGEMENT MANAGEMENT

19 OR FEWER RESIDENTS

12.27 IN ASSISTED LIVING RESIDENCES THAT ARE LICENSED FOR 19 OR FEWER RESIDENTS, THE ADMINISTRATOR SHALL BE PRIMARILY RESPONSIBLE FOR ORGANIZING, CONDUCTING AND EVALUATING RESIDENT ENGAGEMENT. IF AN ASSISTED LIVING RESIDENCE CAN DEMONSTRATE THAT ITS RESIDENTS ARE SELF-DIRECTED TO THE EXTENT THAT THEY ARE ABLE TO PLAN, ORGANIZE AND CONDUCT THE ALR'S RESIDENT ENGAGEMENT ACTIVITIES THEMSELVES, THE ALR MAY REQUEST A WAIVER OF THIS REQUIREMENT.

20 TO 49 RESIDENTS

12.28 IN ASSISTED LIVING RESIDENCES THAT ARE LICENSED FOR 20 TO 49 RESIDENTS, THE ADMINISTRATOR SHALL DESIGNATE ONE STAFF MEMBER TO BE RESPONSIBLE FOR ORGANIZING, CONDUCTING AND EVALUATING RESIDENT ENGAGEMENT. THE DESIGNATED STAFF MEMBER SHALL HAVE HAD AT LEAST SIX MONTHS EXPERIENCE IN PROVIDING STRUCTURED RESIDENT ENGAGEMENT OFFERINGS OR HAVE COMPLETED OR BE ENROLLED IN AN EQUIVALENT EDUCATION AND/OR TRAINING PROGRAM.

50 OR MORE RESIDENTS

12.29 IN ASSISTED LIVING RESIDENCES THAT ARE LICENSED FOR 50 OR MORE RESIDENTS, THERE SHALL BE AT LEAST ONE STAFF MEMBER WHOSE SOLE RESPONSIBILITY IS TO ORGANIZE, CONDUCT AND EVALUATE RESIDENT ENGAGEMENT. THE ALR SHALL PROVIDE SUCH STAFF MEMBER WITH AS MUCH ACCOMMODATION AND STAFF SUPPORT AS NECESSARY TO ENSURE THAT ALL RESIDENTS HAVE ON-GOING OPPORTUNITIES TO PARTICIPATE IN PLANNED IN ADVANCE, DOCUMENTED IN WRITING, KEPT UP TO DATE AND MADE AVAILABLE TO ALL RESIDENTS. THE RESPONSIBLE STAFF MEMBER SHALL HAVE HAD AT LEAST ONE YEAR OF EXPERIENCE OR EQUIVALENT EDUCATION AND/OR TRAINING IN PROVIDING STRUCTURED RESIDENT ENGAGEMENT OFFERINGS AND BE KNOWLEDGEABLE IN EVALUATING RESIDENT NEEDS, SUPERVISING OTHER STAFF AND IN TRAINING VOLUNTEERS.

USE OF VOLUNTEERS

12.30 EACH ASSISTED LIVING RESIDENCE SHALL ENCOURAGE PARTICIPATION OF VOLUNTEERS IN RESIDENT ENGAGEMENT OPPORTUNITIES. ALL SUCH VOLUNTEERS SHALL BE SUPERVISED AND DIRECTED BY THE ADMINISTRATOR OR STAFF MEMBER PRIMARILY RESPONSIBLE FOR RESIDENT ENGAGEMENT.

PHYSICAL SPACE AND EQUIPMENT:

12.31 EACH ASSISTED LIVING RESIDENCE SHALL HAVE SUFFICIENT PHYSICAL SPACE TO ACCOMMODATE BOTH INDOOR AND OUTDOOR RESIDENT ENGAGEMENT. SUCH ACCOMMODATIONS SHALL INCLUDE, AT A MINIMUM:

(A) A COMFORTABLE, APPROPRIATELY FURNISHED AREA SUCH AS A LIVING ROOM, FAMILY ROOM OR GREAT ROOM AVAILABLE TO ALL RESIDENTS FOR THEIR RELAXATION AND FOR SOCIALIZING WITH FRIENDS AND RELATIVES; AND

(B) AN OUTDOOR ACTIVITY AREA WHICH IS EASILY ACCESSIBLE TO RESIDENTS AND PROTECTED FROM TRAFFIC. OUTDOOR SPACES SHALL BE SUFFICIENT IN SIZE TO COMFORTABLY ACCOMMODATE ALL RESIDENTS PARTICIPATING IN AN ACTIVITY.

12.32 EACH ASSISTED LIVING RESIDENCE SHALL PROVIDE SUFFICIENT RECREATIONAL EQUIPMENT AND SUPPLIES TO MEET THE NEEDS OF THE RESIDENT ENGAGEMENT PROGRAM. SPECIAL EQUIPMENT AND SUPPLIES NECESSARY TO ACCOMMODATE PERSONS WITH SPECIAL NEEDS SHALL BE MADE AVAILABLE AS APPROPRIATE. WHEN NOT IN USE, RECREATIONAL EQUIPMENT AND SUPPLIES SHALL BE STORED IN SUCH A WAY THAT THEY DO NOT CREATE A SAFETY HAZARD.

12.33 EACH ASSISTED LIVING RESIDENCE SHALL ENSURE THAT STAFF WHO ACCOMPANY RESIDENTS AWAY FROM THE ASSISTED LIVING RESIDENCE HAVE READY ACCESS TO THE PERTINENT PERSONAL INFORMATION OF THOSE RESIDENTS IN THE EVENT OF AN EMERGENCY.

SECTION 13 - RESIDENT RIGHTS

13.1 THE ASSISTED LIVING RESIDENCE SHALL ADOPT, AND PLACE IN A PUBLICALLY VISIBLE LOCATION, A STATEMENT REGARDING THE RIGHTS AND RESPONSIBILITIES OF ITS RESIDENTS. THE ASSISTED LIVING RESIDENCE AND STAFF SHALL OBSERVE THESE RIGHTS IN THE CARE, TREATMENT AND OVERSIGHT OF THE RESIDENTS. THE STATEMENT OF RIGHTS SHALL INCLUDE, AT A MINIMUM, THE FOLLOWING ITEMS:

(A) THE RIGHT TO PRIVACY AND CONFIDENTIALITY, INCLUDING

(1) THE RIGHT TO HAVE PRIVATE AND UNRESTRICTED COMMUNICATIONS WITH ANY PERSON OF CHOICE;

(2) THE RIGHT TO PRIVATE TELEPHONE CALLS OR USE OF ELECTRONIC COMMUNICATION;

(3) THE RIGHT TO RECEIVE MAIL UNOPENED;

(4) THE RIGHT TO HAVE VISITORS AT ANY TIME; AND

(5) THE RIGHT TO PRIVATE, CONSENSUAL SEXUAL ACTIVITY.

(B) THE RIGHT TO CIVIL AND RELIGIOUS LIBERTIES, INCLUDING

(1) THE RIGHT TO BE TREATED WITH DIGNITY AND RESPECT;

(2) THE RIGHT TO BE FREE FROM SEXUAL, VERBAL, PHYSICAL OR EMOTIONAL ABUSE, HUMILIATION, INTIMIDATION, OR PUNISHMENT;

(3) THE RIGHT TO BE FREE FROM NEGLECT;

(4) THE RIGHT TO LIVE FREE FROM FINANCIAL EXPLOITATION, RESTRAINT AS DEFINED IN THIS CHAPTER, AND INVOLUNTARY CONFINEMENT EXCEPT AS ALLOWED BY THE SECURE ENVIRONMENT REQUIREMENTS OF THIS CHAPTER;

(5) THE RIGHT TO VOTE;

(6) THE RIGHT TO EXERCISE CHOICE IN ATTENDING AND PARTICIPATING IN RELIGIOUS ACTIVITIES;

(7) THE RIGHT TO WEAR CLOTHING OF CHOICE UNLESS OTHERWISE INDICATED IN THE CARE PLAN; AND

(8) THE RIGHT TO CARE AND SERVICES THAT ARE NOT CONDITIONED OR LIMITED BECAUSE OF A RESIDENT'S DISABILITY, SEXUAL ORIENTATION, ETHNICITY, AND/OR PERSONAL PREFERENCES.

(C) THE RIGHT TO PERSONAL AND COMMUNITY ENGAGEMENT, INCLUDING

(1) THE RIGHT TO SOCIALIZE WITH OTHER RESIDENTS AND PARTICIPATE IN ASSISTED LIVING RESIDENCE ACTIVITIES, IN ACCORDANCE WITH THE APPLICABLE CARE PLAN;

(2) THE RIGHT TO FULL USE OF THE ASSISTED LIVING RESIDENCE COMMON AREAS IN COMPLIANCE WITH WRITTEN HOUSE RULES;

(3) THE RIGHT TO PARTICIPATE IN RESIDENT MEETINGS, VOICE GRIEVANCES AND RECOMMEND CHANGES IN POLICIES AND SERVICES WITHOUT FEAR OF REPRISAL;

(4) THE RIGHT TO PARTICIPATE IN ACTIVITIES OUTSIDE THE ASSISTED LIVING RESIDENCE AND REQUEST ASSISTANCE WITH TRANSPORTATION; AND

(5) THE RIGHT TO USE OF THE TELEPHONE INCLUDING ACCESS TO OPERATOR ASSISTANCE FOR PLACING COLLECT TELEPHONE CALLS.

(A) AT LEAST ONE TELEPHONE ACCESSIBLE TO RESIDENTS UTILIZING AN AUXILIARY AID SHALL BE AVAILABLE IF THE ASSISTED LIVING RESIDENCE IS OCCUPIED BY ONE OR MORE RESIDENTS UTILIZING SUCH AN AID.

(D) THE RIGHT TO CHOICE AND PERSONAL INVOLVEMENT REGARDING CARE AND SERVICES, INCLUDING

(1) THE RIGHT TO BE INFORMED AND PARTICIPATE IN DECISION MAKING REGARDING CARE AND SERVICES, IN COORDINATION WITH FAMILY MEMBERS WHO MAY HAVE DIFFERENT OPINIONS;

(2) THE RIGHT TO BE INFORMED ABOUT AND FORMULATE ADVANCE DIRECTIVES;

(3) THE RIGHT TO FREEDOM OF CHOICE IN SELECTING A HEALTH CARE SERVICE OR PROVIDER;

(4) THE RIGHT TO EXPECT THE COOPERATION OF THE ASSISTED LIVING RESIDENCE IN ACHIEVING THE MAXIMUM DEGREE OF BENEFIT FROM THOSE SERVICES WHICH ARE MADE AVAILABLE BY THE ASSISTED LIVING RESIDENCE;

(A) FOR RESIDENTS WITH LIMITED ENGLISH PROFICIENCY OR IMPAIRMENTS THAT INHIBIT COMMUNICATION, THE ASSISTED LIVING RESIDENCE SHALL FIND A WAY TO FACILITATE COMMUNICATION OF CARE NEEDS.

(5) THE RIGHT TO MAKE DECISIONS AND CHOICES IN THE MANAGEMENT OF PERSONAL AFFAIRS, FUNDS AND PROPERTY IN ACCORDANCE WITH RESIDENT ABILITY;

(6) THE RIGHT TO REFUSE TO PERFORM TASKS REQUESTED BY THE ASSISTED LIVING RESIDENCE OR STAFF IN EXCHANGE FOR ROOM, BOARD, OTHER GOODS OR SERVICES;

(7) THE RIGHT TO HAVE ADVOCATES, INCLUDING MEMBERS OF COMMUNITY ORGANIZATIONS WHOSE PURPOSES INCLUDE RENDERING ASSISTANCE TO THE RESIDENTS;

(8) THE RIGHT TO RECEIVE SERVICES IN ACCORDANCE WITH THE RESIDENT AGREEMENT AND THE CARE PLAN; AND

(9) THE RIGHT TO 30 CALENDAR DAYS WRITTEN NOTICE OF CHANGES IN SERVICES PROVIDED BY THE ASSISTED LIVING RESIDENCE INCLUDING, BUT NOT LIMITED TO, INVOLUNTARILY CHANGE OF ROOM OR CHANGES IN CHARGES FOR A SERVICE. EXCEPTIONS TO THIS NOTICE ARE:

(A) CHANGES IN THE RESIDENT'S MEDICAL ACUITY THAT RESULT IN A DOCUMENTED DECLINE IN CONDITION AND THAT CONSTITUTE AN INCREASE IN CARE NECESSARY TO PROTECT THE HEALTH AND SAFETY OF THE RESIDENT; AND

(B) REQUESTS BY THE RESIDENT OR THE FAMILY FOR ADDITIONAL SERVICES TO BE ADDED TO THE CARE PLAN.

OMBUDSMAN ACCESS

13.2 IN ACCORDANCE WITH THE OLDER AMERICANS ACT REAUTHORIZATION ACT OF 2016 (P.L. 114-144), AND §§26-11.5-108 AND 25-27-104(2)(e), C.R.S., AN ASSISTED LIVING RESIDENCE SHALL PERMIT ACCESS TO THE PREMISES AND RESIDENTS BY THE STATE OMBUDSMAN AND THE DESIGNATED LOCAL LONG-TERM CARE OMBUDSMAN AT ANY TIME DURING AN ALR'S REGULAR BUSINESS HOURS OR REGULAR VISITING HOURS, AND AT ANY OTHER TIME WHEN ACCESS MAY BE REQUIRED BY THE CIRCUMSTANCES TO BE INVESTIGATED.

HOUSE RULES

13.3 THE ASSISTED LIVING RESIDENCE SHALL ESTABLISH WRITTEN HOUSE RULES AND PLACE THEM IN A PUBLICALLY VISIBLE LOCATION SO THAT THEY ARE ALWAYS AVAILABLE TO RESIDENTS AND VISITORS.

13.4 THE HOUSE RULES SHALL LIST ALL POSSIBLE ACTIONS WHICH MAY BE TAKEN BY THE ASSISTED LIVING RESIDENCE IF ANY RULE IS KNOWINGLY VIOLATED BY A RESIDENT. HOUSE RULES SHALL NOT SUPERSEDE OR CONTRADICT ANY REGULATION HEREIN, OR IN ANY WAY DISCOURAGE OR HINDER A RESIDENT'S EXERCISE OF HIS OR HER RIGHTS. HOUSE RULES SHALL ADDRESS, AT A MINIMUM, THE FOLLOWING ITEMS:

(A) SMOKING INCLUDING THE USE OF ELECTRONIC CIGARETTES AND VAPORIZERS,

(B) COOKING,

(C) PROTECTION OF VALUABLES ON PREMISES,

(D) VISITORS,

(E) TELEPHONE USAGE INCLUDING FREQUENCY AND DURATION OF CALLS,

(F) USE OF COMMON AREAS AND DEVICES SUCH AS TELEVISION, RADIO AND COMPUTER,

(G) CONSUMPTION OF ALCOHOL AND MARIJUANA, AND

(H) PETS.

RESIDENT MEETINGS

13.5 EACH ASSISTED LIVING RESIDENCE SHALL HOLD REGULAR MEETINGS WITH RESIDENTS, STAFF, FAMILY AND FRIENDS OF RESIDENTS SO THAT ALL HAVE THE OPPORTUNITY TO VOICE CONCERNS AND MAKE RECOMMENDATIONS CONCERNING ASSISTED LIVING RESIDENCE CARE, SERVICES, ACTIVITIES, POLICIES AND PROCEDURES.

13.6 MEETINGS SHALL BE HELD AT LEAST QUARTERLY WITH AN OPPORTUNITY FOR MORE FREQUENT MEETINGS IF REQUESTED.

13.7 WRITTEN MINUTES OF SUCH MEETINGS SHALL BE MAINTAINED AND MADE READILY AVAILABLE FOR REVIEW BY RESIDENTS OR FAMILY MEMBERS.

13.8 BEFORE THE NEXT REGULARLY SCHEDULED MEETING, ASSISTED LIVING RESIDENCE STAFF SHALL RESPOND IN WRITING TO ANY SUGGESTIONS OR ISSUES RAISED AT THE PRIOR MEETING.

13.9 RESIDENTS AND FAMILY MEMBERS SHALL ALSO HAVE THE OPPORTUNITY TO MEET WITHOUT THE PRESENCE OF ASSISTED LIVING RESIDENCE STAFF.

INTERNAL GRIEVANCE AND COMPLAINT RESOLUTION PROCESS

13.10 EACH ASSISTED LIVING RESIDENCE SHALL DEVELOP AND IMPLEMENT AN INTERNAL PROCESS TO ENSURE THE ROUTINE AND PROMPT HANDLING OF GRIEVANCES OR COMPLAINTS BROUGHT BY RESIDENTS, FAMILY MEMBERS OR ADVOCATES. THE PROCESS FOR RAISING AND ADDRESSING GRIEVANCES AND COMPLAINTS SHALL BE PLACED IN A VISIBLE ON-SITE LOCATION ALONG WITH FULL CONTACT INFORMATION FOR THE FOLLOWING AGENCIES.

(A) THE STATE AND LOCAL LONG-TERM CARE OMBUDSMAN,

(B) THE ADULT PROTECTION SERVICES OF THE APPROPRIATE COUNTY DEPARTMENT OF SOCIAL SERVICES,

(C) THE ADVOCACY SERVICES OF THE AREA'S AGENCY ON AGING,

(D) THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, AND

(E) THE COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING IN THOSE CASES WHERE THE ASSISTED LIVING RESIDENCE IS LICENSED TO PROVIDE SERVICES SPECIFICALLY FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES.

INVESTIGATION OF ABUSE AND NEGLECT ALLEGATIONS

13.11 THE ASSISTED LIVING RESIDENCE SHALL INVESTIGATE ALL ALLEGATIONS OF ABUSE, NEGLECT OR EXPLOITATION OF RESIDENTS IN ACCORDANCE WITH SECTION 5 AND ITS WRITTEN POLICY WHICH SHALL INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING:

(A) REPORTING REQUIREMENTS TO THE APPROPRIATE AGENCIES SUCH AS THE ADULT PROTECTION SERVICES OF THE APPROPRIATE COUNTY DEPARTMENT OF SOCIAL SERVICES AND TO THE ASSISTED LIVING RESIDENCE ADMINISTRATOR,

(B) A REQUIREMENT THAT THE ASSISTED LIVING RESIDENCE NOTIFY THE LEGAL REPRESENTATIVE ABOUT THE ALLEGATION WITHIN 24 HOURS OF THE ASSISTED LIVING RESIDENCE BECOMING AWARE OF THE ALLEGATION,

(C) THE PROCESS FOR INVESTIGATING SUCH ALLEGATIONS,

(D) How the assisted living residence will document the investigation process to evidence the required reporting and that a thorough investigation was conducted,

(E) A requirement that the resident shall be protected from potential future abuse and neglect while the investigation is being conducted,

(F) A requirement that if the alleged neglect or abuse is verified, the assisted living residence shall take appropriate corrective action, and

(G) A requirement that a copy of the report with the investigation findings shall be retained by the facility and available for Department review.

SECTION 14 – MEDICATION AND MEDICATION ADMINISTRATION

General Requirements:

14.1 An assisted living residence shall not allow an employee or volunteer to administer or assist with administering medication to a resident unless such individual is a practitioner, a nurse, a qualified medication administration person (QMAP) or a certified nurse medication aide (CNA – Med) acting within his or her scope of practice.

14.2 For purposes of this section 14, a practitioner is "authorized" if state law allows the practitioner to prescribe treatment, medication or medical devices.

14.3 An assisted living residence shall not allow a QMAP or a CNA-Med to assist a resident with medication administration unless the resident is able to consent and participate in the consumption of the medication.

14.4 If a CNA-Med is used to administer or assist with administering medication to a resident, the assisted living residence shall ensure that the CNA-Med complies with the medication administration procedures listed in this section 14, except that a CNA-Med may perform additional tasks associated with medication administration as authorized by his or her certification.

14.5 An assisted living residence that utilizes qualified medication administration persons shall comply with the requirements of 6 CCR 1011-1, Chapter 24, Medication Administration Regulations, in addition to the requirements set forth in this section 14.

14.6 The assisted living residence shall comply with all federal and state laws and regulations relating to procurement, storage, administration and disposal of controlled substances.

14.7 The assisted living residence shall ensure that each resident receives proper administration and/or monitoring of medications.

14.8 The assisted living residence shall be responsible for ensuring compliance with all safety requirements regarding oxygen use, handling and storage as set forth in sections 22.29 through 22.34 of this chapter.

14.9 No medication shall be administered by a qualified medication administration person on a pro re nata (PRN) or "as needed" basis except:

(A) In a residential treatment facility that is licensed to provide services for the mentally ill;

(B) WHERE THE RESIDENT UNDERSTANDS THE PURPOSE OF THE MEDICATION, IS CAPABLE OF VOLUNTARILY REQUESTING THE MEDICATION, AND THE ASSISTED LIVING RESIDENCE HAS DOCUMENTATION FROM AN AUTHORIZED PRACTITIONER THAT THE USE OF SUCH MEDICATION IN THIS MANNER IS APPROPRIATE; OR

(C) WHERE SPECIFICALLY ALLOWED BY STATUTE.

14.10 UNLESS OTHERWISE ALLOWED BY STATUTE, THE ASSISTED LIVING RESIDENCE SHALL NOT PERMIT A QUALIFIED MEDICATION ADMINISTRATION PERSON TO PERFORM ANY OF THE FOLLOWING TASKS:

(A) INTRAVENOUS, INTRAMUSCULAR OR SUBCUTANEOUS INJECTIONS,

(B) GASTROSTOMY OR JEJUNOSTOMY TUBE FEEDING,

(C) CHEMICAL DEBRIDEMENT,

(D) ADMINISTRATION OF MEDICATION FOR PURPOSES OF RESTRAINT,

(E) TITRATION OF OXYGEN,

(F) DECISION MAKING REGARDING PRN OR "AS NEEDED" MEDICATION ADMINISTRATION,

(G) ASSESSMENT OF RESIDENTS OR USE OF JUDGMENT INCLUDING, BUT NOT LIMITED TO, MEDICATION EFFECT,

(H) PRE-POURING OF MEDICATION, OR

(I) MASKING OR DECEIVING ADMINISTRATION OF MEDICATION INCLUDING, BUT NOT LIMITED TO, CONCEALING IN FOOD OR LIQUID.

14.11 ONLY MEDICATION THAT HAS BEEN ORDERED BY AN AUTHORIZED PRACTITIONER SHALL BE PREPARED FOR OR ADMINISTERED TO RESIDENTS.

TRAINING, COMPETENCY AND SUPERVISION

14.11 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT ALL QUALIFIED MEDICATION ADMINISTRATION PERSONS ARE TRAINED IN AND ADHERE TO THE FOLLOWING MEDICATION ADMINISTRATION PROCEDURES:

(A) IDENTIFICATION OF THE RIGHT RESIDENT FOR EACH MEDICATION ADMINISTRATION OR MONITORING BY ASKING FOR THE RESIDENT'S NAME OR COMPARING THE RESIDENT TO A PHOTOGRAPH MAINTAINED SPECIFICALLY FOR MEDICATION ADMINISTRATION IDENTIFICATION,

(B) PROVIDING THE CORRECT MEDICATION BY THE CORRECT ROUTE AT THE CORRECT TIME AND IN THE CORRECT DOSE AS ORDERED BY THE AUTHORIZED PRACTITIONER, AND

(C) IMPLEMENTING ANY CHANGES IN MEDICATION ORDERS UPON RECEIPT.

14.12 THE ASSISTED LIVING RESIDENCE SHALL DESIGNATE A QMAP SUPERVISOR WHO IS A NURSE, PRACTITIONER OR MEETS THE REQUIREMENTS OF A QUALIFIED MEDICATION ADMINISTRATION PERSON.

(A) THE QMAP SUPERVISOR SHALL, BEFORE INITIAL ASSIGNMENT OF EACH QUALIFIED MEDICATION ADMINISTRATION PERSON, CONDUCT A COMPETENCY ASSESSMENT WITH DIRECT OBSERVATION OF ALL MEDICATION ADMINISTRATION TASKS THAT THE QMAP WILL BE ASSIGNED TO PERFORM.

(1) Whenever a QMAP is assigned additional medication administration tasks, the QMAP supervisor shall conduct a competency assessment with direct observation of each new task that the QMAP will be assigned.

Resident Rights

14.13 All personal medication is the property of the resident and no resident shall be required to surrender the right to possess or self-administer any personal medication unless an authorized practitioner has determined that the resident lacks the decisional capacity to possess or self-administer such medication safely.

14.14 The assisted living residence shall ensure each resident's right to privacy and dignity with respect to medication monitoring and administration.

14.15 Each resident shall have the right to refuse medications.

Orders

14.16 The assisted living residence shall ensure that each authorized practitioner's order for medication includes the correct name of the resident, date of the order, medication name, strength of medication, dosage to administer, route of administration along with timing and/or frequency of administration, any specific considerations, if substitutions are allowed or restricted, and the signature of the practitioner.

14.17 All medication orders shall be documented in writing by the authorized prescribing practitioner. Verbal orders for medication shall not be valid unless received by a licensed staff member who is authorized to receive and transcribe such orders.

14.18 Any orders received from medical staff on behalf of an authorized practitioner must be countersigned by said practitioner as soon as possible.

14.19 The assisted living residence shall contact the authorized practitioner for clarification of any orders which are incomplete or unclear and obtain new orders in writing.

14.20 The assisted living residence shall be responsible for complying with authorized practitioner orders associated with medication administration except for those medications which a resident self-administers.

14.20 The assisted living residence shall coordinate care and medication administration with external providers.

Medication Reminder Boxes

14.21 For medication reminder boxes that the assisted living residence is responsible for, the assisted living residence shall ensure that the box contains:

(A) No more than a 14 calendar day supply of medications at a time,

(B) No PRN medications including PRN controlled substances,

(C) Only medication intended for oral ingestion, and

(D) No medications that require administration within specific timeframes unless the medication reminder box is specifically designed and labeled with specific instructions to address this situation.

14.22 MEDICATION REMINDER BOXES SHALL BE STORED IN A MANNER THAT ENSURES ACCESS FOR THE DESIGNATED RESIDENT AND PREVENTS ACCESS FROM UNAUTHORIZED PERSONS.

MEDICATION PREPARATION AND HANDLING

14.23 THE ASSISTED LIVING RESIDENCE SHALL MAINTAIN MEDICATION STORAGE AND PREPARATION AREAS WHICH ARE CLEAN AND FREE OF CLUTTER.

14.24 ALL REUSABLE MEDICAL DEVICES SHALL BE CLEANED ACCORDING TO THE MANUFACTURER INSTRUCTIONS AND APPROPRIATELY STORED.

14.25 NO STOCK MEDICATIONS SHALL BE STORED OR ADMINISTERED BY QUALIFIED MEDICATION ADMINISTRATION PERSONS.

(A) ALL OVER-THE-COUNTER MEDICATION PRESCRIBED FOR ADMINISTRATION SHALL BE LABELED OR MARKED WITH THE INDIVIDUAL RESIDENT'S FULL NAME.

14.26 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT QUALIFIED MEDICATION ADMINISTRATION PERSONS ARE TRAINED IN AND APPLY NATIONALLY RECOGNIZED PROTOCOLS FOR BASIC INFECTION CONTROL AND PREVENTION WHEN PREPARING AND ADMINISTERING MEDICATIONS.

RECORD KEEPING

14.27 ALL PRESCRIBED AND PRN MEDICATIONS SHALL BE LISTED AND RECORDED ON A MEDICATION ADMINISTRATION RECORD (MAR) WHICH CONTAINS THE NAME AND DATE OF BIRTH OF THE RESIDENT, THE RESIDENT'S ROOM LOCATION, ANY KNOWN ALLERGIES, AND THE NAME AND TELEPHONE NUMBER OF THE RESIDENT'S AUTHORIZED PRACTITIONER.

(A) THE MEDICATION ADMINISTRATION RECORD SHALL REFLECT THE NAME, STRENGTH, DOSAGE AND MODE OF ADMINISTRATION OF EACH MEDICATION, THE DATE THE ORDER WAS RECEIVED, THE DATE AND TIME OF ADMINISTRATION, ANY SPECIAL CONSIDERATIONS RELATED TO ADMINISTRATION AND THE SIGNATURE OR INITIAL OF THE PERSON ADMINISTERING THE MEDICATION.

(B) AS PART OF THE MEDICATION ADMINISTRATION RECORD, THE ASSISTED LIVING RESIDENCE SHALL MAINTAIN A LEGIBLE LIST OF THE NAMES OF THE PERSONS UTILIZING THE RECORD FOR MEDICATION ADMINISTRATION, ALONG WITH EACH OF THEIR SIGNATURES AND, IF USED, THEIR INITIALS.

(C) EACH QUALIFIED MEDICATION ADMINISTRATION PERSON, NURSE OR PRACTITIONER SHALL ACCURATELY DOCUMENT EACH MEDICATION ADMINISTRATION OR MONITORING EVENT AT THE TIME THE EVENT IS COMPLETED FOR EACH RESIDENT.

(D) EACH QUALIFIED MEDICATION ADMINISTRATION PERSON, NURSE OR AUTHORIZED PRACTITIONER SHALL DOCUMENT ACCURATE INFORMATION IN THE MEDICATION ADMINISTRATION RECORD INCLUDING ANY MEDICATION OMISSIONS, REFUSALS AND RESIDENT REPORTED RESPONSES TO MEDICATIONS.

14.28 THE ASSISTED LIVING RESIDENCE SHALL MAINTAIN A RECORD ON A SEPARATE SHEET FOR EACH RESIDENT RECEIVING A CONTROLLED SUBSTANCE WHICH CONTAINS THE NAME OF THE CONTROLLED SUBSTANCE, STRENGTH AND DOSAGE, DATE AND TIME ADMINISTERED, RESIDENT NAME, NAME OF AUTHORIZED PRACTITIONER AND THE QUANTITY OF THE CONTROLLED SUBSTANCE REMAINING.

14.29 THE ADMINISTRATOR AND THE QMAP SUPERVISOR SHALL, ON A QUARTERLY BASIS, AUDIT THE ACCURACY AND COMPLETENESS OF THE MEDICATION ADMINISTRATION RECORDS, CONTROLLED SUBSTANCE LIST, MEDICATION ERROR REPORTS AND MEDICATION DISPOSAL RECORDS. ANY IRREGULARITIES SHALL BE INVESTIGATED AND RESOLVED. THE RESULTS OF THE AUDITS SHALL BE DOCUMENTED AND ROUTINELY INCLUDED AS PART OF THE ASSISTED LIVING RESIDENCE'S QUALITY MANAGEMENT PROGRAM ASSESSMENT AND REVIEW.

REPORTING

14.30 THE ASSISTED LIVING RESIDENCE SHALL HAVE POLICIES AND PROCEDURES FOR DOCUMENTING, INVESTIGATING, REPORTING AND RESPONDING TO ANY ERRORS RELATED TO ACCURATE ACCOUNTING OF CONTROLLED SUBSTANCES AND /OR MEDICATION ADMINISTRATION.

14.31 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT THE RESIDENT'S AUTHORIZED PRACTITIONER AND RESIDENT'S LEGAL REPRESENTATIVE IS PROMPTLY NOTIFIED OF:

(A) A DECLINE FROM A RESIDENT'S BASELINE STATUS,

(B) A RESIDENT'S PATTERN OF REFUSAL,

(C) A RESIDENT'S REPETITIVE REQUEST FOR AND USE OF PRN MEDICATION,

(D) ANY OBSERVED OR REPORTED UNFAVORABLE REACTIONS TO MEDICATIONS,

(E) THE ADMINISTRATION OF MEDICATIONS USED TO EMERGENTLY TREAT ANGINA, AND

(F) MEDICATION ERRORS THAT AFFECT THE RESIDENT.

SELF-ADMINISTRATION

14.32 THE ASSISTED LIVING RESIDENCE SHALL COMPILE A LIST OF ALL RESIDENT MEDICATIONS ALONG WITH ANY KNOWN ALLERGIES AND VERIFY THE ACCURACY AND COMPLETENESS OF THE LIST WITH THE RESIDENT AND AUTHORIZED PRACTITIONER AT THE TIME OF ADMISSION.

14.33 THE ASSISTED LIVING RESIDENCE SHALL REVIEW THIS LIST WITH THE RESIDENT AND AUTHORIZED PRACTITIONER AT LEAST ONCE A YEAR AND MAINTAIN DOCUMENTATION OF SUCH REVIEW.

14.34 THE ASSISTED LIVING RESIDENCE SHALL REPORT NON-COMPLIANCE, MISUSE OR INAPPROPRIATE USE OF KNOWN MEDICATIONS BY A RESIDENT WHO IS SELF-ADMINISTERING TO THAT RESIDENT'S AUTHORIZED PRACTITIONER.

MEDICATION STORAGE

14.35 ALL MEDICATIONS SHALL BE STORED IN THE ORIGINAL PRESCRIBED/MANUFACTURER CONTAINERS WITH THE EXCEPTION OF MEDICATIONS PLACED IN MEDICATION REMINDER BOXES PURSUANT TO SECTION 14.21

14.36 ALL MEDICATIONS SHALL BE STORED IN A LOCKED CABINET, CART OR STORAGE AREA WHEN UNATTENDED BY QUALIFIED MEDICATION ADMINISTRATION PERSONS OR OTHER LICENSED STAFF.

14.37 CONTROLLED SUBSTANCES SHALL BE KEPT IN DOUBLE LOCK STORAGE.

(A) TWO INDIVIDUALS WHO ARE EITHER QUALIFIED MEDICATION ADMINISTRATION PERSONS, NURSES, OR PRACTITIONERS SHALL JOINTLY COUNT ALL CONTROLLED SUBSTANCES AT THE END OF EACH SHIFT AND SIGN DOCUMENTATION REGARDING THE RESULTS OF THE COUNT AT THE TIME IT OCCURS. ANY DISCREPANCY IN THE CONTROLLED SUBSTANCE COUNT SHALL BE IMMEDIATELY REPORTED TO THE ADMINISTRATOR.

14.38 ALL REFRIGERATED MEDICATIONS SHALL BE STORED IN A REFRIGERATOR THAT DOES NOT CONTAIN FOOD AND THAT IS NOT ACCESSIBLE TO RESIDENTS.

(A) ALL MEDICATION STORED IN A REFRIGERATOR SHALL BE CLEARLY LABELED WITH THE RESIDENT'S NAME AND PRESCRIBING INFORMATION.

14.39 THE ASSISTED LIVING RESIDENCE SHALL NOT STORE OR RETAIN FOR MORE THAN 30 CALENDAR DAYS ANY OUTDATED, DISCONTINUED AND/OR EXPIRED MEDICATIONS.

14.40 OUTDATED, DISCONTINUED AND/OR EXPIRED MEDICATIONS THAT ARE NOT RETURNED TO THE RESIDENT OR LEGAL REPRESENTATIVE SHALL BE STORED IN A LOCKED STORAGE AREA UNTIL PROPERLY DISPOSED OF.

(A) ANY CONTROLLED SUBSTANCE MEDICATIONS WHICH ARE DESIGNATED FOR DESTRUCTION SHALL BE KEPT IN A SEPARATE LOCKED CONTAINER WITHIN THE LOCKED STORAGE AREA UNTIL THEY ARE DESTROYED.

14.41 THE ASSISTED LIVING RESIDENCE SHALL CONDUCT, ON A MONTHLY BASIS, A JOINT TWO PERSON AUDIT OF MEDICATIONS DESIGNATED FOR DISPOSAL.

(A) AT LEAST ONE OF THE PERSONS CONDUCTING THE AUDIT SHALL BE A QUALIFIED MEDICATION ADMINISTRATION PERSON.

(B) THE RESULTS OF THE AUDIT SHALL BE DOCUMENTED AND SIGNED BY BOTH STAFF MEMBERS CONDUCTING THE AUDIT.

(C) AUDIT RECORDS SHALL BE MAINTAINED FOR A MINIMUM OF THREE YEARS. ANY DISCREPANCY IN THE LIST AND COUNT OF MEDICATIONS DESIGNATED FOR DISPOSAL SHALL BE IMMEDIATELY REPORTED TO THE ADMINISTRATOR.

MEDICATION DESTRUCTION AND DISPOSAL

14.42 MEDICATION SHALL BE RETURNED TO THE RESIDENT OR RESIDENT'S LEGAL REPRESENTATIVE, UPON DISCHARGE OR DEATH, EXCEPT THAT RETURN OF MEDICATION TO THE RESIDENT MAY BE WITHHELD IF SPECIFIED IN THE CARE PLAN OF A RESIDENT OF A FACILITY WHICH IS LICENSED TO PROVIDE SERVICES SPECIFICALLY FOR THE MENTALLY ILL OR IF A PRACTITIONER HAS DETERMINED THAT THE RESIDENT LACKS THE DECISIONAL CAPACITY TO POSSESS OR ADMINISTER SUCH MEDICATION SAFELY.

(A) A RESIDENT OR RESIDENT'S LEGAL REPRESENTATIVE MAY AUTHORIZE THE ASSISTED LIVING RESIDENCE TO RETURN UNUSED MEDICATIONS OR MEDICAL SUPPLIES AND USED OR UNUSED MEDICAL DEVICES TO A PRESCRIPTION DRUG OUTLET OR DONATE TO A NONPROFIT ENTITY IN ACCORDANCE WITH § 12-42.5-133, C.R.S., AND 6 CCR 1011-1, CHAPTER 2, PART 7.202.

(B) THE ASSISTED LIVING RESIDENCE SHALL REQUEST AND MAINTAIN SIGNED DOCUMENTATION FROM THE RESIDENT OR RESIDENT'S LEGAL REPRESENTATIVE REGARDING THE RETURN OR DONATION OF ALL MEDICATIONS, MEDICAL SUPPLIES OR DEVICES.

14.43 THE ASSISTED LIVING RESIDENCE SHALL HAVE POLICIES AND PROCEDURES REGARDING THE DESTRUCTION AND DISPOSAL OF OUTDATED, UNUSED, DISCONTINUED AND/OR EXPIRED MEDICATIONS WHICH ARE NOT RETURNED TO THE RESIDENT OR LEGAL REPRESENTATIVE. AT A MINIMUM, THE POLICIES AND PROCEDURES SHALL INCLUDE THE FOLLOWING REQUIREMENTS:

(A) MEDICATION SHALL BE DESTROYED IN THE PRESENCE OF TWO INDIVIDUALS, EACH OF WHOM ARE EITHER A QUALIFIED MEDICATION ADMINISTRATION PERSON, NURSE, OR PRACTITIONER;

(B) ALL MEDICATIONS SHALL BE DESTROYED IN A MANNER THAT RENDERS THE SUBSTANCES TOTALLY IRRETRIEVABLE;

(C) THERE SHALL BE DOCUMENTATION WHICH IDENTIFIES THE MEDICATIONS, THE DATE OF DESTRUCTION AND THE SIGNATURES OF THE WITNESSES PERFORMING THE MEDICATION DESTRUCTION; AND

(D) ALL DESTROYED MEDICATIONS SHALL BE DISPOSED OF IN COMPLIANCE WITH SECTIONS 24.2 AND 24.3 REGARDING MEDICAL WASTE DISPOSAL.

SECTION 15 - LAUNDRY SERVICES

GENERAL REQUIREMENTS:

15.1 THE ASSISTED LIVING RESIDENCE SHALL MAKE LAUNDRY SERVICES AVAILABLE IN ONE OR MORE OF THE FOLLOWING WAYS:

(A) PROVIDING LAUNDRY SERVICE FOR THE RESIDENTS,

(B) PROVIDING ACCESS TO LAUNDRY EQUIPMENT SO THAT THE RESIDENTS MAY DO THEIR OWN LAUNDRY,

(C) MAKING ARRANGEMENTS WITH A COMMERCIAL LAUNDRY, OR

(D) COORDINATING WITH FRIENDS OR FAMILY MEMBERS WHO CHOOSE TO PROVIDE LAUNDRY SERVICES FOR A RESIDENT.

15.2 THERE SHALL BE SEPARATE STORAGE AREAS FOR SOILED LINEN AND CLOTHING.

15.3 THE ASSISTED LIVING RESIDENCE SHALL ADDRESS RESIDENT SENSITIVITIES OR ALLERGIES WITH REGARD TO LAUNDRY DETERGENTS OR METHODS.

ASSISTED LIVING RESIDENCE LAUNDRY SERVICE

15.4 IF PROVIDING LAUNDRY SERVICE FOR RESIDENTS, THE ASSISTED LIVING RESIDENCE SHALL ENSURE THE FOLLOWING:

(A) WASHING MACHINES AND DRYERS ARE PROPERLY MAINTAINED ACCORDING TO THE MANUFACTURER'S INSTRUCTIONS;

(B) BED AND BATH LINENS ARE CLEANED AT LEAST WEEKLY OR MORE FREQUENTLY TO MEET INDIVIDUAL RESIDENT NEEDS WHILE BLANKETS ARE CLEANED AS NECESSARY;

(D) LAUNDRY PERSONNEL OR DESIGNATED STAFF HANDLE, STORE, PROCESS, TRANSPORT AND RETURN LAUNDRY IN A WAY THAT PREVENTS THE SPREAD OF INFECTION OR CROSS CONTAMINATION;

(E) PERSONAL CLOTHING IS RETURNED TO THE APPROPRIATE RESIDENT IN A PRESENTABLE, READY TO WEAR MANNER IN ORDER TO PROMOTE RESIDENT RESPECT AND DIGNITY; AND

(E) THE APPROPRIATE RESIDENT REPRESENTATIVE IS NOTIFIED IF A RESIDENT NEEDS ADDITIONAL CLOTHING OR LINENS.

RESIDENT ACCESS

15.5 IF A RESIDENT INDEPENDENTLY USES THE ASSISTED LIVING RESIDENCE LAUNDRY AREA, THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT:

(A) THE RESIDENT IS INSTRUCTED IN THE PROPER USE OF THE EQUIPMENT,

(B) THERE IS A READILY AVAILABLE SCHEDULE SHOWING WHEN RESIDENT USE IS PERMITTED, AND

(C) THE RESIDENT HAS THE MEANS TO INDEPENDENTLY ACCESS THE AREA DURING THE PERMITTED TIMES.

SECTION 16 – FOOD SAFETY

ALL ASSISTED LIVING RESIDENCES

16.1 RESIDENTS HANDLING OR PREPARING FOOD FOR OTHER RESIDENTS SHALL HAVE ACCESS TO A HAND-SINK, SOAP AND DISPOSABLE PAPER TOWELS. THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT SUCH RESIDENTS UNDERSTAND WHEN TO WASH HANDS AND THE PROPER PROCEDURE FOR DOING SO. SUPPLIES FOR CLEANING AND A PRE-MADE SOLUTION FOR SANITIZING FOOD CONTACT SURFACES SHALL BE READILY AVAILABLE. THE INGREDIENTS USED SHALL BE ALLOWABLE FOODS FROM APPROVED SOURCES AND WITHIN THE "USE-BY" DATE.

16.2 THE FOOD SAFETY REQUIREMENTS SPECIFIED IN THIS CHAPTER DO NOT PRECLUDE RESIDENTS FROM CONSUMING FOODS NOT PROCURED BY THE ASSISTED LIVING RESIDENCE.

20 OR MORE BEDS

16.3 AN ASSISTED LIVING RESIDENCE THAT IS LICENSED FOR 20 BEDS OR MORE SHALL COMPLY WITH THE DEPARTMENT'S REGULATIONS CONCERNING COLORADO RETAIL FOOD ESTABLISHMENTS AT 6 CCR 1010-2.

FEWER THAN 20 BEDS

16.4 AN ASSISTED LIVING RESIDENCE THAT IS LICENSED FOR FEWER THAN 20 BEDS SHALL COMPLY WITH ALL OF THE REQUIREMENTS IN SECTIONS 16.5 THROUGH 16.37. A COMMERCIAL KITCHEN IS NOT A REQUIREMENT FOR AN ASSISTED LIVING RESIDENCE WITH FEWER THAN 20 BEDS.

EMPLOYEE TRAINING

16.5 ANYONE PREPARING OR SERVING FOOD SHALL COMPLETE RECOGNIZED FOOD SAFETY TRAINING AND MAINTAIN EVIDENCE OF COMPLETION ON SITE. FOOD SAFETY TRAINING SHALL BE PROVIDED BY RECOGNIZED FOOD SAFETY EXPERTS OR AGENCIES, SUCH AS THE DIVISION OF ENVIRONMENTAL HEALTH AND SUSTAINABILITY, LOCAL PUBLIC HEALTH AGENCIES OR COLORADO STATE UNIVERSITY EXTENSION SERVICES. AT A MINIMUM, A CERTIFICATE OF COMPLETION OF THE AVAILABLE ONLINE MODULES IS SUFFICIENT TO COMPLY WITH THIS SECTION. THE SUCCESSFUL COMPLETION OF OTHER ACCREDITED FOOD SAFETY COURSES IS ALSO ACCEPTABLE.

PERSONAL HEALTH

16.6 STAFF SHALL BE IN GOOD HEALTH AND FREE OF COMMUNICABLE DISEASE WHILE HANDLING, PREPARING OR SERVING FOOD OR HANDLING UTENSILS.

16.7 STAFF ARE PROHIBITED FROM HANDLING, PREPARING OR SERVING FOOD OR HANDLING UTENSILS FOR RESIDENTS OR OTHER STAFF WHILE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS: VOMITING, DIARRHEA, SORE THROAT WITH FEVER, JAUNDICE OR LESION CONTAINING PUS ON THE HANDS OR WRISTS.

(A) STAFF MEMBERS EXPERIENCING THESE SYMPTOMS ARE PERMITTED TO RETURN TO HANDLING FOOD AND UTENSILS ONLY WHEN THEY HAVE BEEN SYMPTOM-FREE FOR AT LEAST 24 HOURS AND/OR THE LESIONS ON THEIR HANDS ARE BANDAGED AND COMPLETELY COVERED WITH AN IMPERVIOUS GLOVE OR FINGER COT.

HANDWASHING

16.8 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT FOOD HANDLERS, COOKS AND SERVERS PROPERLY WASH THEIR HANDS USING THE FOLLOWING PROCEDURE:

(A) WASH HANDS IN WARM (100^0F TO 120^0F) SOAPY WATER BY VIGOROUSLY SCRUBBING ALL SURFACES OF THE HANDS AND WRISTS FOR AT LEAST 20 SECONDS. RINSE HANDS CLEAN. THOROUGHLY DRY HANDS WITH A DISPOSABLE PAPER TOWEL. USE THE PAPER TOWEL TO TURN OFF SINK FAUCETS BEFORE DISPOSING.

16.9 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT FOOD HANDLERS, COOKS AND SERVERS ALWAYS WASH THEIR HANDS AT THE FOLLOWING TIMES:

(A) BEFORE LEAVING THE RESTROOM, AND AGAIN BEFORE RETURNING TO FOOD OR BEVERAGE PREPARATION, FOOD AND FOOD EQUIPMENT STORAGE AREAS OR DISHWASHING;

(B) AFTER COUGHING, SNEEZING, USING A HANDKERCHIEF OR TISSUE, USING TOBACCO PRODUCTS OR EATING;

(C) WHEN SWITCHING BETWEEN WORKING WITH RAW ANIMAL DERIVED FOODS AND READY-TO-EAT FOODS;

(D) AFTER TOUCHING THE HAIR, FACE OR BODY;

(E) DURING FOOD PREPARATION, AS OFTEN AS NECESSARY TO REMOVE SOIL AND CONTAMINATION AND TO PREVENT CROSS CONTAMINATION WHEN CHANGING TASKS;

(F) BEFORE HANDLING OR PUTTING ON SINGLE USE GLOVES FOR FOOD HANDLING AND BETWEEN REMOVING SOILED GLOVES AND PUTTING ON NEW, CLEAN GLOVES;

(G) AFTER HANDLING SOILED DISHES OR UTENSILS, SUCH AS BUSING TABLES OR LOADING A DISHWASHING MACHINE;

(H) AFTER FEEDING OR CARING FOR A RESIDENT;

(I) AFTER CARING FOR PETS OR OTHER ANIMALS; AND

(J) AFTER ENGAGING IN ANY ACTIVITY THAT CONTAMINATES THE HANDS SUCH AS HANDLING GARBAGE, MOPPING, WORKING WITH CHEMICALS AND OTHER CLEANING ACTIVITIES.

EMPLOYEE HYGIENE

16.10 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT ALL STAFF MEMBERS HAVE GOOD HYGIENIC PRACTICES AND WEAR CLEAN CLOTHING OR PROTECTIVE COVERINGS WHILE HANDLING FOOD OR UTENSILS.

16.11 THE ASSISTED LIVING RESIDENCE SHALL PROHIBIT STAFF MEMBERS FROM USING COMMON TOWELS AND OTHER MULTIPLE USE LINENS OR CLOTHING TO WIPE OR DRY THEIR HANDS. WHEN HANDS BECOME SOILED, THE ALR SHALL ENSURE THAT STAFF WASH THEIR HANDS IN ACCORDANCE WITH SECTION 16.8(A).

16.12 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT STAFF MEMBERS REFRAIN FROM EATING OR SMOKING IN THE AREA USED FOR FOOD PREPARATION OR STORAGE. DRINKING IN THESE AREAS IS ALLOWED WITH ENCLOSED CONTAINERS THAT DO NOT REQUIRE MANUAL MANIPULATION OF THE DRINKING SURFACE.

16.13 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT STAFF MEMBERS DO NOT TOUCH THEIR FACES, HAIR OR OTHER BODY SURFACES WHILE HANDLING FOOD.

16.14 TASTING FOOD DURING PREPARATION SHALL BE DONE WITH A UTENSIL THAT IS CLEAN AND SANITIZED. THE SAME UTENSIL MUST BE WASHED, RINSED AND SANITIZED BEFORE IT IS REUSED.

16.15 UTENSILS USED TO DISPENSE FOOD SHALL HAVE HANDLES. UTENSIL HANDLES SHALL BE KEPT OUT OF FOOD AND ICE. FOR EXAMPLE, SCOOPING ICE WITH A GLASS IS PROHIBITED.

BARE HAND CONTACT

16.16 READY-TO-EAT FOODS SHALL NOT BE HANDLED WITH BARE HANDS. INSTEAD GLOVES OR UTENSILS MUST BE USED TO HANDLE, PREPARE AND SERVE THESE FOODS.

PROPER GLOVE USE

16.17 Disposable food service gloves shall be used in a manner that prevents contamination of food and food contact surfaces. Gloves shall be changed whenever switching from handling raw animal products to ready-to-eat foods and whenever else gloved hands become contaminated. When gloves are changed, hands shall be washed in accordance with section 16.8(A).

Approved Source

16.18 All foods, including raw ingredients and prepared foods, shall be obtained from approved, licensed or registered sources or food manufacturers. Raw uncut produce can be obtained from other sources, including grown onsite, as long as good agricultural practices defined by the United States Department of Agriculture are used. Further guidance for produce grown by an assisted living residence is detailed in a Department brochure entitled "Food Safety for Vegetable Gardens, tips for Schools, Child Care and Long Term Care Facilities." The brochure is available online at Colorado Food Safety Tips or by contacting the Division of Environmental Health and Sustainability at 303-692-3645.

Prohibited Foods

16.19 Prohibited foods shall not be served by the assisted living residence. Prohibited foods include raw or undercooked meat, poultry, fish, and molluscan shellfish; raw unpasteurized eggs; raw milk and raw seed sprouts. Unpasteurized juice is also prohibited unless it is freshly squeezed and made to order.

16.20 Foods that pose a greater risk for the long-term care population include deli meats, hot dogs, and soft cheeses. These foods are allowed, but it is strongly recommended that they be heated before service to control Listeria monocytogenes, a particularly dangerous bacteria for older adults and immune compromised populations.

16.21 An assisted living residence shall not distribute or dispense raw milk products of any kind.

Date Marking

16.22 Refrigerated foods opened or prepared and not used within 24 hours must be marked with a "use by" or "discard by" date. The "use by" or "discard by" date is seven calendar days following opening or preparation. The seven days cannot surpass the manufacturer's expiration date for the product or its ingredients or seven days since the date any of the ingredients in the food were opened or prepared. This requirement does not apply to commercially prepared condiments and dressings.

Required Cooking temperatures

16.23 Animal derived foods; meat, poultry, fish and unpasteurized eggs must be cooked to the minimum internal temperatures in the following table before being served or held hot.

Poultry (ground or intact), stuffed meats	165^0F
Eggs, pork, lamb, fish	145^0F
Ground beef, fish, pork, lamb, veal	155^0F
Whole muscle beef steaks	145^0F
Whole roasts (beef, lamb, pork)	135^0F

Required Holding Temperatures

16.24 POTENTIALLY HAZARDOUS FOODS SHALL BE MAINTAINED AT THE PROPER TEMPERATURES AT ALL TIMES. POTENTIALLY HAZARDOUS FOODS THAT ARE STORED COLD SHALL BE HELD AT OR BELOW 41^{0}F.

16.25 POTENTIALLY HAZARDOUS FOODS THAT ARE STORED HOT SHALL BE HELD AT OR ABOVE 135^{0}F.

16.26 WHEN FOODS ARE BEING PREPARED, COOLED OR REHEATED, THEY SHALL NOT BE HELD BELOW 135^{0}F OR ABOVE 41^{0}F FOR EXTENDED TIME TO CONTROL THE GROWTH OF HARMFUL BACTERIA.

RAPID REHEATING

16.27 POTENTIALLY HAZARDOUS FOODS THAT ARE BEING REHEATED FROM ROOM TEMPERATURE, SUCH AS OPENING A CAN, OR FROM COLD STORAGE BEFORE HOT HOLDING SHALL BE RAPIDLY HEATED WITHIN 2 HOURS TO 165^{0}F. RAPID HEATING CAN BE ACCOMPLISHED ON A STOVE TOP, IN AN OVEN, MICROWAVE OR ANOTHER APPROVED REHEATING DEVICE.

RAPID COOLING

16.28 POTENTIALLY HAZARDOUS FOODS THAT ARE BEING COOLED FROM ROOM TEMPERATURE, SUCH AS AFTER OPENING A CAN OR PREPARING FOOD FROM ROOM TEMPERATURE INGREDIENTS, SHALL BE COOLED TO 41°F WITHIN FOUR HOURS.

FOLLOWING COOKING OR REMOVAL FROM HOT STORAGE, FOODS MUST BE COOLED WITHIN SIX HOURS TO 41^{0}F. BEGIN ACTIVE COOLING FOODS WHEN FOODS ARE 135^{0}F. COOL TO 70^{0}F WITHIN TWO HOURS OR LESS. THEN COOL FROM 70^{0}F TO 41^{0}F WITHIN FOUR HOURS OR LESS. ACTIVE COOLING MEANS USING UNCOVERED SHALLOW PANS, ICE AS AN INGREDIENT, ICE WANDS, BREAKING FOODS DOWN INTO SMALL PORTIONS AND FULLY SUBMERGING CONTAINERS IN ICE BATHS OR A COMBINATION OF THESE METHODS.

FOOD PREPARATION

16.29 WHEN FOODS ARE BEING ASSEMBLED OR PREPARED OUTSIDE OF TEMPERATURE CONTROL, THE PROCESS SHOULD BE COMPLETED AS QUICKLY AS POSSIBLE AND NO MORE THAN TWO HOURS.

THAWING

16.30 FROZEN FOODS SHALL BE THAWED UNDER REFRIGERATION, UNDER COOL, RUNNING WATER BETWEEN 60-70^{0}F, IN A MICROWAVE OVEN OR AS PART OF THE COOKING PROCESS.

16.31 LEAVING FOOD OUT TO THAW WITHOUT TEMPERATURE CONTROL IS PROHIBITED.

EQUIPMENT

16.32 EQUIPMENT SHALL BE MAINTAINED IN WORKING ORDER AND CLEANABLE. REFRIGERATION EQUIPMENT SHALL MAINTAIN FOODS BELOW 41^{0}F. HOT HOLDING EQUIPMENT MUST HOLD FOOD AT OR ABOVE 135^{0}F.

CLEANING AND SANITIZING

16.33 FOOD CONTACT SURFACES OF EQUIPMENT SHALL BE WASHED, RINSED AND SANITIZED BEFORE USE OR AT LEAST EVERY FOUR HOURS OF CONTINUAL USE. DISH DETERGENT SHALL BE LABELED FOR THE INTENDED PURPOSE. SANITIZER SHALL BE APPROVED FOR USE AS A NO-RINSE FOOD CONTACT SANITIZER. SANITIZERS SHALL BE REGISTERED WITH EPA AND USED IN ACCORDANCE WITH LABELED INSTRUCTIONS.

PLUMBING

16.34 A HANDWASHING SINK SUPPLIED WITH SOAP AND DISPOSABLE PAPER TOWELS SHALL BE AVAILABLE IN ALL FOOD HANDLING AREAS.

16.35 SINKS SHALL BE WASHED, RINSED AND SANITIZED WHEN SWITCHING BETWEEN FOOD PREPARATION OR PRODUCE WASHING AND THAWING ANIMAL DERIVED FOODS.

DISH WASHING

16.36 DISHES, UTENSILS AND COOKWARE SHALL BE WASHED USING ONE OF THE FOLLOWING METHODS:

(A) IN A SINGLE OR MULTIPLE COMPARTMENT SINK USING A DISH DETERGENT THAT IS LABELED FOR THAT INTENDED PURPOSE. ONCE WASHED, DISHES AND UTENSILS SHALL BE RINSED CLEAN, AND THEN SUBMERGED IN AN APPROVED NO-RINSE FOOD CONTACT SANITIZER AND ALLOWED TO AIR DRY. SANITIZER SHALL BE REGISTERED WITH EPA AND USED IN ACCORDANCE WITH LABELED INSTRUCTIONS; OR

(B) A DOMESTIC OR COMMERCIAL DISHWASHING MACHINE WITH A WASH WATER TEMPERATURE THAT REACHES A MINIMUM OF 155°F OR IS EQUIPPED WITH A CHEMICAL SANITIZING CYCLE.

MOP WATER

16.37 MOP WATER SHALL ONLY BE FILLED IN A DEDICATED UTILITY SINK, A BATH TUB OR USING A QUICK RELEASE HOSE ATTACHMENT ON ANOTHER SINK THAT IS IMMEDIATELY REMOVED AND STORED AWAY FROM THE SINK AFTER FILLING. MOP WATER SHALL BE DISPOSED IN THE SANITARY SEWER (E.G., TOILET, BATHTUB OR UTILITY SINK). MOP WATER SHALL NOT BE DISCARDED ON THE GROUND OUTSIDE OR IN A STORM DRAIN.

SECTION 17 – FOOD AND DINING SERVICES

MEALS, DRINKS AND SNACKS

17.1 THE ASSISTED LIVING RESIDENCE SHALL PROVIDE AT LEAST THREE MEALS DAILY, AT REGULAR TIMES COMPARABLE TO NORMAL MEALTIMES IN THE COMMUNITY OR IN ACCORDANCE WITH RESIDENT NEEDS, PREFERENCES, AND PLANS OF CARE.

(A) NOURISHING MEAL SUBSTITUTES AND BETWEEN MEAL SNACKS SHALL BE PROVIDED, IN ACCORDANCE WITH PLANS OF CARE, TO RESIDENTS WHO WANT TO EAT AT NON-TRADITIONAL TIMES OR OUTSIDE OF SCHEDULED MEAL SERVICE TIMES.

17.2 MEALS SHALL INCLUDE A VARIETY OF FOODS, BE NUTRITIONALLY BALANCED AND SUFFICIENT IN AMOUNT TO SATISFY RESIDENT APPETITES.

(A) APPEALING SUBSTITUTES OF SIMILAR NUTRITIVE VALUE SHALL BE AVAILABLE FOR RESIDENTS WHO CHOOSE NOT TO EAT FOOD THAT IS INITIALLY SERVED OR WHO REQUEST AN ALTERNATIVE MEAL.

17.3 THE ASSISTED LIVING RESIDENCE SHALL OFFER DRINKS, INCLUDING WATER AND OTHER LIQUIDS TO RESIDENTS WITH EVERY MEAL AND BETWEEN MEALS THROUGHOUT THE DAY. THE ASSISTED LIVING RESIDENCE SHALL ALSO ENSURE THAT RESIDENTS HAVE INDEPENDENT ACCESS TO DRINKS AT ALL TIMES.

17.4 ASSISTED LIVING RESIDENCE STAFF SHALL OBSERVE RESIDENT FOOD CONSUMPTION ON A REGULAR BASIS IN ORDER TO DETECT UNPLANNED CHANGES SUCH AS WEIGHT GAIN, WEIGHT LOSS OR DEHYDRATION. CHANGES IN CONSUMPTION THAT MAY INDICATE THE NEED FOR ASSISTANCE WITH EATING SHALL BE REPORTED TO THE RESIDENT'S PRACTITIONER AND CASE MANAGER, IF APPLICABLE.

17.5 IF A RESIDENT REPEATEDLY CHOOSES NOT TO FOLLOW THE DIETARY RECOMMENDATIONS OF HIS OR HER PRACTITIONER, THE ASSISTED LIVING RESIDENCE SHALL DOCUMENT SUCH IN THE RECORD OR CARE PLAN AND NOTIFY THE RESIDENT'S PRACTITIONER AND CASE MANAGER, IF APPLICABLE.

MENUS

17.6 MENUS SHALL VARY DAILY AND INCORPORATE SEASONAL AND/OR HOLIDAY FOODS.

17.7 WEEKLY MENUS SHALL BE READILY AVAILABLE FOR RESIDENTS AND PUBLIC VIEWING NO LESS THAN 24 HOURS PRIOR TO SERVING.

17.8 RESIDENTS SHALL BE ENCOURAGED TO PARTICIPATE IN PLANNING MENUS AND THE ASSISTED LIVING RESIDENCE SHALL MAKE REASONABLE EFFORTS TO ACCOMMODATE RESIDENT SUGGESTIONS.

FOOD SUPPLY

17.9 EACH ASSISTED LIVING RESIDENCE SHALL HAVE SUFFICIENT FOOD ON HAND TO PREPARE THREE NUTRITIONALLY BALANCED MEALS PER DAY FOR THREE CALENDAR DAYS.

THERAPEUTIC DIETS

17.10 AN ASSISTED LIVING RESIDENCE MAY PROVIDE THERAPEUTIC DIETS WHEN THE FOLLOWING CONDITIONS ARE MET:

(A) THE DIET IS PRESCRIBED BY THE RESIDENT'S PRACTITIONER, AND

(B) THE ASSISTED LIVING RESIDENCE HAS TRAINED STAFF TO PREPARE THE FOOD IN ACCORDANCE WITH THE DIET AND ENSURE IT IS BEING SERVED TO THE APPROPRIATE RESIDENT.

ASSISTANCE WITH DINING AND FEEDING

17.11 IF A RESIDENT DEMONSTRATES DIFFICULTY OPENING, REACHING OR ACCESSING FOOD AND BEVERAGE ITEMS AT MEAL TIME, STAFF SHALL PROMPTLY ASSIST THAT RESIDENT IN DOING SO REGARDLESS OF THE RESIDENT'S DINING LOCATION.

17.12 STAFF MAY ASSIST RESIDENTS BY CUEING AND PROMPTING THEM TO EAT AND DRINK SO LONG AS THAT ASSISTANCE IS NOT UNDERTAKEN FOR THE CONVENIENCE OF STAFF.

17.13 STAFF MAY ASSIST FEEDING A RESIDENT ONLY IF THE RESIDENT IS ABLE TO MAINTAIN AN UPRIGHT POSITION AND CHEW AND SWALLOW WITHOUT DIFFICULTY.

17.14 STAFF WHO ASSIST FEEDING A RESIDENT SHALL BE TRAINED IN THE PROPER TECHNIQUES FOR SUPPORTING NUTRITION AND HYDRATION BY A LICENSED OR REGISTERED PROFESSIONAL QUALIFIED BY EDUCATION AND TRAINING TO ASSESS CHOKING RISKS, SUCH AS A REGISTERED NURSE, SPEECH LANGUAGE PATHOLOGIST OR REGISTERED DIETITIAN.

(A) THE ASSISTED LIVING RESIDENCE SHALL NOT ALLOW STAFF TO ASSIST FEEDING A RESIDENT IF THE RESIDENT HAS DIFFICULTY CHEWING AND SWALLOWING OR HAS A HISTORY OF CHRONIC CHOKING OR COUGHING WHILE EATING OR DRINKING.

(B) IF A RESIDENT WHO IS RECEIVING FEEDING ASSISTANCE EXPERIENCES A CHANGE IN EATING AND SWALLOWING THAT IS A DECLINE FROM BASELINE AS IDENTIFIED IN THE INDIVIDUALIZED RESIDENT CARE PLAN, STAFF SHALL STOP PROVIDING ASSISTANCE, DOCUMENT THE ISSUE IN THE RESIDENT'S RECORD AND ENSURE THAT THE RESIDENT'S PRACTITIONER IS NOTIFIED.

(1) UNLESS TEMPORARY MEASURES ARE ORDERED BY THE PRACTITIONER, FEEDING ASSISTANCE SHALL NOT BE RESUMED UNTIL A MEDICAL EVALUATION HAS BEEN PERFORMED AND THE ASSISTED LIVING RESIDENCE HAS DOCUMENTATION FROM THE PRACTITIONER THAT IT IS SAFE TO RESUME.

DINING AREA AND EQUIPMENT

17.15 EACH ASSISTED LIVING RESIDENCE SHALL HAVE A DESIGNATED DINING AREA WITH TABLES AND CHAIRS THAT ALL RESIDENTS ARE ABLE TO ACCESS AND THAT IS SUFFICIENT IN SIZE TO COMFORTABLY ACCOMMODATE ALL RESIDENTS. RESIDENTS SHALL BE GIVEN THE OPPORTUNITY TO CHOOSE WHERE AND WITH WHOM TO SIT.

17.16 NO RESIDENT OR GROUP OF RESIDENTS SHALL BE EXCLUDED FROM THE DESIGNATED DINING AREA DURING MEAL TIME UNLESS OTHERWISE INDICATED IN THE RESIDENT'S INDIVIDUALIZED CARE PLAN.

17.17 MEALS SHALL NOT BE ROUTINELY SERVED IN RESIDENT ROOMS UNLESS OTHERWISE INDICATED IN THE RESIDENT'S INDIVIDUALIZED CARE PLAN. THE ASSISTED LIVING RESIDENCE SHALL, HOWEVER, MAKE REASONABLE EFFORTS TO ACCOMMODATE RESIDENTS THAT CHOOSE TO DINE SOMEWHERE OTHER THAN THE DINING ROOM.

17.18 THE LOCATION OF RESIDENT DINING SHALL NOT BE CHOSEN SOLELY FOR STAFF CONVENIENCE.

17.19 PAPER OR DISPOSABLE PLASTIC WARE SHALL NOT BE USED FOR REGULAR MEALS WITH THE EXCEPTION OF EMERGENCIES AND OUTDOOR DINING.

SECTION 18 - RESIDENT HEALTH INFORMATION RECORDS

GENERAL

18.1 EACH ASSISTED LIVING RESIDENCE SHALL HAVE A CONFIDENTIAL HEALTH INFORMATION RECORD FOR EACH RESIDENT AND MAINTAIN IT IN A MANNER THAT ENSURES ACCURACY OF INFORMATION.

18.2 HEALTH INFORMATION RECORDS FOR CURRENT RESIDENTS SHALL BE KEPT ON SITE AT ALL TIMES.

18.3 EACH ASSISTED LIVING RESIDENCE SHALL IMPLEMENT A POLICY AND PROCEDURE FOR AN EFFECTIVE INFORMATION MANAGEMENT SYSTEM THAT IS EITHER PAPER-BASED OR ELECTRONIC. IF THE ALR MAINTAINS BOTH PAPER-BASED AND ELECTRONIC RECORDS, THERE SHALL BE A METHOD FOR INTEGRATION OF THOSE RECORDS THAT ALLOWS EFFECTIVE CONTINUITY OF CARE. PROCESSES SHALL INCLUDE EFFECTIVE MANAGEMENT FOR CAPTURING REPORTING, PROCESSING, STORING AND RETRIEVING CARE/SERVICE DATA AND INFORMATION.

18.4 AT THE TIME OF ADMISSION, THE RESIDENT RECORD SHALL CONTAIN, AT A MINIMUM, THE FOLLOWING ITEMS:

(A) FACE SHEET,

(B) PRACTITIONER ORDERS,

(C) INDIVIDUALIZED RESIDENT CARE PLAN,

(D) COPIES OF ANY ADVANCE DIRECTIVES, AND

(E) A SIGNED COPY OF THE RESIDENT AGREEMENT.

CONFIDENTIALITY AND ACCESS

18.5 THE ASSISTED LIVING RESIDENCE SHALL HAVE A MEANS OF SECURING RESIDENT RECORDS THAT PRESERVES THEIR CONFIDENTIALITY AND PROVIDES PROTECTION FROM LOSS, DAMAGE AND UNAUTHORIZED ACCESS.

18.6 THE CONFIDENTIALITY OF THE RESIDENT RECORD INCLUDING ALL MEDICAL, PSYCHOLOGICAL AND SOCIOLOGICAL INFORMATION SHALL BE PROTECTED IN ACCORDANCE WITH ALL APPLICABLE FEDERAL AND STATE LAWS AND REGULATIONS.

18.7 EACH RESIDENT OR LEGAL REPRESENTATIVE OF A RESIDENT SHALL BE ALLOWED TO INSPECT THAT RESIDENT'S OWN RECORD IN ACCORDANCE WITH §25-1-801, C.R.S. UPON REQUEST, RESIDENT RECORDS SHALL ALSO BE MADE AVAILABLE FOR INSPECTION BY THE STATE AND LOCAL LONG-TERM CARE OMBUDSMAN PURSUANT TO §26-11.5-108, C.R.S., DEPARTMENT REPRESENTATIVES AND OTHER LAWFULLY AUTHORIZED INDIVIDUALS.

CONTENT

18.8 RESIDENT RECORDS SHALL CONTAIN, BUT NOT BE LIMITED TO, THE FOLLOWING ITEMS:

(A) FACE SHEET,

(B) PRACTITIONER ORDER,

(C) INDIVIDUALIZED RESIDENT CARE PLAN,

(D) PROGRESS NOTES WHICH SHALL INCLUDE INFORMATION ON RESIDENT STATUS AND WELLBEING, AS WELL AS DOCUMENTATION REGARDING ANY OUT OF THE ORDINARY EVENT OR ISSUE THAT AFFECTS A RESIDENT'S PHYSICAL, BEHAVIORAL, COGNITIVE AND/OR FUNCTIONAL CONDITION ALONG WITH THE ACTION TAKEN BY STAFF TO ADDRESS THAT RESIDENT'S CHANGING NEEDS;

(1) THE ASSISTED LIVING RESIDENCE SHALL REQUIRE STAFF MEMBERS TO DOCUMENT, BEFORE THE END OF THEIR SHIFT, ANY OUT OF THE ORDINARY EVENT OR ISSUE REGARDING A RESIDENT THAT THEY PERSONALLY OBSERVED, OR WAS REPORTED TO THEM.

(E) MEDICATION ADMINISTRATION RECORD,

(F) DOCUMENTATION OF ON-GOING SERVICES PROVIDED BY EXTERNAL SERVICE PROVIDERS INCLUDING, BUT NOT LIMITED TO, FAMILY MEMBERS, AIDES, PODIATRISTS, PHYSICAL THERAPISTS, HOSPICE AND HOME CARE SERVICES, AND OTHER PRACTITIONERS, ASSISTANTS AND CAREGIVERS;

(G) ADVANCE DIRECTIVES, IF APPLICABLE, WITH EXTRA COPIES; AND

(H) FINAL DISPOSITION OF RESIDENT INCLUDING, IF APPLICABLE, DATE, TIME AND CIRCUMSTANCES OF A RESIDENT'S DEATH ALONG WITH THE NAME OF THE PERSON TO WHOM THE BODY IS RELEASED.

18.9 THE FACE SHEET SHALL BE UPDATED AT LEAST ANNUALLY AND CONTAIN THE FOLLOWING INFORMATION:

(A) RESIDENT'S FULL NAME, INCLUDING MAIDEN NAME, IF APPLICABLE;

(B) RESIDENT'S SEX, DATE OF BIRTH, AND MARITAL STATUS;

(C) RESIDENT'S MOST RECENT FORMER ADDRESS;

(D) RESIDENT'S MEDICAL INSURANCE INFORMATION AND MEDICAID NUMBER, IF APPLICABLE;

(E) DATE OF ADMISSION AND READMISSION, IF APPLICABLE;

(F) NAME, ADDRESS AND CONTACT INFORMATION FOR FAMILY MEMBERS, LEGAL REPRESENTATIVES, AND/OR OTHER PERSONS TO BE NOTIFIED IN CASE OF EMERGENCY;

(G) NAME, ADDRESS AND CONTACT INFORMATION FOR RESIDENT'S PRACTITIONER AND CASE MANAGER, IF APPLICABLE;

(H) RESIDENT'S PRIMARY SPOKEN LANGUAGE AND ANY ISSUES WITH ORAL COMMUNICATION;

(I) INDICATION OF RESIDENT'S RELIGIOUS PREFERENCE, IF ANY;

(J) RESIDENT'S CURRENT DIAGNOSES; AND

(K) NOTATION OF RESIDENT'S ALLERGIES, IF ANY.

RECORD TRANSFER AND RETENTION

18.10 IF A RESIDENT'S CARE IS TRANSFERRED TO ANOTHER HEALTH FACILITY OR AGENCY, A COPY OF THE FACE SHEET, INDIVIDUALIZED RESIDENT CARE PLAN AND MEDICATION ADMINISTRATION RECORD FOR THE CURRENT MONTH SHALL BE TRANSFERRED WITH THE RESIDENT.

18.11 IF AN ASSISTED LIVING RESIDENCE CEASES OPERATION, EACH RESIDENT'S RECORDS MUST BE TRANSFERRED TO THE LICENSED HEALTH FACILITY OR AGENCY THAT ASSUMES THAT RESIDENT'S CARE.

18.12 RECORDS OF FORMER RESIDENTS SHALL BE COMPLETE AND MAINTAINED FOR AT LEAST THREE YEARS FOLLOWING THE TERMINATION OF THE RESIDENT'S STAY IN THE ASSISTED LIVING RESIDENCE.

18.13 SUCH RECORDS SHALL BE MAINTAINED AND READILY AVAILABLE AT THE ASSISTED LIVING RESIDENCE LOCATION FOR A MINIMUM OF SIX MONTHS FOLLOWING TERMINATION OF THE RESIDENT'S STAY.

SECTION 19 - INFECTION CONTROL

EDUCATION

19.1 THE ASSISTED LIVING RESIDENCE SHALL HAVE AN INFECTION CONTROL PROGRAM THAT PROVIDES INITIAL AND ANNUAL STAFF TRAINING ON INFECTION PREVENTION AND CONTROL. SUCH TRAINING SHALL COVER, AT A MINIMUM, THE FOLLOWING ITEMS:

(A) MODES OF INFECTION TRANSMISSION,

(B) THE IMPORTANCE OF HAND WASHING AND PROPER TECHNIQUES,

(C) USE OF PERSONAL PROTECTIVE EQUIPMENT INCLUDING PROPER USE OF DISPOSABLE GLOVES, AND

(D) CLEANING AND DISINFECTION TECHNIQUES.

POLICIES AND PROCEDURES

19.2 THE ASSISTED LIVING RESIDENCE SHALL HAVE AND FOLLOW WRITTEN POLICIES AND PROCEDURES THAT ADDRESS THE TRANSMISSION OF COMMUNICABLE DISEASES WITH A SIGNIFICANT RISK OF TRANSMISSION TO OTHER PERSONS AND FOR REPORTING DISEASES TO THE STATE AND/OR LOCAL HEALTH DEPARTMENT, PURSUANT TO 6 CCR 1009-1, EPIDEMIC AND COMMUNICABLE DISEASE CONTROL.

19.3 THE POLICIES AND PROCEDURES SHALL INCLUDE AT A MINIMUM, ALL OF THE FOLLOWING CRITERIA:

(A) THE METHOD FOR MONITORING AND ENCOURAGING EMPLOYEE WELLNESS,

(B) THE METHOD FOR TRACKING INFECTION PATTERNS AND TRENDS AND INITIATING A RESPONSE,

(C) THE METHOD FOR DETERMINING WHEN TO SEEK ASSISTANCE FROM A MEDICAL PROFESSIONAL AND/OR THE LOCAL HEALTH DEPARTMENT,

(D) ISOLATION TECHNIQUES, AND

(E) APPROPRIATE HANDLING OF LINEN AND CLOTHING OF RESIDENTS WITH COMMUNICABLE INFECTIONS.

INFECTIOUS WASTE MANAGEMENT

19.4 ANY ITEM CONTAINING BLOOD, BODY FLUID OR BODY WASTE FROM A RESIDENT WITH A CONTAGIOUS CONDITION SHALL BE PRESUMED TO BE INFECTIOUS WASTE AND SHALL BE DISPOSED OF IN THE ROOM WHERE IT IS USED INTO A STURDY PLASTIC BAG, THEN RE-BAGGED OUTSIDE THE ROOM AND DISPOSED OF CONSISTENT WITH THE MEDICAL WASTE DISPOSAL REQUIREMENTS AT SECTION 24.2.

SECTION 20 – PHYSICAL PLANT STANDARDS

COMPLIANCE WITH STATE AND LOCAL REQUIREMENTS

20.1 EACH ASSISTED LIVING RESIDENCE SHALL BE IN COMPLIANCE WITH ALL APPLICABLE LOCAL ZONING, HOUSING, FIRE AND SANITARY CODES AND ORDINANCES OF THE CITY, CITY AND COUNTY, OR COUNTY WHERE THE ALR IS SITUATED, TO THE EXTENT THAT SUCH CODES AND ORDINANCES ARE CONSISTENT WITH THE FEDERAL "FAIR HOUSING AMENDMENT ACT OF 1988" AS AMENDED, AT 42 U.S.C. §3601, ET SEQ.

COMPLIANCE WITH FIRE SAFETY, CONSTRUCTION AND DESIGN STANDARDS

20.2 AN ASSISTED LIVING RESIDENCE SHALL BE CONSTRUCTED IN CONFORMITY WITH THE STANDARDS ADOPTED BY THE DIRECTOR OF THE DIVISION OF FIRE PREVENTION AND CONTROL (DFPC) AT THE COLORADO DEPARTMENT OF PUBLIC SAFETY.

20.3 AN ASSISTED LIVING RESIDENCE APPLYING FOR AN INITIAL LICENSE ON OR AFTER JUNE 1, 2019, SHALL COMPLY WITH PARTS 1.1 THROUGH 1.5, ANY CROSS-REFERENCED PART 2 SYSTEMS, AND 4.1 OF THE GUIDELINES FOR DESIGN AND CONSTRUCTION OF RESIDENTIAL HEALTH, CARE AND SUPPORT FACILITIES, FACILITY GUIDELINES INSTITUTE (FGI) (2018 EDITION), AS INCORPORATED HEREIN, UNLESS OTHERWISE INDICATED.

(A) SMALL MODEL ASSISTED LIVING FACILITIES APPLYING FOR A LICENSE FOR 10 BEDS OR LESS SHALL BE EXEMPT FROM COMPLIANCE WITH FGI GUIDELINES THAT EACH RESIDENT HAVE ACCESS TO A BATHROOM WITHOUT ENTERING A CORRIDOR AND THAT THE BUILDING HAVE AN ELEVATOR THAT IS SIZED TO ACCOMMODATE A GURNEY AND/OR MEDICAL CARTS.

20.4 RENOVATION OF AN ASSISTED LIVING RESIDENCE THAT IS INITIATED ON OR AFTER DECEMBER 1, 2019, SHALL COMPLY WITH PARTS 1.1 THROUGH 1.5, ANY CROSS-REFERENCED PART 2 SYSTEMS, AND 4.1 OF THE GUIDELINES FOR DESIGN AND CONSTRUCTION OF RESIDENTIAL HEALTH, CARE AND SUPPORT FACILITIES, FACILITY GUIDELINES INSTITUTE (FGI) (2018 EDITION), AS INCORPORATED HEREIN, UNLESS MODIFIED ELSEWHERE IN THIS CHAPTER.

(A) SMALL MODEL ASSISTED LIVING FACILITIES APPLYING FOR A LICENSE FOR 10 BEDS OR LESS SHALL BE EXEMPT FROM COMPLIANCE WITH FGI GUIDELINES THAT EACH RESIDENT HAVE ACCESS TO A BATHROOM WITHOUT ENTERING A CORRIDOR AND THAT THE BUILDING HAVE AN ELEVATOR THAT IS SIZED TO ACCOMMODATE A GURNEY AND/OR MEDICAL CARTS.

20.5 THE GUIDELINES FOR DESIGN AND CONSTRUCTION OF RESIDENTIAL HEALTH, CARE AND SUPPORT FACILITIES, FACILITIES GUIDELINES INSTITUTE (2018 EDITION), IS HEREBY INCORPORATED BY REFERENCE CONSISTENT WITH SECTION 1.3 OF THIS CHAPTER AND EXCLUDES ANY LATER AMENDMENTS TO OR EDITIONS OF THE GUIDELINES. FGI APPENDIX MATERIAL IS ADVISORY ONLY AND NOT INCORPORATED UNLESS EXPLICITLY STATED OTHERWISE IN THIS CHAPTER. THE 2018 FGI GUIDELINES ARE AVAILABLE AT NO COST IN A LIMITED READ-ONLY VERSION AT: HTTP://FGIGUIDELINES.ORG

SECTION 21 – EXTERIOR ENVIRONMENT

21.1 THE ASSISTED LIVING RESIDENCE GROUNDS SHALL BE KEPT FREE OF HIGH WEEDS, GARBAGE AND RUBBISH.

21.2 THE ASSISTED LIVING RESIDENCE GROUNDS SHALL BE MAINTAINED TO PROTECT RESIDENTS FROM SLOPES, HOLES OR OTHER HAZARDS AND SHALL BE CONSISTENT WITH ANY LANDSCAPE PLAN APPROVED BY THE LOCAL JURISDICTION.

21.3 EXTERIOR STAIRS SHALL BE LIGHTED AT NIGHT.

21.4 PORCHES, STAIRS, HANDRAILS AND RAMPS SHALL BE MAINTAINED IN GOOD REPAIR.

21.5 FOR NEW CONSTRUCTION INITIATED ON OR AFTER JUNE 1, 2019, PORCHES AND EXTERIOR AREAS WITH MORE THAN ONE STEP WITHIN A SIX FOOT LINEAR RUN SHALL HAVE A HANDRAIL IN ADDITION TO THE REQUIREMENTS OF SECTION 20.3. FOR RENOVATION INITIATED ON OR AFTER DECEMBER 1, 2019, PORCHES AND EXTERIOR AREAS WITH MORE THAN ONE STEP WITHIN A SIX FOOT LINEAR RUN SHALL HAVE A HANDRAIL IN ADDITION TO THE REQUIREMENTS OF SECTION 20.4.

21.6 NOTWITHSTANDING SECTION 20.3, FOR INITIAL LICENSE APPLICATIONS AND NEW CONSTRUCTION INITIATED ON OR AFTER JUNE 1, 2019, THE TOTAL NUMBER OF PARKING SPACES SHALL BE BASED SOLELY ON LOCAL REQUIREMENTS AND THE FUNCTIONAL NEED OF THE RESIDENT POPULATION. NOTWITHSTANDING SECTION 20.4, FOR RENOVATION INITIATED ON OR AFTER DECEMBER 1, 2019, THE TOTAL NUMBER OF PARKING SPACES TO BE PROVIDED SHALL BE BASED SOLELY ON LOCAL REQUIREMENTS AND THE FUNCTIONAL NEED OF THE RESIDENT POPULATION.

21.7 THE ASSISTED LIVING RESIDENCE SHALL SUBMIT BUILDING PLANS, IN THE FORM AND MANNER SPECIFIED, TO THE DEPARTMENT FOR PLAN REVIEW AND APPROVAL.

(A) APPLICANTS FOR AN INITIAL ALR LICENSE SHALL SUBMIT BUILDING PLANS FOR NEWLY CONSTRUCTED OR EXISTING BUILDINGS BEFORE THE ISSUANCE OF THE INITIAL LICENSE.

(B) EXISTING LICENSEES SHALL SUBMIT PLANS FOR RENOVATIONS, ADDITIONAL SQUARE FOOTAGE, AND REPLACEMENT BUILDINGS BEFORE BEGINNING CONSTRUCTION.

SECTION 22 – INTERIOR ENVIRONMENT

GENERAL

22.1 ALL INTERIOR AREAS INCLUDING ATTICS, BASEMENTS AND GARAGES SHALL BE FREE FROM ACCUMULATIONS OF EXTRANEOUS MATERIAL SUCH AS REFUSE, UNUSED OR DISCARDED FURNITURE AND POTENTIAL COMBUSTIBLE MATERIALS.

22.2 COMBUSTIBLES SUCH AS CLEANING RAGS AND COMPOUNDS SHALL BE KEPT IN CLOSED METAL CONTAINERS.

22.3 CLEANING COMPOUNDS AND OTHER HAZARDOUS SUBSTANCES (INCLUDING PRODUCTS LABELED "KEEP OUT OF REACH OF CHILDREN" ON THEIR ORIGINAL CONTAINERS) SHALL BE CLEARLY LABELED TO INDICATE CONTENTS AND (EXCEPT WHEN A STAFF MEMBER IS PRESENT) SHALL BE STORED IN A LOCATION SUFFICIENTLY SECURE TO DENY ACCESS TO CONFUSED RESIDENTS.

(A) THE ALR SHALL MAINTAIN A READILY AVAILABLE LIST AND THE SAFETY DATA SHEET OF POTENTIALLY HAZARDOUS SUBSTANCES USED BY HOUSEKEEPING AND OTHER STAFF.

(B) UTILITY ROOMS USED FOR STORING DISINFECTANTS AND DETERGENT CONCENTRATES, CAUSTIC BOWL AND TILE CLEANERS AND INSECTICIDES SHALL BE LOCKED.

22.4 DESIGNATED AREAS WHERE SMOKING IS ALLOWED SHALL BE EQUIPPED WITH FIRE RESISTANT WASTEBASKETS. RESIDENT ROOMS OCCUPIED BY SMOKERS, EVEN WHEN HOUSE RULES PROHIBIT SMOKING IN RESIDENT ROOMS, SHALL HAVE FIRE RESISTANT WASTEBASKETS.

HEATING, LIGHTING AND VENTILATION

22.5 EACH ROOM SHALL HAVE HEAT, LIGHTING AND VENTILATION SUFFICIENT TO MEET THE USE OF THE ROOM AND THE NEEDS OF THE RESIDENTS.

22.6 ALL INTERIOR STAIRS AND CORRIDORS SHALL BE ADEQUATELY LIGHTED.

WATER

22.7 THERE SHALL BE AN ADEQUATE SUPPLY OF SAFE, POTABLE WATER AVAILABLE FOR DOMESTIC PURPOSES.

22.8 THERE SHALL BE A SUFFICIENT SUPPLY OF HOT WATER DURING PEAK USAGE DEMAND.

22.9 HOT WATER SHALL NOT MEASURE MORE THAN 120 DEGREES FAHRENHEIT AT TAPS WHICH ARE ACCESSIBLE BY RESIDENTS.

COMMON AREAS

22.10 COMMON AREAS SHALL BE SUFFICIENT IN SIZE TO REASONABLY ACCOMMODATE ALL RESIDENTS.

22.11 ALL COMMON AND DINING AREAS SHALL BE ACCESSIBLE TO A RESIDENT USING AN AUXILIARY AID WITHOUT REQUIRING TRANSFER FROM A WHEELCHAIR TO WALKER OR FROM A WHEELCHAIR TO A STATIONARY CHAIR FOR USE IN THE DINING AREA. ALL DOORS TO THOSE ROOMS REQUIRING ACCESS SHALL BE AT LEAST 32 INCHES WIDE.

22.12 EFFECTIVE JULY 1, 2018, AN ASSISTED LIVING RESIDENCE THAT HAS ONE OR MORE RESIDENTS USING AN AUXILIARY AID SHALL HAVE A MINIMUM OF TWO MEANS OF ACCESS AND EGRESS FROM THE BUILDING UNLESS LOCAL CODE REQUIRES OTHERWISE.

SLEEPING ROOM

22.13 NO RESIDENT SHALL BE ASSIGNED TO RESIDE IN ANY ROOM OTHER THAN ONE REGULARLY DESIGNATED FOR SLEEPING.

22.14 NO MORE THAN TWO RESIDENTS SHALL OCCUPY A SLEEPING ROOM.

(A) AN ASSISTED LIVING RESIDENCE INITIALLY LICENSED PRIOR TO JULY 1, 1986 IS PERMITTED TO HAVE UP TO FOUR RESIDENTS PER ROOM UNLESS THE ALR UNDERTAKES RENOVATION OR CHANGES OWNERSHIP, AT WHICH TIME THE NEWER, MORE STRINGENT REQUIREMENT SHALL APPLY.

22.15 SLEEPING ROOMS, EXCLUSIVE OF BATHROOM AREAS AND CLOSETS, SHALL HAVE THE FOLLOWING MINIMUM SQUARE FOOTAGE:

(A) 100 SQUARE FEET FOR SINGLE OCCUPANCY, AND

(B) 60 SQUARE FEET PER PERSON FOR DOUBLE OCCUPANCY.

22.16 EACH RESIDENT SHALL HAVE STORAGE SPACE, SUCH AS A CLOSET, FOR CLOTHING AND PERSONAL ARTICLES.

22.17 EACH SLEEPING ROOM SHALL HAVE AT LEAST ONE WINDOW OF 8 SQUARE FEET WHICH SHALL HAVE OPENING CAPABILITY.

(A) AN ASSISTED LIVING RESIDENCE INITIALLY LICENSED PRIOR TO JANUARY 1, 1992, IS PERMITTED TO HAVE A WINDOW OF SMALLER DIMENSIONS UNLESS THE ALR UNDERTAKES RENOVATION OR CHANGES OWNERSHIP, AT WHICH TIME THE NEWER, MORE STRINGENT REQUIREMENT SHALL APPLY.

22.18 IN ASSISTED LIVING RESIDENCES THAT PROVIDE FURNISHINGS FOR RESIDENTS PURSUANT TO A RESIDENT AGREEMENT, EACH RESIDENT SHALL BE PROVIDED, AT A MINIMUM, WITH THE FOLLOWING ITEMS:

(A) A STANDARD-SIZED BED WITH A COMFORTABLE, CLEAN MATTRESS, MATTRESS PROTECTOR, PAD, AND PILLOW (ROLLAWAY TYPE BEDS, COTS, FOLDING BEDS, FUTONS, OR BUNK BEDS ARE PROHIBITED), AND

(B) A STANDARD-SIZED CHAIR IN GOOD CONDITION.

BATHROOM

22.19 THERE SHALL BE AT LEAST ONE FULL BATHROOM FOR EVERY SIX RESIDENTS.

22.20 A FULL BATHROOM SHALL CONTAIN THE FOLLOWING:

(A) TOILET,

(B) HAND-WASHING STATION,

(C) MIRROR,

(D) PRIVATE INDIVIDUAL STORAGE FOR RESIDENT PERSONAL EFFECTS; AND

(E) SHOWER.

22.21 ALL BATHTUBS AND SHOWER FLOORS SHALL HAVE PROPER SAFETY FEATURES TO PREVENT SLIPS AND FALLS.

22.22 TOILET SEATS SHALL BE CONSTRUCTED OF NON-ABSORBENT MATERIAL AND FREE OF CRACKS.

22.23 EACH ASSISTED LIVING RESIDENCE SHALL PROVIDE TOILET PAPER IN EACH RESIDENT BATHROOM, EXCEPT WHERE A RESIDENT HAS A SPECIFIC PREFERENCE AND AGREES TO SUPPLY IT.

22.24 TOILET PAPER IN A DISPENSER, LIQUID SOAP AND PAPER TOWELS OR HAND DRYING DEVICES SHALL BE AVAILABLE AT ALL TIMES IN EACH COMMON BATHROOM.

22.25 IN AN ASSISTED LIVING RESIDENCE THAT HAS ONE OR MORE RESIDENTS USING AUXILIARY AIDS, THE ASSISTED LIVING RESIDENCE SHALL PROVIDE AT LEAST ONE FULL BATHROOM WITH FIXTURES POSITIONED SO THAT THEY ARE FULLY ACCESSIBLE TO ANY RESIDENT UTILIZING AN AUXILIARY AID.

22.26 GRAB BARS SHALL BE PROPERLY INSTALLED AT EACH TUB AND SHOWER, AND ADJACENT TO AT LEAST ONE TOILET IN EVERY MULTI-STALL TOILET ROOM IN AN ASSISTED LIVING RESIDENCE IF ANY RESIDENT USES AN AUXILIARY AID OR AS OTHERWISE INDICATED BY THE NEEDS OF THE RESIDENT POPULATION.

(A) WHEN RESIDENTS CAN UNDERTAKE INDEPENDENT TRANSFERS, ALTERNATIVE GRAB BAR CONFIGURATIONS ARE PERMITTED.

HEATING DEVICES

22.27 THE ASSISTED LIVING RESIDENCE SHALL PROHIBIT THE USE OF PORTABLE HEATERS IN RESIDENT ROOMS. THE USE OF FIREPLACES, SPACE HEATERS AND LIKE UNITS THAT GENERATE HEAT SHALL BE PROHIBITED IN THE COMMON AREAS OF THE ASSISTED LIVING RESIDENCE UNLESS THE ALR IS ABLE TO ENSURE THAT SUCH DEVICES HAVE A UL (UNDERWRITERS LABORATORY) OR SIMILAR CERTIFICATION LABEL, DO NOT PRESENT A RESIDENT BURN RISK, AND ARE USED IN ACCORDANCE WITH MANUFACTURER INSTRUCTIONS.

22.28 THE ASSISTED LIVING RESIDENCE SHALL PROHIBIT THE USE OF ELECTRIC BLANKETS AND/OR HEATING PADS IN RESIDENT ROOMS UNLESS THERE IS STAFF SUPERVISION OR WRITTEN DOCUMENTATION THAT THE

ADMINISTRATOR HAS ASSESSED THE RESIDENT AND DETERMINED HE OR SHE IS CAPABLE OF USING SUCH DEVICE IN A SAFE AND APPROPRIATE MANNER.

OXYGEN USE, HANDLING AND STORAGE

22.29 THE ASSISTED LIVING RESIDENCE'S HANDLING AND STORAGE OF OXYGEN SHALL COMPLY WITH ALL APPLICABLE LOCAL, STATE AND FEDERAL REQUIREMENTS.

22.30 THE ASSISTED LIVING RESIDENCE SHALL PROHIBIT SMOKING IN AREAS WHERE OXYGEN IS STORED AND/OR USED AND SHALL POST A CONSPICUOUS "NO SMOKING" SIGN IN THOSE AREAS.

22.31 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT OXYGEN TANKS ARE NOT ROLLED ON THEIR SIDE OR DRAGGED.

22.32 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT OXYGEN TANKS ARE SECURED UPRIGHT AT ALL TIMES IN A MANNER THAT PREVENTS TANKS FROM FALLING OVER, BEING DROPPED OR STRIKING EACH OTHER.

22.33 OXYGEN TANK VALVES SHALL BE CLOSED EXCEPT WHEN IN USE.

22.34 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT OXYGEN TANKS ARE NOT PLACED AGAINST ELECTRICAL PANELS, LIVE ELECTRICAL CORDS OR NEAR RADIATORS OR HEAT SOURCES. IF STORED OUTDOORS, TANKS SHALL BE PROTECTED FROM WEATHER EXTREMES AND DAMP GROUND TO PREVENT CORROSION.

SMOKING

22.35 ASSISTED LIVING RESIDENCES SHALL COMPLY WITH THE COLORADO CLEAN INDOOR AIR ACT AT § 25-14-201 THROUGH 25-14-209, C.R.S.

22.36 DESIGNATED OUTDOOR SMOKING AREAS SHALL BE MONITORED WHENEVER RESIDENTS ARE PRESENT.

22.37 DESIGNATED OUTDOOR SMOKING AREAS SHALL HAVE FIRE RESISTANT WASTE DISPOSAL CONTAINERS.

COOKING

22.38 COOKING SHALL NOT BE PERMITTED IN SLEEPING ROOMS.

22.39 RESIDENTS SHALL HAVE ACCESS TO AN ALTERNATIVE AREA WHERE MINIMAL FOOD PREPARATION IS PERMITTED.

22.40 IN ASSISTED LIVING RESIDENCES WHERE RESIDENTS HAVE DWELLING UNITS RATHER THAN SIMPLY SLEEPING ROOMS, COOKING MAY BE ALLOWED IN ACCORDANCE WITH HOUSE RULES.

(A) ONLY RESIDENTS WHO ARE CAPABLE OF COOKING SAFELY SHALL BE ALLOWED TO DO SO AND THE ASSISTED LIVING RESIDENCE SHALL DOCUMENT SUCH ASSESSMENT.

(B) IF COOKING EQUIPMENT IS PRESENT IN DWELLING UNITS, THE ASSISTED LIVING RESIDENCE SHALL HAVE A DEFINITIVE WAY OF DISABLING SUCH EQUIPMENT IF THEY BECOME UNSAFE FOR RESIDENTS TO USE.

ELECTRICAL EQUIPMENT

22.41 ELECTRICAL SOCKET ADAPTORS OR CONNECTORS DESIGNED TO MULTIPLY OUTLET CAPACITY SHALL BE PROHIBITED.

22.42 EXTENSION CORDS ARE PERMITTED FOR TEMPORARY USE ONLY.

22.43 POWER STRIP SURGE PROTECTORS ARE PERMITTED THROUGHOUT THE ASSISTED LIVING RESIDENCE WITH THE FOLLOWING LIMITATIONS:

(A) THE POWER STRIP SHALL HAVE OVERCURRENT PROTECTION IN THE FORM OF A CIRCUIT BREAKER OR FUSE,

(B) THE POWER STRIP SHALL HAVE A UL (UNDERWRITERS LABORATORIES) OR SIMILAR CERTIFICATION LABEL, AND

(C) POWER STRIPS SHALL NOT BE LINKED TOGETHER.

PERSONAL ELECTRIC APPLIANCES

22.44 PERSONAL ELECTRIC APPLIANCES ARE ALLOWED IN RESIDENT ROOMS ONLY IF THE FOLLOWING CRITERIA ARE MET:

(A) SUCH APPLIANCES DO NOT REQUIRE THE USE OF AN EXTENSION CORD OR MULTIPLE USE ELECTRICAL SOCKETS,

(B) SUCH APPLIANCE IS IN GOOD REPAIR AS EVALUATED BY THE ADMINISTRATOR OR DESIGNEE, AND

(C) THERE IS WRITTEN DOCUMENTATION THAT THE RESIDENT HAS BEEN ASSESSED AND DETERMINED TO BE CAPABLE OF USING SUCH APPLIANCE IN A SAFE AND APPROPRIATE MANNER.

SECTION 23 – ENVIRONMENTAL PEST CONTROL

23.1 THE ASSISTED LIVING RESIDENCE SHALL HAVE WRITTEN POLICIES AND PROCEDURES THAT PROVIDE FOR EFFECTIVE CONTROL AND ERADICATION OF INSECTS, RODENTS AND OTHER PESTS.

23.2 THE ASSISTED LIVING RESIDENCE SHALL HAVE A CONTRACT WITH A LICENSED PEST CONTROL COMPANY OR AN EFFECTIVE MEANS FOR PEST CONTROL USING THE LEAST TOXIC AND LEAST FLAMMABLE EFFECTIVE PESTICIDES. THE PESTICIDES SHALL NOT BE STORED IN RESIDENT OR FOOD AREAS AND SHALL BE KEPT UNDER LOCK AND ONLY PROPERLY TRAINED RESPONSIBLE PERSONNEL SHALL BE ALLOWED TO APPLY THEM.

23.3 SCREENS OR OTHER PEST CONTROL MEASURES SHALL BE PROVIDED ON ALL EXTERIOR OPENINGS EXCEPT WHERE PROHIBITED BY FIRE REGULATIONS. ASSISTED LIVING RESIDENCE DOORS, DOOR SCREENS AND WINDOW SCREENS SHALL FIT WITH SUFFICIENT TIGHTNESS AT THEIR PERIMETERS TO EXCLUDE PESTS.

SECTION 24 – WASTE DISPOSAL

SEWAGE AND SEWER SYSTEMS

24.1 ALL SEWAGE SHALL BE DISCHARGED INTO A PUBLIC SEWER SYSTEM, OR IF SUCH IS NOT AVAILABLE, DISPOSED OF IN A MANNER APPROVED BY THE STATE AND LOCAL HEALTH AUTHORITIES AND THE COLORADO WATER QUALITY CONTROL COMMISSION.

A) WHEN PRIVATE SEWAGE DISPOSAL SYSTEMS ARE IN USE, RECORDS OF MAINTENANCE AND THE SYSTEM DESIGN PLANS SHALL BE KEPT ON THE PREMISES.

B) NO UNPROTECTED EXPOSED SEWER LINE SHALL BE LOCATED DIRECTLY ABOVE WORKING, STORAGE OR EATING SURFACES IN KITCHENS, DINING ROOMS, PANTRIES, FOOD STORAGE ROOMS, OR WHERE MEDICAL OR NURSING SUPPLIES ARE PREPARED, PROCESSED OR STORED.

MEDICAL WASTE

24.2 Assisted living residents shall not transport, manage or dispose of medical waste unless in accordance with the 6 CCR 1007-2, Part 1, Regulations pertaining to Solid Waste Disposal Sites and Facilities, Section 13, Medical Waste.

24.3 Assisted living residences that generate waste including medical waste shall make a hazardous waste determination in accordance with Part 261 of the state hazardous waste regulations at 6 CCR 1007-3. If the facility generates hazardous waste, it shall manage, transport and dispose of such waste in accordance with 6 CCR 1007-3.

Refuse

24.4 All garbage and rubbish that is not disposed of as sewage shall be collected in impervious containers in such manner as not to become a nuisance or a health hazard and shall be removed to an outside storage area at least once a day.

A) The refuse storage area shall be kept clean, and free from nuisance.

B) A sufficient number of impervious containers with tight fitting lids shall be provided and kept clean and in good repair.

C) Carts used to transport refuse shall be constructed of impervious materials, enclosed, used solely for refuse and maintained in a sanitary manner.

SECTION 25 – SECURE ENVIRONMENT

25.1 An assisted living residence may choose to provide a secure environment as that term is defined in section 2. A secure environment, which may be provided throughout an entire assisted living residence or in a distinct part of an assisted living residence, shall comply with sections 1 through 24 of this chapter in addition to the requirements in this section 25.

25.2 An assisted living residence that uses any methods or devices to limit, restrict or prohibit free egress of one or more residents to move unsupervised outside of the ALR or any separate and distinct part of the ALR shall comply with this section regarding secure environment.

25.3 An assisted living residence with a secure environment shall include all the services provided in an unsecured environment plus any additional services specified in this section 25.

Written Disclosure

25.4 In addition to the information listed in section 11.7(A) through (K), an assisted living residence shall also disclose the following information to each potential resident and his or her legal representative before such individual moves into a secure environment:

(A) The criteria for admission including the types of required assessments used to determine unique resident needs,

(B) The location of the secure environment and the methods of restrictions that are used,

(C) How the safety of residents is monitored within the building and the outdoor area, and

(D) Information on any specialty services such as memory care and/or special care services, including, but not limited to, a description of daily engagement opportunities.

Pre-Admission Assessment

25.5 BEFORE AN INDIVIDUAL MOVES IN, THE ASSISTED LIVING RESIDENCE SHALL COMPLETE A PRE-ADMISSION ASSESSMENT TO DETERMINE THE APPROPRIATENESS AND NEED FOR SECURE ENVIRONMENT RESIDENCY. THE PRE-ADMISSION ASSESSMENT SHALL INCLUDE ALL THE ITEMS REQUIRED FOR THE COMPREHENSIVE ASSESSMENT IN SECTION 12.7(A) THROUGH (M), PLUS THE FOLLOWING:

(A) A FACE TO FACE EVALUATION BY A LICENSED PRACTITIONER WHICH HAS OCCURRED WITHIN THE PREVIOUS 90 CALENDAR DAYS AND WHICH DESCRIBES THE RESIDENT'S MEDICAL CONDITION AND ANY COGNITIVE DEFICITS THAT CONTRIBUTE TO WANDERING, COMPROMISED SAFETY AWARENESS AND OTHER TYPES OF CONDUCT; AND

(B) DETAILED INFORMATION FROM THE RESIDENT'S FAMILY AND/OR REPRESENTATIVE CONCERNING THE RESIDENT'S RECENT RELEVANT HISTORY AND PATTERNS OF REDUCED SAFETY AWARENESS AND WANDERING ALONG WITH ANY STRATEGIES USED TO PREVENT UNSAFE WANDERING OR SUCCESSFUL EXITING AND ANY OTHER KNOWN TYPES OF CONDUCT.

RESIDENT ADMISSION

25.6 NO INDIVIDUAL SHALL BE REQUIRED TO MOVE IN TO A SECURE ENVIRONMENT AGAINST THEIR WILL UNLESS LEGAL AUTHORITY FOR THE ADMISSION OF THE INDIVIDUAL HAS BEEN ESTABLISHED BY GUARDIANSHIP, COURT ORDER, MEDICAL DURABLE POWER OF ATTORNEY, HEALTH CARE PROXY OR OTHER MEANS ALLOWED BY COLORADO LAW.

25.7 AN INDIVIDUAL MAY VOLUNTARILY AGREE TO RESIDE IN A SECURE ENVIRONMENT EVEN THOUGH HIS OR HER PHYSICAL OR PSYCHOSOCIAL STATUS DOES NOT REQUIRE SUCH PLACEMENT. IN SUCH CIRCUMSTANCES, THE ASSISTED LIVING RESIDENCE SHALL ASSURE THAT THE RESIDENT HAS FREEDOM OF MOVEMENT INSIDE AND OUTSIDE OF THE SECURE ENVIRONMENT AT ALL TIMES AND THAT THERE IS A SIGNED RESIDENT AGREEMENT TO THAT EFFECT.

25.8 ONCE A RESIDENT MOVES INTO A SECURE ENVIRONMENT, THE ASSISTED LIVING RESIDENCE SHALL COMPLY WITH THE FOLLOWING:

(A) THE ASSISTED LIVING RESIDENCE SHALL EVALUATE A RESIDENT WHEN THE RESIDENT EXPRESSES THE DESIRE TO MOVE OUT OF A SECURE ENVIRONMENT AND CONTACT THE RESIDENT'S LEGAL REPRESENTATIVE, PRACTITIONER AND THE STATE AND/OR LOCAL LONG-TERM CARE OMBUDSMAN, WHEN APPROPRIATE;

(B) THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT ADMISSION TO AND CONTINUING RESIDENCE IN A SECURE ENVIRONMENT IS THE LEAST RESTRICTIVE ALTERNATIVE AVAILABLE AND IS NECESSARY FOR THE PHYSICAL AND PSYCHOSOCIAL WELL-BEING OF THE RESIDENT; AND

(C) IF AT ANY TIME A RESIDENT IS DETERMINED TO BE A DANGER TO SELF OR OTHERS, THE ASSISTED LIVING RESIDENCE SHALL BE RESPONSIBLE FOR DEVELOPING AND IMPLEMENTING A TEMPORARY PLAN TO MONITOR THE RESIDENT'S SAFETY ALONG WITH THE PROTECTION OF OTHERS UNTIL THE ISSUE IS APPROPRIATELY RESOLVED AND/OR THE RESIDENT IS DISCHARGED FROM THE ASSISTED LIVING RESIDENCE.

RE-ASSESSMENT

25.9 EACH RESIDENT SHALL BE RE-ASSESSED TO DETERMINE HIS OR HER CONTINUED NEED FOR A SECURE ENVIRONMENT EVERY SIX MONTHS AND WHENEVER THE RESIDENT'S CONDITION CHANGES FROM BASELINE STATUS.

(A) AS PART OF THE SECURE ENVIRONMENT RE-ASSESSMENT, THE ASSISTED LIVING RESIDENCE SHALL CONSULT WITH THE RESIDENT'S ATTENDING PRACTITIONER, FAMILY AND/OR RESIDENT REPRESENTATIVE AND REVIEW SERVICE DOCUMENTATION DATING BACK TO THE MOST RECENT COMPREHENSIVE ASSESSMENT.

ENHANCED RESIDENT CARE PLAN

25.10 IN ADDITION TO THE INFORMATION REQUIRED FOR A RESIDENT CARE PLAN AT SECTION 12.10, THE CARE PLAN FOR EACH RESIDENT IN A SECURE ENVIRONMENT SHALL INCLUDE THE FOLLOWING:

(A) A DESCRIPTION OF THE RESIDENT'S WANDERING PATTERNS AND KNOWN BEHAVIORAL EXPRESSIONS ALONG WITH INDIVIDUALIZED APPROACHES TO BE IMPLEMENTED BY STAFF TO PROTECT THE RESIDENT AND OTHER RESIDENTS WITH WHOM THEY HAVE CONTACT,

(B) A DESCRIPTION OF HOW THE RESIDENT WILL HAVE CONTINUOUS INDEPENDENT ACCESS TO HIS OR HER INDIVIDUAL ROOM ALONG WITH THE ALR'S PLAN TO PROTECT THE RESIDENT FROM UNWANTED VISITATION BY OTHER RESIDENTS,

(C) IDENTIFICATION OF THE TYPE AND LEVEL OF STAFF OVERSIGHT, MONITORING AND/OR ACCOMPANIMENT THAT THE ALR DEEMS NECESSARY TO MEET THE NEEDS OF THE RESIDENT WITHIN THE SECURE ENVIRONMENT AND SECURE OUTDOOR AREA, AND

(D) DOCUMENTATION DESCRIBING THE PERSONAL GROOMING AND HYGIENE ITEMS THAT ARE DETERMINED SAFE FOR THE RESIDENT TO HAVE IN THEIR OWN POSSESSION FOR SELF-CARE AND HOW THOSE ITEMS ARE STORED TO PREVENT UNAUTHORIZED ACCESS BY OTHER RESIDENTS.

25.11 THE ENHANCED RESIDENT CARE PLAN SHALL BE UPDATED TO REFLECT CHANGES IN THE STAFF APPROACH TO MEETING RESIDENT NEEDS AND WHEN ANY MEDICAL ASSESSMENT, APPRAISAL OR OBSERVATIONS INDICATE THE RESIDENT'S CARE NEEDS HAVE CHANGED.

STAFF TRAINING

25.12 THE ASSISTED LIVING RESIDENCE SHALL HAVE A POLICY AND PROCEDURE REGARDING THE TRAINING OF STAFF WHO PROVIDE SERVICES IN A SECURE ENVIRONMENT. THE POLICY SHALL INCLUDE, AT A MINIMUM, INFORMATION ON THE APPROPRIATE STAFF RESPONSE WHEN THERE IS A MISSING RESIDENT OR RESIDENT INCIDENT/ALTERCATION ALONG WITH DISTRIBUTION OF STAFF WHEN RESPONDING TO SUCH AN EVENT TO ENSURE THAT THERE IS SUFFICIENT STAFF PRESENCE FOR THE CONTINUED SUPERVISION OF OTHER RESIDENTS.

25.13 IN ADDITION TO THE TRAINING REQUIREMENTS IN SECTION 7.9, STAFF ASSIGNED TO A SECURE ENVIRONMENT SHALL RECEIVE TRAINING AND EDUCATION ON ASSISTED LIVING RESIDENCE POLICIES AND PROCEDURES SPECIFIC TO THE SECURE ENVIRONMENT RESIDENT CARE, SERVICES AND PROTECTIONS. SUCH TRAINING SHALL INCLUDE, AT A MINIMUM, THE FOLLOWING:

(A) INFORMATION ON THE SECURE ENVIRONMENT THAT IDENTIFIES AND DESCRIBES THE AREAS WHERE RESIDENTS HAVE FREE PASSAGE, WHERE PASSAGE MAY BE RESTRICTED AND WHERE PASSAGE IS PROHIBITED,

(B) INFORMATION REGARDING THE CURRENT MOBILITY STATUS OF ALL RESIDENTS SO THAT STAFF ARE PREPARED TO SUCCESSFULLY EVACUATE ALL RESIDENTS IN THE EVENT OF AN EMERGENCY,

(C) INFORMATION ON THE LOCATION OF THE STORAGE AREA WHICH IS NOT ACCESSIBLE TO RESIDENTS, INCLUDING A DESCRIPTION OF WHAT ITEMS OR CONTENTS ARE REQUIRED TO BE KEPT IN THE STORAGE AREA, AND

(D) INFORMATION ON THE EQUIPMENT AND DEVICES USED TO SECURE THE ENVIRONMENT INCLUDING HOW TO OVERRIDE OR DISARM SUCH DEVICES, ALONG WITH EXPECTATIONS FOR RESPONSE IF STAFF ARE ALERTED TO AN ALARM.

25.14 BEFORE A STAFF MEMBER IS ALLOWED TO WORK INDEPENDENTLY IN THE SECURE ENVIRONMENT, THE ASSISTED LIVING RESIDENCE SHALL PROVIDE EACH STAFF MEMBER WITH A MINIMUM OF EIGHT HOURS OF TRAINING AND EDUCATION ON THE PROVISION OF CARE AND SERVICES FOR RESIDENTS WITH DEMENTIA/COGNITIVE IMPAIRMENT.

(A) THE TRAINING SHALL BE PROVIDED THROUGH STRUCTURED, FORMALIZED CLASSES, CORRESPONDENCE COURSES, COMPETENCY-BASED COMPUTER COURSES, TRAINING VIDEOS OR DISTANCE LEARNING PROGRAMS.

(B) THE TRAINING CONTENT SHALL BE PROVIDED OR RECOGNIZED BY AN ACADEMIC INSTITUTION, A RECOGNIZED STATE OR NATIONAL ORGANIZATION OR ASSOCIATION, OR AN INDEPENDENT CONTRACTOR OR GROUP THAT EMPHASIZES DEMENTIA/COGNITIVE IMPAIRMENT CARE.

(C) THE TRAINING SHALL COVER, AT A MINIMUM, THE FOLLOWING TOPICS:

(1) INFORMATION ON DISEASE PROCESSES ASSOCIATED WITH DEMENTIA AND COGNITIVE IMPAIRMENT INCLUDING PROGRESSION OF THE DISEASES, TYPES AND STAGES OF MEMORY LOSS, FAMILY DYNAMICS, BEHAVIORAL SYMPTOMS AND LIMITATIONS TO NORMAL ACTIVITIES OF DAILY LIVING;

(2) INFORMATION ON NON-PHARMACOLOGICAL TECHNIQUES AND APPROACHES USED TO GUIDE AND SUPPORT RESIDENTS WITH DEMENTIA/COGNITIVE IMPAIRMENT, WANDERING AND SOCIALLY CHALLENGING BEHAVIORAL EXPRESSIONS OF NEED OR DISTRESS;

(3) INFORMATION ON COMMUNICATION TECHNIQUES THAT FACILITATE SUPPORTIVE AND INTERACTIVE STAFF-RESIDENT RELATIONS;

(4) POSITIVE THERAPEUTIC APPROACHES AND ACTIVITIES SUCH AS EXERCISE, SENSORY STIMULATION, ACTIVITIES OF DAILY LIVING AND SOCIAL, RECREATION AND REHABILITATIVE ACTIVITIES;

(5) INFORMATION ON RECOGNIZING PHYSICAL SYMPTOMS THAT MAY CAUSE A CHANGE IN DEMENTIA/COGNITIVE IMPAIRMENT SUCH AS DEHYDRATION, INFECTION, AND SWALLOWING DIFFICULTY; ALONG WITH INDIVIDUALIZED APPROACHES TO ASSIST OR ADDRESS ASSOCIATED SYMPTOMS SUCH AS PAIN, DECREASED APPETITE AND FLUID INTAKE AND/OR ISOLATION; AND

(6) BENEFITS AND IMPORTANCE OF PERSON-CENTERED CARE PLANNING AND COLLABORATIVE APPROACHES TO DELIVERY OF CARE.

25.15 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT EACH STAFF MEMBER ASSIGNED TO THE SECURE ENVIRONMENT COMPLETES EIGHT CLOCK HOURS OF CONTINUING EDUCATION WITHIN EACH 12-MONTH PERIOD BEGINNING WITH THE DATE OF INITIAL ASSIGNMENT. THE EDUCATION SHALL INCLUDE TOPICS COVERED IN THE INITIAL TRAINING AND MAY INCLUDE OTHER TOPICS RELEVANT TO THE POPULATION SERVED AT THE ASSISTED LIVING RESIDENCE.

STAFFING

25.16 THE ASSISTED LIVING RESIDENCE SHALL HAVE A SUFFICIENT NUMBER OF TRAINED STAFF MEMBERS ON DUTY IN THE SECURE ENVIRONMENT TO ENSURE EACH RESIDENT'S PHYSICAL, SOCIAL AND EMOTIONAL HEALTH CARE AND SAFETY NEEDS ARE MET IN ACCORDANCE WITH THEIR INDIVIDUALIZED CARE PLAN.

25.17 THE ASSISTED LIVING RESIDENCE SHALL CONSIDER THE DAY TO DAY RESIDENT NEEDS AND ACTIVITY, INCLUDING THE INTENSITY OF STAFF ASSISTANCE, ON AN INDIVIDUAL RESIDENT BASIS TO DETERMINE THE APPROPRIATE

LEVEL OF STAFFING. AT A MINIMUM, THERE SHALL BE ONE TRAINED, AWAKE STAFF MEMBER ON DUTY AT ALL TIMES.

25.18 STAFF MEMBERS SHALL BE FAMILIAR WITH EACH RESIDENT'S SPECIFIC CARE-PLANNED NEEDS AND THE UNIQUE APPROACHES FOR ASSISTING WITH CARE AND SAFETY.

CARE AND SERVICES

25.19 IN ADDITION TO THE REQUIREMENTS FOR RESIDENT CARE SERVICES IN SECTION 12, EACH ASSISTED LIVING RESIDENCE WITH A SECURE ENVIRONMENT SHALL ESTABLISH POLICIES AND PROCEDURES FOR THE DELIVERY OF RESIDENT CARE AND SERVICES THAT INCLUDE, AT A MINIMUM, THE FOLLOWING:

(A) A SYSTEM OR METHOD OF ACCOUNTING FOR THE WHEREABOUTS OF EACH RESIDENT;

(B) THE SYSTEM OR METHOD STAFF MEMBERS ARE TO USE FOR OBSERVATION, IDENTIFICATION, EVALUATION, INDIVIDUALIZED APPROACH TO AND DOCUMENTATION OF RESIDENT BEHAVIORAL EXPRESSION; AND

(C) ASSISTANCE WITH THE TRANSITION OF RESIDENTS TO AND FROM THE SECURE ENVIRONMENT AND WHEN CHANGING ROOMS WITHIN A SECURE ENVIRONMENT.

25.20 RESIDENTS WHO INDICATE A DESIRE TO GO OUTSIDE THE SECURED AREA SHALL BE PERMITTED TO DO SO WITH STAFF SUPERVISION EXCEPT IN THOSE SITUATIONS WHERE IT WOULD BE DETRIMENTAL TO THE RESIDENT'S HEALTH, SAFETY OR WELFARE.

(A) IF THE ASSISTED LIVING RESIDENCE IS AWARE OF AN ONGOING ISSUE OR PATTERN OF BEHAVIORAL EXPRESSION THAT WOULD BE EXACERBATED BY ALLOWING A RESIDENT TO GO OUTSIDE THE SECURE AREA, IT SHALL BE DOCUMENTED IN THE RESIDENT'S ENHANCED, INDIVIDUALIZED CARE PLAN.

FAMILY COUNCIL

25.21 THE ASSISTED LIVING RESIDENCE SHALL MEET THE REQUIREMENTS OF SECTION 13.10 REGARDING THE INTERNAL GRIEVANCE AND COMPLAINT RESOLUTION PROCESS. IN ADDITION, THE ASSISTED LIVING RESIDENCE SHALL HOLD REGULAR MEETINGS TO ALLOW RESIDENTS, THEIR FAMILY MEMBERS, FRIENDS, AND REPRESENTATIVES TO PROVIDE MUTUAL SUPPORT AND SHARE CONCERNS AND/OR RECOMMENDATIONS ABOUT THE CARE AND SERVICES WITHIN EACH SEPARATE SECURE ENVIRONMENT.

(A) SUCH MEETINGS SHALL BE HELD AT LEAST QUARTERLY AT A PLACE AND TIME THAT REASONABLY ACCOMMODATES PARTICIPATION; AND

(B) THE ASSISTED LIVING RESIDENCE SHALL PROVIDE ADEQUATE ADVANCE NOTICE OF THE MEETING AND ENSURE THAT DETAILS REGARDING ANY MEETING ARE READILY AVAILABLE IN A COMMON AREA WITHIN THE SECURE ENVIRONMENT.

RESIDENT RIGHTS

25.22 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT RESIDENTS IN A SECURE ENVIRONMENT HAVE ALL THE SAME RESIDENT RIGHTS AS SET FORTH IN SECTION 13 OF THIS CHAPTER INCLUDING, BUT NOT LIMITED TO, THE RIGHT TO PRIVACY AND CONFIDENTIALITY.

DISCHARGE

25.23 THE ASSISTED LIVING RESIDENCE SHALL FOLLOW THE REQUIREMENTS OF SECTIONS 11.11 THROUGH 11.17 REGARDING RESIDENT DISCHARGE WHEN MOVING A RESIDENT OUT OF A SECURE ENVIRONMENT UNLESS THE MOVE IS VOLUNTARILY INITIATED BY THE RESIDENT'S LEGAL REPRESENTATIVE.

PHYSICAL DESIGN, ENVIRONMENT AND SAFETY

25.24 THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT RESIDENTS HAVE FREEDOM OF MOVEMENT TO COMMON AREAS AND RESIDENT PERSONAL SPACES.

25.25 TO ENSURE SAFE ACCESS TO OUTDOOR SPACE AND SAFE EVACUATION, THE FOLLOWING REQUIREMENTS SHALL APPLY IN ADDITION TO THE FGI GUIDELINES AT SECTIONS 20.3 AND 20.4.

(A) FOR INITIAL LICENSE APPLICANTS AND NEW CONSTRUCTION INITIATED ON OR AFTER JUNE 1, 2019, ALL PARTS OF THE SECURE ENVIRONMENT SHALL BE LOCATED ON THE GROUND LEVEL OF THE BUILDING.

(B) FOR RENOVATION INITIATED ON OR AFTER DECEMBER 1, 2019, ALL PARTS OF THE SECURE ENVIRONMENT SHALL BE LOCATED ON THE GROUND LEVEL OF THE BUILDING.

(C) IF AN APPLICANT OR LICENSEE DETERMINES THAT THE ABOVE REQUIREMENTS IMPEDE ITS ABILITY TO PROVIDE APPROPRIATE AND EFFECTIVE SERVICES FOR THE RESIDENT POPULATION, THE APPLICANT OR LICENSEE SHALL CONFER WITH THE DEPARTMENT REGARDING ALTERNATIVES. THE DEPARTMENT MAY APPROVE AN ALTERNATE PLAN FOR THE LOCATION OF THE SECURE ENVIRONMENT AND OUTDOOR ACCESS IF ASSURED THAT RESIDENT HEALTH, SAFETY, WELFARE AND INDIVIDUAL RIGHTS ARE ADEQUATELY PROTECTED.

25.26 A SECURE ENVIRONMENT SHALL MEET THE FOLLOWING CRITERIA:

(A) THERE SHALL BE A MULTIPURPOSE ROOM FOR DINING, GROUP AND INDIVIDUAL ACTIVITIES AND FAMILY VISITS,

(B) RESIDENT ACCESS TO APPLIANCES SHALL ONLY BE ALLOWED WITH STAFF SUPERVISION,

(C) THERE SHALL BE A STORAGE AREA WHICH IS INACCESSIBLE TO RESIDENTS FOR STORAGE OF ITEMS THAT COULD POSE A RISK OR DANGER SUCH AS CHEMICALS, TOXIC MATERIALS AND SHARP OBJECTS;

(D) THE CORRIDORS AND PASSAGEWAYS SHALL BE FREE OF OBJECTS OR OBSTACLES THAT COULD POSE A HAZARD,

(E) THERE SHALL BE DOCUMENTATION OF ROUTINE MONTHLY TESTING OF ALL EQUIPMENT AND DEVICES USED TO SECURE THE ENVIRONMENT, AND

(F) THERE SHALL BE A SECURE OUTDOOR AREA THAT IS AVAILABLE FOR RESIDENT USE YEAR-ROUND THAT:

(1) IS DIRECTLY SUPERVISED BY STAFF,

(2) IS INDEPENDENTLY ACCESSIBLE TO RESIDENTS WITHOUT STAFF ASSISTANCE FOR ENTRANCE OR EXIT,

(3) HAS COMFORTABLE SEATING AREAS,

(4) HAS ONE OR MORE AREAS THAT PROVIDE PROTECTION FROM WEATHER ELEMENTS, AND

(5) HAS A FENCE OR ENCLOSURE AROUND THE PERIMETER OF THE OUTDOOR AREA THAT IS NO LESS THAN 6 FEET IN HEIGHT AND CONSTRUCTED TO REDUCE THE RISK OF RESIDENT WANDERING OR ELOPEMENT FROM THE AREA.

(A) IF THE FENCE OR ENCLOSURE HAS GATED ACCESS WHICH IS LOCKED, ALL STAFF ASSIGNED TO THE SECURE ENVIRONMENT SHALL HAVE A READILY AVAILABLE MEANS OF UNLOCKING THE GATE IN CASE OF EMERGENCY.

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