COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Dr. Steve Cox, Branch Manager, Home and Community Facilities

Through: Elaine McManis, Division Director, Heath Facilities and Emergency Medical Services Division *EMcM*

Date: October 18, 2023

Subject: Rulemaking Hearing concerning 6 CCR 1011-1, Chapter 7 – Assisted Living Residences

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The Division is requesting the Board of Health adopt revisions to 6 CCR 1011-1, Chapter 7 – Assisted Living Residences. These revisions were developed in collaboration with stakeholders over a nine-month stakeholder process before being reviewed and recommended for presentation to the Board of Health by the statutory Assisted Living Advisory Committee, and are primarily focused on the implementation of Senate Bill (SB) 22-154. The bill, concerning increasing safety in assisted living residences (ALRs), modifies statutory requirements regarding administrator qualifications, requires a fine be assessed when an ALR is found to be without a qualified administrator or interim administrator, adds notification and grievance/appeal procedures related to involuntary discharge of a resident, requires civil fines be assessed for violations resulting in harm, and increases the dollar limits on fines as an enforcement tool. SB 22-154 also includes specific language reaffirming that ALRs are required to obtain checks of the Colorado Adult Protective Services (CAPS) data system for administrators and staff, as has been required through general licensing rules and statutes applicable to all licensed facilities since 2020. It also added statutory definitions of "local ombudsman" and "state long-term care ombudsman".

The Division is also proposing revisions to update the term "name-based criminal history record check" to "name-based judicial record check" throughout the chapter to ensure consistency with statutes related to the record checks performed on ALR administrators and staff. This terminology was changed throughout the Colorado Revised Statutes by House Bill 22-1270.

Though most of the rule changes being proposed are responsive to legislation passed during the 2022 Legislative Session, the Department is also clarifying an existing rule related to the qualifications of the staff member who is onsite at all times with a current certification in cardiopulmonary resuscitation (CPR). This update is being proposed due to an uptick in noncompliance with this particular rule, stemming from confusion among the regulated community regarding what kind of training qualifies staff as having certification in CPR. This rulemaking also includes non-substantive changes to increase consistency across the chapter in rule formatting, grammar, and word usage.

Note: This document has been modified from the information presented to the Board during the August 16, 2023, request for hearing with the addition of information and rule language related to Senate Bill 22-079, regarding dementia training for direct care staff, and Senate Bill 22-053, regarding visitation rights for residents. These were part of a rulemaking packet heard and adopted by the Board of Health on June 21, 2023, but which was rendered

ineffective due to technical error with the Administrative Procedure Act. They are included here for re-adoption. The Department is presenting re-adoption of these rules for 6 CCR 1011-1, Chapter 5 – Nursing Care Facilities, in a different rulemaking.

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

Note: This document has been modified from the information presented to the Board during the August 16, 2023, request for hearing with the addition of information related to Senate Bill 22-079, regarding dementia training for direct care staff, and Senate Bill 22-053, regarding visitation rights for residents. These were part of a rulemaking packet heard and adopted by the Board of Health on June 21, 2023, but which was rendered ineffective due to technical error with the Administrative Procedure Act. It is included here for re-adoption.

Basis and Purpose.

The Department is proposing rule revisions to:

- Implement Senate Bill (SB) 22-154, concerning increasing safety in assisted living residences (ALRs), as detailed below.
- Modify record check requirements for administrators and staff whose fingerprint-based criminal history record check reveals an arrest without disposition, changing it from a name-based criminal history record check to a name-based judicial record check for consistency with statutory changes to background check terminology made by House Bill 22-1270.
- Modify existing rule language to clarify what it means to be certified in cardiopulmonary resuscitation (CPR) for the purposes of compliance with the existing rule that requires an ALR to have at least one staff member with a current certification in CPR onsite at all times.
- Improve consistency in formatting and grammar/word usage throughout the chapter.

The majority of the proposed changes are due to the passage of SB 22-154, concerning safety in assisted living residences. Though much of the bill's statutory language is fairly prescriptive, the Department has worked with stakeholders to develop rule language that provides clarity of requirements and allows as much flexibility as possible within those confines. The proposed rules include:

- New statutory definitions of local ombudsman and state long-term care ombudsman.
- Elimination of a long-term administrator's ability to meet previous standards regarding qualifications, if they were an administrator of record prior to July 1, 2019. This change is being proposed so that rules are consistent with SB 22-154's statutory requirement that all administrators meet the same qualifications, as set by the Board of Health, regardless of hire date.
- A fine for ALRs that are found to be operating without an administrator or interim administrator who meets the same standards for education and experience as an administrator.
- Interim administrator requirements. Prior to SB 22-154, the concept of an interim administrator was not part of ALR statutes nor were there requirements in rule. With an ALR facing a fine if they are found to be without an administrator or interim administrator, the Department is proposing rules that provide clarity regarding expectations related to interim administrators, including standards regarding appointment, record checks, change of administrator notification, interim administrator training requirements, etc.
- A requirement that an ALR have involuntary discharge policies compliant with statute, as well as requiring the ALR meet standards for providing notice to residents and other

individuals related to involuntary discharge, grievance procedures, and readmission in specific cases regarding to involuntary discharge for non-payment for services.
- Language reflecting the statutory increase on the limit of fines the Department may assess against an ALR as part of intermediate restrictions and conditions for the purposes of license enforcement activities, from $2,000 per year for all violations, to $10,000 per violation, with acknowledgement that the per-violation cap may be exceeded in cases where an egregious violation results in serious injury to or death of a resident.
- Language reflecting the statutory requirement that the Department assess fines for all violations resulting in harm, in accordance with statute. To implement this, the Department is proposing a range of fines for C, D, and E-level deficiencies, as well as the statutory guidance on factors that shall or may be considered when determining the amount of the fine to be assessed.
- A requirement for ALRs to obtain checks of the Colorado Adult Protective Services (CAPS) data system for administrators and staff, though ALRs were already subject to such requirements through general licensing rules and statutes prior to the passage of SB 22-154.

The proposed rules were developed in collaboration with stakeholders over a nine-month stakeholder process before being reviewed and recommended for presentation to the Board of Health by the statutory Assisted Living Advisory Committee.

Re-adoption of Rules Previously Adopted on June 21, 2023:

Basis and Purpose.
The Department is proposing rules to address mandates created in two laws passed during the 2022 legislative session:
- Senate Bill 22-079, "Concerning required dementia training for direct-care staff of specified facilities that provide services to clients living with dementia," and
- Senate Bill 22-053, "Concerning visitation rights at health-care facilities…"

The proposed rules regarding SB 22-079, the dementia training requirements, include:
- New definitions of dementia diseases and related disabilities, direct-care staff member, and equivalent training.
- An effective date for the dementia training requirement.
- Requirements for both initial training and continuing education.
- Allowance for an exception to the initial training.
- Minimum requirements for individuals conducting dementia training.
- Requirements for record-keeping regarding initial and continuing education.

Senate Bill 22-079 requires the Board of Health to adopt rules regarding training requirements no later than January 1, 2024.

The proposed rules regarding SB 22-053, the requirement for visitation rights, include:
- New definitions of advance medical directive, caregiver, communicable disease, compassionate care visit, essential caregiver, and patient or resident with a disability.
- A resident right to visitation.
- Requirements for visitation policies and procedures at every facility.
- Limitations to the visitation right allowed by law during heightened risk of a communicable disease.

The proposed rules are the response to directives in the two new statutes and reflect statutory language directly in many instances. Additional rules fulfill statutory mandates, such as setting minimum requirements for the individuals conducting dementia training and provision for an exception to the initial training.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:
Section 25-27-104, C.R.S.
Section 25-1.5-118, C.R.S.
Section 25-1.5-103, C.R.S.

Other relevant statutes:
Section 25-27-102, C.R.S.
Section 25-27-104.3, C.R.S.
Section 25-27-106, C.R.S.
Section 25-3-125, C.R.S.

Is this rulemaking due to a change in state statute?

____x__ Yes, the bill number is _ Senate Bill 22-154__. Rules are ___ authorized _x__ required.

____x__ Yes, the bill number is _ House Bill 22-1270__. Rules are ___ authorized ___ required. N/A—HB22-1270 modifies the underlying statutory language mirrored in the rules.

____x__ Yes, the bill number is _ Senate Bill 22-079__. Rules are ___ authorized _x__ required.

____x__ Yes, the bill number is _ Senate Bill 22-053__. Rules are ___ authorized ___ required. N/A—SB22-1270 adds visitation requirements to which facilities will be held.

_____ No

Does this rulemaking include proposed rule language that incorporate materials by reference?

_____ Yes ___ URL

___xx___ No

Does this rulemaking include proposed rule language to create or modify fines or fees?

___x___ Yes

___x___ No-- Re-adoption of Rules Previously Adopted on June 21, 2023

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

_xx__ No.

- The proposed rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed;
- The proposed rule requires a local government to perform or increase a specific activity because the local government has opted to perform an activity, or;
- The proposed rule reduces or eliminates a state mandate on local government.

REGULATORY ANALYSIS
for Amendments to
6 CCR 1011-1, Chapter 7 – Assisted Living Residences

Note: This document has been modified from the information presented to the Board during the August 16, 2023, request for hearing with the addition of information related to Senate Bill 22-079, regarding dementia training for direct care staff, and Senate Bill 22-053, regarding visitation rights for residents. These were part of a rulemaking packet heard and adopted by the Board of Health on June 21, 2023, but which was rendered ineffective due to technical error with the Administrative Procedure Act. It is included here for re-adoption.

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.

Group of persons/entities Affected by the Proposed Rule	Size of the Group	Relationship to the Proposed Rule Select category: C/S/B
Assisted Living Residences Licensees (ALRs)	665	C
Residents living in ALRs	Over 20,000*	B
Industry organizations	4	S
Consumer advocacy groups	6	S
*estimate based on 25,395 licensed ALR beds		

While all are stakeholders, groups of persons/entities connect to the rule and the problem being solved by the rule in different ways. To better understand those different relationships, please use this relationship categorization key:

C = individuals/entities that implement or apply the rule.
S = individuals/entities that do not implement or apply the rule but are interested in others applying the rule.
B = the individuals that are ultimately served, including the customers of our customers. These individuals may benefit, be harmed by or be at-risk because of the standard communicated in the rule or the manner in which the rule is implemented.

More than one category may be appropriate for some stakeholders.

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.

Economic outcomes
Summarize the financial costs and benefits, include a description of costs that must be incurred, costs that may be incurred, any Department measures taken to reduce or eliminate these costs, any financial benefits.

C: The costs to ALRs will be dependent upon how much the proposed changes will change current practices of any given ALR. ALRs may experience increased costs related to complying with new requirements related to involuntary discharge, depending on their existing notice and grievance procedures. They may also incur costs should residents file grievances or appeals related to an involuntary discharge or

to meet the standards for CPR certification, depending on whether the training already being used meets the requirements. ALRs may have increased financial costs related to fines but only in cases where the ALR is violating the rules. The broadness of the fine levels and the factors the Department shall and may consider allow the maximum flexibility to minimize fines when appropriate. Additionally, compliant ALRs will not be assessed fines, so every ALR has the opportunity to avoid any fines and related economic impact by complying with the rules. ALRs may also experience costs related to the appointment of an interim administrator, but the bulk of such costs will primarily depend on the individual appointed and whether or not the individual needs to take the administrator training course.

Re-adoption of Rules Previously Adopted on June 21, 2023:

C:
SB22-079 – Dementia Training
Every licensed ALR will be required to provide training at no cost to each direct-care staff member regarding the care of individuals with dementia. An initial four-hour training is required as well as continuing education of at least two hours, every two years.

The cost to each facility will include the cost of staff time for training, the cost of in-person or online training modules, or the cost of course materials (if purchased from an outside vendor) and the trainer's time (if provided internally.) There will be additional time (cost) required to set up policy and procedures and a method for tracking training. Since there are many options to fulfill these statutory requirements, it is not possible to provide an estimated per person dollar amount for the training.

While there is a fiscal impact to meeting this new requirement, it is somewhat mitigated by several factors.

1) The four hours is the minimum required in law and is less than the dementia training already required for staff in secure units of these facilities. Thus as long as the current training
   - meets the minimum requirements for initial training per statute,
   - meets the qualifications for an exception, and
   - is provided by an individual who meets the minimum requirements per the proposed rule,

   there will not be a need for additional training for some individuals, particularly those working in a secure environment. The exception will also apply to anyone who has taken and can document equivalent training as defined in the rule, within the 24 months prior to the effective date of the dementia training requirement in this rule or the start date of the employment. If the training was more than 24 months prior to the hire date, the employee may document the required continuing education to qualify for the exception.

2) There are ongoing discussions between industry representatives, association leaders, and the Department to explore ways to improve access to low-cost or free training meeting the statutory requirements. This may include the use of Department resources such as expansion of training already available on the Department's website https://rise.articulate.com/share/SlasrdhEv9NclDnl5-t8XEnJiwz38m5t#/

or the involvement of 3rd party experts to build appropriate training. No plans have been finalized, but the Department and leaders in the ALR industry are committed to ensuring that high quality training is readily available.

3) Current staff training and orientation requirements include some topics (e.g. behavior management, person-centered care, and communication with residents with disabilities) that overlap the dementia training requirements. Thus, with careful planning, there may be ways to integrate the topics so that dementia training augments other necessary trainings.

4) The requirements for the individuals providing the dementia training were designed to allow for an informal train-the-trainer model to be developed, particularly for continuing education.

The cost of the two hours of required continuing education every two years should have less impact than the required initial training if planned to coincide with other training, staff meetings, or educational events.

During the development of these proposed rules, the potential cost to facilities was considered with the understanding that facility costs are passed on to facility residents. The work group and staff worked to frame the rules to meet the intent of establishing a baseline of education for all direct-care workers while providing options for the development and implementation of the training to minimize the fiscal impact. Also, the draft rules only require the minimum training mandated by the law, and the consensus was not to add to the prescribed minimum, in part to manage the cost to facilities.

The residents of ALRs may bear the burden of slight cost increases to meet the new requirements for additional staff training. It is not anticipated that this would be significant compared to the cost of other services offered by facility. In addition, it is anticipated that additional training may help improve staff retention by helping direct care staff develop the skills necessary to manage residents with dementia.

SB22-053 – Visitation Rights
The main cost to facilities in implementing these new requirements will be the development of policies and procedures for the implementation of the new requirements. Facilities are NOT required to provide any personal protective equipment (e.g. masks), nor are they required to provide test kits if testing for communicable diseases is necessary. Thus the cost for implementation of this new law should be largely limited to the initial administrative time required to come into compliance with the requirements.

Non-economic outcomes
Summarize the anticipated favorable and non-favorable non-economic outcomes (short-term and long-term), and, if known, the likelihood of the outcomes for each affected class of persons by the relationship category.

Favorable non-economic outcomes include:

C: Clarifying language regarding the meaning of a current certification in CPR will increase ALRs' ability to comply with the rules.

B: The rule updates are generally expected to improve the health, safety, and welfare of the individuals residing in ALRs. The proposed rules ensure facilities have qualified administrators or interim administrators, clarify language to improve compliance with CPR training requirements, add grievance and appeal procedures for involuntary discharges, and include a greater financial incentive to comply with rules.

Re-adoption of Rules Previously Adopted on June 21, 2023:
Non-economic outcomes include:

C:
SB22-079 – Dementia Training
When the new dementia training requirements become effective (proposed for January 1, 2024), facilities will have 120 days to ensure that all direct-care staff members receive the initial four-hour training or qualify for an exception if staff has received an equivalent training prior to January 1 2024. Facility administrators will need to research training opportunities and ensure that all employees are compliant no later than April 30, 2024 (120 days after January 1). However, any training that is equivalent to the proposed rules and is taken prior to January 1, 2024, will also be allowable, so the cost and time away from work for all can be spread over the coming months. Also, this will require some small amount of additional time in the hiring process as the administrator or designee will need to check credentials for new employees who are claiming an exception, as well as the ongoing need to track initial training and continuing education for all employees. The additional time and effort should result in a better-trained staff caring for residents.

Additionally, staff who have the initial training and any required continuing education will benefit by the ability to take those training records with them as they move to new jobs with the industry. This should benefit staff members and facilities alike by providing for the portability of training.

SB22-053 – Visitation Rights
For visitation rights, the outcomes will be challenging to measure until the next major communicable disease event. The new law requires facilities to determine policies and procedures in advance to help the facility cope in the event of another pandemic or location-specific outbreak. This will reduce the time needed to make decisions and increase the efficiency of the response while reducing the potential for isolation of residents from outside visitors during an outbreak event.

S:
SB22-079 – Dementia Training
Friends, family members, guardians, etc., of residents will benefit from having loved ones taken care of by staff with enhanced training in recognizing and appropriately caring for residents with dementia.

SB22-053 – Visitation Rights
Friends, family members, guardians, etc., of residents will benefit from the establishment of visitation rights for residents in the event of a communicable disease event, as facilities will have policies determined in advance to ensure the right to visitation.

B:
SB22-079 – Dementia Training
Residents will benefit from being cared for by better-trained staff who can appropriately identify and problem-solve when there are dementia-related issues.

SB22-053 – Visitation Rights
Residents will benefit from having an established right to visitation even during communicable disease events. The policies established by the facility are to provide a predictable path for people to exercise the visitation rights on behalf of a resident, which will result in less isolation for residents.

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:

   N/A. Any efforts necessary to implement the new rules will be absorbed within current staffing/resources.

   Re-adoption of Rules Previously Adopted on June 21, 2023:

   SB22-079 – Dementia Training
   The Department anticipated General Fund costs of $90,868 and 0.7 FTE in FY 2022-23 and $48,218 and 0.4 FTE in FY 2023-24, followed by cash fund costs of $137,402 and 1.3 FTE in FY 2024-25 and $147,630 and 1.4 FTE in FY 2025-26 and ongoing. These costs assume staff resources for the stakeholder process through FY 2023-24, followed by staff resources for assessing compliance with new rules during the facility compliance survey process. These costs were not included in the fiscal note, so if they do come to fruition, the Department may seek a budget action in order to gain resources. If costs are realized for SB 22-079 they will be paid from the appropriate cash fund for whatever facility is impacted.

   SB22-053 – Visitation Rights
   The Department anticipates an ongoing need of 0.6 FTE for personal services (surveyor positions) to investigate any complaints received by facilities. This is estimated to be $54,390 per year.

   Anticipated CDPHE Revenues:

   These proposed rules make no changes to existing fee structures related to ALR licensing; and therefore, there is no impact on anticipated fee revenue that supports general ALR licensing and oversight operations.

   The proposed rules do, however, increase the limits on fines assessed as part of the Department's enforcement activities related to ALRs that violate standards regarding the health, safety, and welfare of residents. In accordance with statute, such fines are deposited in the Assisted Living Residence Improvement Cash Fund, and per statute these monies may only be used for limited purposes, such as educating licensees on how to comply with rules, helping to relocate ALR residents, or reimbursing residents for personal funds lost, as determined necessary by the Department

Re-adoption of Rules Previously Adopted on June 21, 2023:
N/A

B. Anticipated personal services, operating costs or other expenditures by another state agency:

N/A

Anticipated Revenues for another state agency:

N/A

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

Along with the costs and benefits discussed above, the proposed revisions:

_xx__ Comply with a statutory mandate to promulgate rules.
_xx__ Comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.
___ Maintain alignment with other states or national standards.
___ Implement a Regulatory Efficiency Review (rule review) result
_xx__ Improve public and environmental health practice.
_xx__ Implement stakeholder feedback.

Advance the following CDPHE Strategic Plan priorities (select all that apply):

1. Reduce Greenhouse Gas (GHG) emissions economy-wide from 125.716 million metric tons of CO2e (carbon dioxide equivalent) per year to 119.430 million metric tons of CO2e per year by June 30, 2020 and to 113.144 million metric tons of CO2e by June 30, 2023. ___ Contributes to the blueprint for pollution reduction ___ Reduces carbon dioxide from transportation ___ Reduces methane emissions from oil and gas industry ___ Reduces carbon dioxide emissions from electricity sector
2. Reduce ozone from 83 parts per billion (ppb) to 80 ppb by June 30, 2020 and 75 ppb by June 30, 2023. ___ Reduces volatile organic compounds (VOC) and oxides of nitrogen (NOx) from the oil and gas industry. ___ Supports local agencies and COGCC in oil and gas regulations. ___ Reduces VOC and NOx emissions from non-oil and gas contributors
3. Decrease the number of Colorado adults who have obesity by 2,838 by June 30, 2020 and by 12,207 by June 30, 2023. ___ Increases the consumption of healthy food and beverages through education,

policy, practice and environmental changes.
___ Increases physical activity by promoting local and state policies to improve active transportation and access to recreation.
___ Increases the reach of the National Diabetes Prevention Program and Diabetes Self-Management Education and Support by collaborating with the Department of Health Care Policy and Financing.

4. Decrease the number of Colorado children (age 2-4 years) who participate in the WIC Program and have obesity from 2120 to 2115 by June 30, 2020 and to 2100 by June 30, 2023.

___ Ensures access to breastfeeding-friendly environments.

5. Reverse the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023.

___ Reverses the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023.
___ Performs targeted programming to increase immunization rates.
___ Supports legislation and policies that promote complete immunization and exemption data in the Colorado Immunization Information System (CIIS).

6. Colorado will reduce the suicide death rate by 5% by June 30, 2020 and 15% by June 30, 2023.

___ Creates a roadmap to address suicide in Colorado.
___ Improves youth connections to school, positive peers and caring adults, and promotes healthy behaviors and positive school climate.
___ Decreases stigma associated with mental health and suicide, and increases help-seeking behaviors among working-age males, particularly within high-risk industries.
___ Saves health care costs by reducing reliance on emergency departments and connects to responsive community-based resources.

7. The Office of Emergency Preparedness and Response (OEPR) will identify 100% of jurisdictional gaps to inform the required work of the Operational Readiness Review by June 30, 2020.

___ Conducts a gap assessment.
___ Updates existing plans to address identified gaps.
___ Develops and conducts various exercises to close gaps.

8. For each identified threat, increase the competency rating from 0% to 54% for outbreak/incident investigation steps by June 30, 2020 and increase to 92% competency rating by June 30, 2023.

___ Uses an assessment tool to measure competency for CDPHE's response to an outbreak or environmental incident.
___ Works cross-departmentally to update and draft plans to address identified gaps

noted in the assessment. ___ Conducts exercises to measure and increase performance related to identified gaps in the outbreak or incident response plan.
9. 100% of new technology applications will be virtually available to customers, anytime and anywhere, by June 20, 2020 and 90 of the existing applications by June 30, 2023. ___ Implements the CDPHE Digital Transformation Plan. ___ Optimizes processes prior to digitizing them. ___ Improves data dissemination and interoperability methods and timeliness.
10. Reduce CDPHE's Scope 1 & 2 Greenhouse Gas emissions (GHG) from 6,561 metric tons (in FY2015) to 5,249 metric tons (20% reduction) by June 30, 2020 and 4,593 tons (30% reduction) by June 30, 2023. ___ Reduces emissions from employee commuting ___ Reduces emissions from CDPHE operations
11. Fully implement the roadmap to create and pilot using a budget equity assessment by June 30, 2020 and increase the percent of selected budgets using the equity assessment from 0% to 50% by June 30, 2023. ___ Used a budget equity assessment

___ Advance CDPHE Division-level strategic priorities.

The costs and benefits of the proposed rule will not be incurred if inaction was chosen. Costs and benefits of inaction not previously discussed include:

Inaction is not a feasible option as SB 22-154 requires rulemaking.

Re-adoption of Rules Previously Adopted on June 21, 2023:
N/A – these rules are responsive to statutory change, and thus action is required.

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 revision 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.

Re-adoption of Rules Previously Adopted on June 21, 2023:
Rulemaking is required for the dementia training standards; thus there would be no other method allowable for this topic. Further, for both topics, the rules have taken language from the law where possible and added to that language only where directed

to by statute, e.g., the law directed the creation of a definition or process. The language proposed in this rulemaking was developed in conjunction with many stakeholders. The benefits, risks, and costs of the proposed language was 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, and are the most feasible manner to achieve compliance with statute.

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

Stakeholders advocated for more specificity with regard to the fines to be assessed for violations resulting in harm, claiming it would allow them to better plan/budget for fines. However, the new statutory language provides factors the Department shall consider, as well as factors the Department may consider when determining the amount of a fine to be assessed. Further, leaving fine ranges broad provides flexibility for the Department to consider these factors as either mitigating or enhancing the amounts to be assessed. Such flexibility creates the ability to tailor each fine to the particular facility and situation, allowing lower fines when appropriate and thus working with a goal of compliance and not focused just on penalizing. Additionally, these are fines for violations of standards, not fees that must be paid by all operating ALRs. ALRs concerned about the impact of fines have the opportunity to avoid any fine-related costs by complying with the rules. Stakeholders additionally questioned whether assessing fines for noncompliance would actually increase rule compliance, but as SB 22-154 added statutory language requiring fines be assessed for lack of an administrator or interim administrator and for violations resulting in harm, such fines must be included in rules.

Re-adoption of Rules Previously Adopted on June 21, 2023:
Because this process included six multi-hour stakeholder meetings and well over 80 individuals representing a multitude of agencies and constituencies, the process included many proposed alternatives to the attached draft rule language. Each new topic was introduced at one meeting with time for discussion and comment and brought back to the group at the next meeting with revised language and time for discussion and comment. An additional discussion was added for several topics for which consensus language was not agreed upon. Topics producing the most discussion are described below.

Cost of training employees/time away from work: There was discussion around the general cost of the required dementia training and how the requirement could be extremely costly depending on what type of training was required. To address these concerns, the decision was made not to exceed the minimum hours required in the statute. Also, while the initial training topic requirements are set in law, the decisions about how to meet those requirements and where to locate such training are left to the facility to allow flexibility. Also, since the Department was not directed to authorize or compile a list of acceptable trainings, this is also left to the facility and allows for flexibility.

Criteria for an “exception to initial training requirement” and definition of “equivalent” training: The law dictates that these topics be addressed in the rule, and they generated considerable discussion. The Department and stakeholders came to agreement that the exception should apply to people who have taken an equivalent training (one that meets the requirements of the initial training) and, if necessary, the

continuing education required every two years. These requirements should allow for staff to move between facilities without being required to retake training, unless the facility wishes to require it. Again, facilities are given autonomy in making the decision to require more than the minimums set in law and rule.

Minimum requirements for trainers: The law dictates that this topic also be addressed in the rule. This topic may have generated more discussion than any other. There was discussion of "certification," "educational background and degrees," official "train the trainer certification," etc. The proposed rule ended up being relatively simple and requires only two years of experience working with persons living with dementia disease and related disabilities, successful completion of the training being offered or similar initial training which meets the minimum standards, and specialized training from recognized experts, agencies, or academic institutions in dementia disease. Again, the focus is on flexibility for the facility so that it can find trainers and trainings that will inform the facility in best practices while meeting any unique needs.

Record keeping: Keeping accurate records of both the training and the trainers providing such training is important to both the facility and to the staff member. Those records serve two purposes: they provide evidence of meeting the regulatory requirements during any surveys and allow staff to move between facilities without retaking the mandatory training. There was a suggestion that the Department keep a record of qualified trainers and of "approved" trainings or maybe even keep track of everyone's training records. Since none of these are contemplated or approved in the law, the Department did not find undertaking such collection to be the best course of action. However, the discussion did inform the determination of "minimum requirements for trainers" (see above) by moving draft language toward the more general requirements that are in the current draft and away from more specific language in previous drafts.

Definition of advance medical directive: The visitation law allows for visitation of a resident with a disability even if that resident has not specifically designated a support person in writing. The visitation right is accorded to an individual who provides an "advance medical directive." Numerous definitions of advance medical directives came up in the discussion. The situation was resolved by referencing the existing statutory definition of advance medical directive as defined elsewhere in law and thereby providing clarity to facilities.

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.

In developing the proposed rules, the Department considered Title 25, Article 27 of the Colorado Revised Statutes, along with other relevant licensing-related statutes; ALR enforcement history, including surveys completed, tags cited, re-surveys required, and enforcement actions taken; information on the openings and closings of ALRs; federal regulations and the Centers for Medicare and Medicaid Services' conditions of participation for non-ALR long-term care facilities; information provided by stakeholders regarding administrator training and CPR certification standards; and the fining models used by the Department's environmental divisions.

Re-adoption of Rules Previously Adopted on June 21, 2023:

Information sources include: stakeholder feedback, deficiency information from past state licensure surveys, information regarding person-centered care, and information from experts regarding dementia training. These sources informed the Department's determination of best practices to incorporate into the proposed revisions.

STAKEHOLDER ENGAGEMENT
for Amendments to
6 CCR 1011-1, Chapter 7 – Assisted Living Residences

Note: This document has been modified from the information presented to the Board during the August 16, 2023, request for hearing with the addition of information and rule language related to Senate Bill 22-079, regarding dementia training for direct care staff, and Senate Bill 22-053, regarding visitation rights for residents. These were part of a rulemaking packet heard and adopted by the Board of Health on June 21, 2023, but which was rendered ineffective due to technical error with the Administrative Procedure Act. It is included here for re-adoption.

State law requires agencies to establish a representative group of participants when considering 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:

Notice of the opportunity to participate in the stakeholder process related to this rule update was provided to over 1,000 individual contacts in advance of each meeting, including the following:

- Members of the Assisted Living Advisory Committee, as created in Section 25-27-110, C.R.S.
- Licensed assisted living residences
- Advocacy organizations serving assisted living residence owners/operators, as well as those representing individuals served
- State and Local Ombudsmen
- All individuals expressing interest in being included in the stakeholder process, as gathered through interested parties links on department communications and on the website for the stakeholder process.

The following individuals attended at least one meeting as part of either the stakeholder process or Assisted Living Advisory Committee review:

Organization	Name	Title (if known)
A Wildflower Assisted Living & Colorado Assisted Living Association	Nicole Schiavone*	Administrator
AARP Colorado	Greg Glischinski	Executive Council Member
	Leslie Kalechman	Legislative Advocate
	Mary Fries	Volunteer Legislative Advocate
ALC of Denver	Sara Wright	Consultant
ALF at Rocky Moutain PACE	Yesenia Cole	
All About Seniors	Marnie Biln	Owner
Alzheimer's Association	Coral Cosway	Senior Director of Public Policy and Advocacy
	Meghan Donahue*	

Answers for Senior Care	Phil Hotaling	Owner/ Family Consultant
Applewood Our House Memory Care	Sherrie Bonham	Administrator
Ascent Living Communities	Susie Finley*	Founder & Principal
	Beth Williams	
Assured Senior Living	Francis LeGasse	President/ Chief Executive Officer
Aurora Mental Health Center	Jenn McBride	
	Shelly Fitzgerald	
BeeHive Home at the Cortez Homestead	Jan Gardner	Administrator
Beehive of Grand Junction	Nicole Free	
Belmont Senior Care	Andrea Sanchez	Assistant Administrator
BrainCare LLC	Linda Draayers	Executive Director
Cadence Senior Living	Ronnie Brown	Vice President of Operations
Colorado Assisted Living Association, Family West	Jason Davis	Associate Vice President Support Services
CDHS Office of Civil and Forensic Mental Health	Bonnie Wright	Division Director
CEU Consulting & Education Unlimited	Kristie Ashby	
Colorado Gerontological Society	Eileen Doherty	Director
	Pat Cook	RN, BSN, MA
Colorado Health Care Association	Jenny Albertson*	Dir. Quality/Reg Affairs
Commons at Hilltop	Timindra Boyer	Director
Community Reach Center	Andrea Brandt	Mental Health Counselor
	Rock Fritz	Senior Clinical Manager
CoWest Insurance	Jeff Hartzler	
	Shawn Munns	
CPRColorado	David Moschner	Instructor
Crestview Assisted Living	Nancy Ruminski	
Cypus Cares	Lourdes Yun	Administrator
Eben Ezer Lutheran Care Center Assisted Living	Lynelle Phillips	Administrator
	Shelly Griffith	CEO
ED Willowbrook Place ALF	Lebana Prahl	
Elders at Disability Law Colorado	Gina Brown	Legal Assistant
Enriched Assisted Living	Karan McGrath	
	Placida Padila	
Erickson Senior Living	Erica Sprenkel	
Family Health West	Travis Dorr	Director of Compliance and Safety
Florence Care Home	Paula Padilla	Owner
Golden West Senior Living AL	Jennifer Giovanetto	Administrator
Good Samaritan Society	Christin Palmer	

Good Samaritan Society Estes Park	Julie Lee* Ronni Howell	
Grand Avenue Broker at a Better Way Realty	Rene Dunnagan	
Heritage Haus and Primrose Place	Megan Hart	Administrator
Heritage Healthcare Management	Arlyn Oakes	
	Lisa Robirds	Director of Finance & Accounting
Hilltop Assisted Living Communities	Angie Wickersham	SLP
Jefferson Center for Mental Health	Lindsay Schneck	Residential Manager
	Nora Claire Kunzmann	MSW
Kavod Senior Living	Christy Martinez	Assisted Living Director
LeadingAge Colorado	Deborah Lively*	Directory of Public Policy & Public Affairs
	Terry Zamell	Staff & Policy Consultant
Legacy Ridge	Melissa Ward	Executive Director
Live to Assist	Molly Stawinoga	Owner
Loving Hand Assisted Living	Janelle Molina	Owner/Operator
LTC Ombudsman	Cindy Sam	
LTC Ombudsman, Boulder County Area Agency on Aging	Ashley Resse*	
LTC Ombudsman, Denver Regional Council of Governments	Shannon Gimbel*	Ombudsman
	Heather Porreca	
LTC Ombudsman for Larimer County	Amber Franzel	
LTC Ombudsman, Weld County	Raegan Maldonado	
LTC Ombudsman, State Ombudsman Program	Saori Kimura	
Maintain Me Senior Services, CoPRA, OpenArms Assisted Living	Morgan Jerkins	Member, Board of Directors
Morningstar at Bear Creek	Terry LaMantiis	
Morningstar Senior Living	Melissa Clement	
Open Arms Assisted Living	Peter Hynes	
Parkview Medical Center	Melissa Santistevan	Administrative Assistant
Pinkowski Law and Policy Groups, LLC	Brian Pinkowski	
Planet View Assisted Living	Motolani Owolabi	Administrator
Ralston Creek Neighborhood Assisted Living & Memory Care	Mary Besson	Executive Director
RMCC	Hilary Samuel	
	Teddi Samuel	CEO
Roaring Fork Senior Living	Jerry Thomas	Executive Director

Rocky Mountain Assisted Living Residences	David Lewis*	Owner
SCS Assisted Living	Chirag Shah	
Senior Care Administrator Coaching	Janet Cornell*	Consultant
Senior Housing Options	Erica Bonila	
	Mike Holbrook	
Serenity House Assisted Living	Caity Mickey	Ombudsman
Seven Lakes Memory Care	Debbie Ahrens	
Stephens Farm at Adeo	Kourtney Campbell	
Summit Supportive Communities	Danyelle Marts	Executive Director
TenderCare Assisted Living	Mary Vargas	Administrator
The Fountains of Hilltop	Jon Tadvick	
The Gardens at St. Elizabeth	Jane Woloson	
The Gardens Care Homes	Jennifer Conrad	Executive Administrator/Owner
The Kyle Group, CoPRA	Corky Kyle	
The Lodge At Palmers Point	Goldie Tippetts	
The Ridge Senior Living	Katrissa Gates	
Turnberry Place Assisted Living	Rachel Robertson	
Valley Assisted Living	Julie Stock	
Vista Mesa Assisted Living Residence	Raven Downs	
Web Publishing and Services & CO Center on Aging	Karin Hall	
Weld County Area on Agency on Aging	Jami Shepherd	
These individuals did not identify an agency.	Amanda Kerr	
	Anne Marie	
	Bart Miller	
	Bill Boles	
	C. Evans	
	Carol Manteuffel	
	D. Hill	
	Erin Ellis	
	Jannelle Molina	
	Kendall Rubottom	
	Kim ODay	
	Kris Boggs	
	Kristin Sutherland	
	Lindsay Matkin	
	Michelle Glasgow	
	Michelle Westerman	
	Rich Mauro	

	Sara Murray	
	Serena Simpson	
	Stacie Naslund	
	Stephine Talley	
	Tara Fox	
	Teresa Harnos	
In addition, there were 17 participants not identified by name or agency (e.g., by phone number or screen name unrelated to an actual name)		

*Assisted Living Advisory Committee Member

Re-adoption of Rules Previously Adopted on June 21, 2023:

Organization	Name	Title (if known)
ALC of Denver	Sara Wright	Consultant
Alzheimer's Association	Coral Cosway	Senior Director of Public Policy and Advocacy
Alzheimer's Association	Kristin Sutherland	Advocacy Manager
Anthem Memory Care	Terry Lallky	
Applewood Our House	Sherrie Bonham	Administrator
Belmont Senior Care	Carol Ritchey	RN
CDHS Veterans Community Living Centers	Elizabeth Mullins	
Colorado Department of Health Care Policy & Financing	Kyra Acuna	
CO Department of Public Health and Env't (CDPHE)	Grace Alford	Admin Assistant
CDPHE	Francile Beights	Policy Advisor
CDPHE	Monica Billig	Policy Advisor
CDPHE	Dee Reda	Section Manager
CDPHE	Michelle Reese	Senior Policy Advisor
CDPHE	Grace Sandeno	Policy Advisor
CDPHE	Jo Tansey	Branch Chief
CDPHE	Steve Cox	Branch Chief
CDPHE	Joanna Espinoza	Program Manager
CDPHE	Chad Fear	Section Manager
CDPHE	Ash Jackson	Policy Advisor
CDPHE	Elaine McManis	Division Director
CDPHE	Shelly Sanderman	Program Manager
CDPHE	Alexandra Haas	Policy Advisor
CDPHE	Anne Strawbridge	Policy Advisor
Colorado Geriatric Care	Chris Horton	MD
Colorado Gerontological Soc.	Pat Cook	RN BSN MA
Colorado Gerontological Soc.	Eileen Doherty	Director
Colorado Health Care Assoc.	Doug Farmer	
Colorado Health Care Assoc.	Jenny Albertson	Dir. of Quality & Reg. Affairs

Colorado Med. Directors Assoc.	Leslie Eber	
Community Reach Center	Andrea Brandt	Mental Health Counselor
CU Geriatric	Hannah Schara	Fellow
DO CMD- CMDA	Rebecca Jackson	
DON Southeast Colorado Hosp.	Sheri Reed	RN
DRCOG	Shannon Gimbel	Ombudsman
Eben Ezer Lutheran Care	Shelly Griffith	CEO
Endura Healthcare	Jessica LeClaire	
Family Health West	Mary Vargas	
Family Health West	Jason Davis	
Frederick County	Jan Gardner	County Commissioner
Gentle Shepherd Dementia Training & Consulting	Sheryl Scheuer	Chief Education Officer
Idaho	Michelle Glasgow	
Inglenook	Terry Johnson	Director of Activities
Junction Creek Health & Rehab	Maggie Gunderman	Admissions
Junction Creek Health & Rehab	Chantelle Jensen	BOD
Junction Creek Health & Rehab	Katy Murga	SSD
Keystone Place at Legacy Ridge	Shalita Allen	
LeadingAge Colorado	Deborah Lively	Dir. of Public Policy & Public Affairs
LeadingAge Colorado	Terry Zamell	Staff & Policy Consultant
Loving Hand Assisted Living	Jannelle Molina	Owner/Operator
Maven Healthcare Consulting	Linda Savage	
Mountain Vista Senior Living	Alicia Herring	
Person Living with Alzheimer's	Joanna Fix	
Sedgwick County Nursing Home		
Senior Housing Options	Mike Holbrook	
State LTCOP	Cindy Sam	
State LTCOP	Kimura Saori	
Stephens Farm @Adeo	Kortney Campbell	
The Academy	Crystal Henry	
The Commons at Hilltop	Timindra Boyer	Director
The Gardens at Columbine	Astringer	
The Gardens at Columbine	Marci Gerke	Director of Memory Care
The Gardens at St. Elizabeth	Jane Woloson	
The Ridge Senior Living	Katrissa Gates	
The Ridge Senior Living	Autumn Stringer	
Walsh Healthcare Center	Julie Arena	
WellAge Senior Living	Dana Andreski	
	Adam Malachi	
	Alyssa Hobbs	
	Apeck	

	Beth Williams	
	Brian	
	Bridget Garcia	
	Christin M Palmer	
	Gia Verras	
	Glenice Wade	
	Heather	
	Hilary Samuel	
	J Ackerman	
	Jameson Hendler	
	Janel Tolchin	
	Jenn	
	Jo Johnson	
	Julie	
	Karen	
	Kmagana	
	Krystal	
	Mallory Montoya	
	Mark Jorgensen	
	Melissa Lantham	
	Melissa Wood	
	PMC Platform	
	Raj Rai	
	Sing Palat	
	Steve Feldman	
	T Samuel	
	Tara	
	Tony	
	Traci Bradley	
Provider Messaging System from the Department to all ALRs regarding each meeting and the opportunity to participate.		
Stakeholder engagement list – notice regarding each meeting and the opportunity to participate. 171 participants were on the list as of March 2023.		

Stakeholder process and timeline:

August 2022 - May 2023—ALR Safety Stakeholder Process

- August 2022—Memo to stakeholders providing information regarding the upcoming rule update, including meeting and topic schedule and the opportunity to be added to the stakeholder process interested parties list.
- September 2022-May 2023—Stakeholder meetings—Three-hour virtual meetings were held each month to present proposed rule language, seek stakeholder feedback, and present proposed new language to incorporate stakeholder feedback received the prior month. Meetings were open to the public and held virtually, through Zoom, to ensure equitable opportunity to participate regardless of geographic location.

Stakeholders were also invited to email rule drafters and/or program staff between meetings with comments or concerns regarding the draft rules.

- Meeting information was posted on the Department's website, distributed to all licensed ALRs through the Department's provider messaging system, and emailed directly to all ALAC members and individuals who signed up to be on the interested parties list for the stakeholder process. Over 1,000 individuals were contacted roughly 2 weeks before each meeting with the meeting information, including a link to the public Google drive for the stakeholder process, which contained the signed laws impacting the updates, a stakeholder information letter including each month's meeting topics, meeting agendas, draft rules, and copies or links to all materials the department shared as part of each meeting, including recordings and chat records for meetings that had already been held.

June 2023 - July 2023 – Assisted Living Advisory Committee (ALAC) Process.

- Created in Section 25-27-110, C.R.S., the ALAC serves as an advisory committee, making recommendations to the Department concerning the rules promulgated by the Board of Health.
- Proposed rules were presented to the ALAC in June 2023, as part of a hybrid meeting which allowed both in-person attendance and virtual attendance to ensure equitable opportunity for participation by all ALAC members, then again in July 2023, for comment and discussion in a virtual meeting. The committee members in attendance at the meeting, along with additional members via email, recommended the proposed rules be presented to the Board of Health.

Re-adoption of Rules Previously Adopted on June 21, 2023:
Stakeholder meetings were held monthly from September 2022 through February 2023. Participation was open to the public and available via a Zoom online platform. Seven to fourteen days before stakeholder meetings were held, impacted facilities were notified of the meeting through the provider messaging system. In addition to these provider messages being sent out to facilities, direct notice was given via email to 171 interested parties. A public link to the Google meeting folder, which contained the signed law, a stakeholder information letter, meeting agendas, draft rules, and all material being shared at the meetings, were available. Once the meetings concluded, a recording of the zoom meeting was posted along with the zoom chat records.

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.

__XX__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.

Administrator Qualifications. Senate Bill (SB) 22-154, added a statutory requirement that all administrators meet the same education and experience qualifications, regardless of hire date, but it did not address all administrators having the same amount of administrator training. Stakeholders pointed out the apparent discrepancy between the intent of the bill and its language only addressing education and experience, not administrator training. They also reported confusion related to the existing rules, as current administrators would either have 30 or 40 hours of required administrator training, depending on their start date, but the proposed rules required 40 hours. Working with stakeholders, the Department was able to create flexible rules that would allow the administrators that had taken the 30 hours of administrator training to do an additional 10 hours of training, so that all administrators, regardless of hire date, have an appropriate way to meet the 40-hour training requirement.

Addition of Requirements Related to Interim Administrators. SB 22-154 requires a fine be assessed if an ALR is found to be without an administrator or interim administrator. Existing rules do not require or recognize the appointment of an interim administrator. The Department worked with stakeholders to develop standards that would help ALRs meet the requirement of having an interim administrator when the administrator position is vacant, including developing a definition of interim administrator and adding rules around interim administrator education, experience, training, appointment, background checks, and responsibilities.

Involuntary Discharge. Stakeholders expressed concern with the additional requirements around involuntary discharge, believing it would slow the process of discharging residents who have become a danger to themselves or others, thus increasing the difficulty of keeping the resident, other residents, and staff safe. The language of SB 22-154 is very prescriptive with regard to the requirements around involuntary discharge, specifying timing, information to be included in the notice of involuntary discharge, facility grievance procedures, appeals processes, and more. With such prescriptive language, the Department had limited ability to modify requirements but worked with stakeholders to add flexibility and clarity where possible. The Department was unable to eliminate or modify rules to the extent preferred by stakeholders.

Enforcement/Fines. Stakeholders expressed considerable concern regarding the increased limits on fines as an enforcement tool and the new requirement that fines be assessed for all violations resulting in harm. Prior to the passage of SB 22-154, the limit on fines as an enforcement tool was $2,000 per year. SB 22-154 raised that limit to $10,000 per violation, with an additional exception that the $10,000 cap may be exceeded for egregious violations that result in serious injury or death. This is a substantial change, and the Department understands the stakeholders' concerns.

Stakeholders advocated for specificity with regard to the fines to be assessed for violations resulting in harm, claiming it would allow them to better plan/budget for them, as well as assuring consistency in fines assessed from facility to facility. However, the new statutory language provides factors the Department *shall* consider, as well as factors the Department *may* consider when determining the amount of the fine to be assessed. Leaving broader fine ranges provides flexibility for the Department to consider these factors as either mitigating or enhancing the amounts to be assessed. Such flexibility creates the ability to tailor each fine to the particular facility and situation. The reality is that the circumstances around a violation and the

level of harm are unique to each situation, as are the other factors that shall and may be considered. The flexibility of broader fine ranges allows lower fines when appropriate, depending on the circumstances. After much discussion, agreement, if not full consensus, was reached regarding the inclusion of broad fine ranges. It is also important to note that these are fines for violations of standards, not fees that must be paid by all operating ALRs. ALRs concerned about the cost impact of fines have the opportunity to avoid any fines by complying with the rules.

Some stakeholders were also concerned about the rule's use of the term "potential for harm," arguing that term was too broad and would lead to inconsistencies, and they advocated that the Centers for Medicare and Medicaid Services' (CMS') "likelihood of harm" and its corresponding definition be used instead. The Department was unable to accommodate this request for several reasons, including:

- There is no federal regulation or oversight of ALRs, so the CMS standard of "likelihood of harm" doesn't apply to ALRs (and is, in fact, related to federal regulation of nursing homes).
- The term "potential for harm" has been included in ALR regulations for many years as part of determining levels of deficiencies when citing ALR noncompliance with rules, and thus is a known term of art.
- "Potential for harm" is one of the statutory factors the Department must consider when determining the amount of a fine to be assessed.

While the Department could not change to "likelihood of harm," it did work with stakeholders on compromise language, clarifying that "potential for harm" means "there is a reasonable expectation that noncompliance will result in an adverse outcome."

Stakeholders additionally questioned whether assessing fines for violations would actually increase rule compliance, but as SB22-154 added statutory language requiring fines be assessed for lack of an administrator or interim administrator and for violations resulting in harm, such fines must be included in rules regardless of the answer to that question. With the low statutory limits on fines prior to the passage of SB 22-154 ($2,000 per year per ALR), the Department has been very limited in its ability to use fines as an enforcement tool. The Department plans to track fines, compliance, and outcomes and hopes to be able to answer the question of the relationship between fines and compliance in the future.

CPR Training Requirements. Current rules require ALRs to have at least one staff member certified in CPR onsite at all times. Such certification must be from a nationally recognized organization. Over the past year, the Department had seen an increase in noncompliance with the rule, seemingly a result of ALRs not understanding what types of certification would be from a "nationally recognized organization," and specifically that such certification should include a real-time observed assessment of an individual's skills in performing CPR. The Department worked with stakeholders as well as Department subject-matter experts to develop clearer language regarding the training standards and need for skills assessment. In addition, the change allows for changing teaching models/practice that evolved during the COVID pandemic.

Re-adoption of Rules Previously Adopted on June 21, 2023:
The Department worked closely to reach consensus on all the issues that were discussed during the stakeholder meetings. Where consensus was not reached, the

Department worked to refine language to achieve as close to consensus as possible while still prioritizing resident safety and rights.

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

Re-adoption of Rules Previously Adopted on June 21, 2023:
All patients with dementia and many other residents impacted by these rules meet the statutory definition of "patient or resident with a disability."

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.	xx	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.
	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.
	Improves access to food and healthy food options.		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.		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.		Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
	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:_____ _____

SENATE BILL 22-154

BY SENATOR(S) Danielson, Buckner, Gonzales, Jaquez Lewis, Kolker, Moreno, Pettersen, Story, Winter;
also REPRESENTATIVE(S) McCormick and Lindsay, Amabile, Bird, Boesenecker, Caraveo, Cutter, Esgar, Exum, Hooton, Sirota, Titone, Young.

CONCERNING INCREASING SAFETY IN ASSISTED LIVING RESIDENCES, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** 25-27-104.3 as follows:

25-27-104.3. Involuntary discharge - notice - grievance process - appeal - hearing - definition. (1) (a) (I) EXCEPT AS PROVIDED IN SUBSECTION (1)(c) OF THIS SECTION, AN ASSISTED LIVING RESIDENCE SHALL PROVIDE WRITTEN NOTICE OF ANY INVOLUNTARY DISCHARGE OF A RESIDENT AT LEAST THIRTY CALENDAR DAYS IN ADVANCE OF THE DISCHARGE TO:

(A) THE RESIDENT;

(B) THE RESIDENT'S LEGAL REPRESENTATIVE; AND

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

(C) ANY RELATIVE OR OTHER PERSON LISTED AS A CONTACT PERSON FOR THE RESIDENT OR DESIGNATED TO RECEIVE NOTICE OF A DISCHARGE.

(II) WITHIN FIVE DAYS AFTER PROVIDING WRITTEN NOTICE TO THE RESIDENT, THE RESIDENCE SHALL SEND THE DISCHARGE NOTICE TO THE STATE LONG-TERM CARE OMBUDSMAN AND THE LOCAL OMBUDSMAN.

(b) (I) AT A MINIMUM, THE NOTICE OF DISCHARGE MUST INCLUDE A DETAILED EXPLANATION OF THE REASON OR REASONS FOR THE INVOLUNTARY DISCHARGE, INCLUDING:

(A) FACTS AND EVIDENCE SUPPORTING EACH REASON GIVEN BY THE RESIDENCE;

(B) A RECOUNTING OF EVENTS LEADING TO THE INVOLUNTARY DISCHARGE, INCLUDING INTERACTIONS WITH THE RESIDENT OVER A PERIOD OF TIME PRIOR TO THE NOTICE, AND ACTIONS TAKEN TO AVOID DISCHARGE AND THE TIMING OF THOSE ACTIONS;

(C) A STATEMENT THAT THE RESIDENT OR A PERSON LISTED IN SUBSECTION (1)(a)(I) OF THIS SECTION HAS THE RIGHT TO FILE A GRIEVANCE WITH THE RESIDENCE CHALLENGING THE INVOLUNTARY DISCHARGE WITHIN FOURTEEN DAYS AFTER THE WRITTEN NOTICE, THAT THE RESIDENCE'S DESIGNEE MUST PROVIDE A RESPONSE TO THE GRIEVANCE WITHIN FIVE BUSINESS DAYS AFTER RECEIVING THE GRIEVANCE, AND, IF THE RESIDENT OR PERSON FILING THE GRIEVANCE IS DISSATISFIED WITH THE RESPONSE, THAT THE RESIDENT OR PERSON FILING THE GRIEVANCE MAY APPEAL TO THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OR THE EXECUTIVE DIRECTOR'S DESIGNEE PURSUANT TO SUBSECTION (3) OF THIS SECTION; AND

(D) NAMES AND CONTACT INFORMATION, INCLUDING TELEPHONE NUMBERS, ADDRESSES, AND E-MAIL ADDRESSES, FOR THE STATE LONG-TERM CARE OMBUDSMAN, THE LOCAL OMBUDSMAN, AND THE DEPARTMENT.

(II) IF THE RESIDENCE'S INVOLUNTARY DISCHARGE OF THE RESIDENT IS DUE TO A MEDICAL OR PHYSICAL CONDITION RESULTING IN A REQUIRED LEVEL OF CARE THAT CANNOT BE TREATED WITH MEDICATION OR SERVICES ROUTINELY PROVIDED BY THE RESIDENCE'S STAFF OR AN EXTERNAL SERVICE PROVIDER, THE NOTICE MUST ALSO INCLUDE AN ASSESSMENT BY THE

RESIDENT'S PHYSICIAN OR APPLICABLE HEALTH-CARE OR BEHAVIORAL HEALTH PROVIDER OF THE RESIDENT'S CURRENT NEEDS IN RELATION TO THE RESIDENT'S MEDICAL AND PHYSICAL CONDITION.

(c) IF THE STATED REASON FOR THE INVOLUNTARY DISCHARGE IS BECAUSE THE RESIDENT REQUIRES A LEVEL OF CARE THAT CANNOT BE MET BY THE RESIDENCE OR THE RESIDENT HAS DEMONSTRATED THAT THE RESIDENT IS A DANGER TO THE RESIDENT OR OTHERS, THIRTY DAYS' NOTICE IS NOT REQUIRED. HOWEVER, THE RESIDENCE SHALL GIVE AS MUCH ADVANCE NOTICE AS IS REASONABLE UNDER THE CIRCUMSTANCES PRIOR TO THE RESIDENT'S REMOVAL FROM THE RESIDENCE. THE RESIDENCE MUST STILL PROVIDE WRITTEN NOTICE OF THE INVOLUNTARY DISCHARGE PURSUANT TO SUBSECTION (1)(b) OF THIS SECTION AS SOON AS POSSIBLE TO THE RESIDENT, OTHER PERSONS LISTED IN SUBSECTION (1)(a)(I) OF THIS SECTION, AND THE STATE LONG-TERM CARE OMBUDSMAN AND THE LOCAL OMBUDSMAN. NOTWITHSTANDING THE RESIDENT'S REMOVAL FROM THE RESIDENCE PURSUANT TO THIS SUBSECTION (1)(c), THE RESIDENT MAY FILE A GRIEVANCE RELATING TO THE INVOLUNTARY DISCHARGE WITHIN FOURTEEN DAYS AFTER THE RESIDENT'S RECEIPT OF THE WRITTEN NOTICE OF INVOLUNTARY DISCHARGE REQUIRED PURSUANT TO SUBSECTION (1)(b) OF THIS SECTION.

(2) (a) (I) EACH ASSISTED LIVING RESIDENCE SHALL DESIGNATE AN INDIVIDUAL TO RECEIVE GRIEVANCES, PURSUANT TO SUBSECTION (2)(a)(II) OF THIS SECTION, RELATING TO THE INVOLUNTARY DISCHARGE OF A RESIDENT.

(II) A RESIDENT OR ANY PERSON LISTED IN SUBSECTION (1)(a)(I) OF THIS SECTION MAY FILE A GRIEVANCE WITH THE DESIGNEE WITHIN FOURTEEN DAYS AFTER WRITTEN NOTICE IS GIVEN TO THE RESIDENT PURSUANT TO SUBSECTION (1)(b) OR (1)(c) OF THIS SECTION CHALLENGING THE INVOLUNTARY DISCHARGE OF THE RESIDENT AND THE REASONS FOR THE DISCHARGE.

(III) A RESIDENT OR A PERSON LISTED IN SUBSECTION (1)(a)(I) OF THIS SECTION FILING A GRIEVANCE SHALL SUBMIT THE GRIEVANCE IN WRITING, CAUSE IT TO BE WRITTEN, OR STATE IT ORALLY TO THE DESIGNEE, WITH THE PERSON FILING THE GRIEVANCE PROVIDING SOME EVIDENCE OF THE ORAL SUBMISSION OF THE GRIEVANCE OR A WITNESS ATTESTING TO THE ORAL SUBMISSION.

(b) NO LATER THAN FIVE BUSINESS DAYS AFTER A GRIEVANCE HAS BEEN SUBMITTED PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION, THE DESIGNEE SHALL PROVIDE A WRITTEN RESPONSE TO THE GRIEVANCE TO THE RESIDENT, THE PERSONS LISTED IN SUBSECTION (1)(a)(I) OF THIS SECTION, AND THE STATE LONG-TERM CARE OMBUDSMAN AND THE LOCAL OMBUDSMAN. THE DESIGNEE'S WRITTEN RESPONSE MUST BE ACCOMPANIED BY AN ORAL EXPLANATION TO THE RESIDENT OR PERSON FILING THE GRIEVANCE IF APPROPRIATE BECAUSE OF THE MENTAL OR PHYSICAL CONDITION OF THE RESIDENT OR PERSON FILING THE GRIEVANCE.

(c) THE STATE LONG-TERM CARE OMBUDSMAN OR THE LOCAL OMBUDSMAN MAY PROVIDE ASSISTANCE TO A RESIDENT OR PERSON FILING A GRIEVANCE IN INVESTIGATING, PREPARING, AND FILING THE GRIEVANCE PURSUANT TO THIS SUBSECTION (2) OR INVESTIGATING, PREPARING, AND FILING AN APPEAL OF THE DESIGNEE'S RESPONSE TO THE GRIEVANCE PURSUANT TO SUBSECTION (3) OF THIS SECTION.

(3) IF THE RESIDENT OR PERSON FILING THE GRIEVANCE IS DISSATISFIED WITH THE DESIGNEE'S WRITTEN RESPONSE, THE RESIDENT OR THE PERSON FILING THE GRIEVANCE MAY APPEAL TO THE DEPARTMENT FOR REVIEW OF THE DESIGNEE'S RESPONSE TO THE GRIEVANCE BY FILING THE SAME GRIEVANCE, THE ORIGINAL NOTICE AND SUPPORTING DOCUMENTATION GIVEN TO THE RESIDENT PURSUANT TO SUBSECTION (1)(b) OR (1)(c) OF THIS SECTION, AND THE DESIGNEE'S WRITTEN RESPONSE PURSUANT TO SUBSECTION (2)(b) OF THIS SECTION, INCLUDING SUPPORTING DOCUMENTATION, ALONG WITH ANY ADDITIONAL INFORMATION OR DOCUMENTATION, TO THE EXECUTIVE DIRECTOR OF THE DEPARTMENT FOR THE DEPARTMENT'S REVIEW. AN APPEAL TO THE EXECUTIVE DIRECTOR OF THE DEPARTMENT MUST BE FILED WITHIN FIVE BUSINESS DAYS AFTER THE RESIDENT OR PERSON FILING THE GRIEVANCE RECEIVES THE DESIGNEE'S WRITTEN RESPONSE. THE DEPARTMENT SHALL REVIEW THE GRIEVANCE AND RESPONSE AS SOON AS POSSIBLE, BUT NO LATER THAN SIXTY DAYS AFTER RECEIVING THE APPEAL, TO DETERMINE WHETHER THE INVOLUNTARY DISCHARGE COMPLIES WITH THE LAW AND THE PROCESS ESTABLISHED IN THIS SECTION. THE DEPARTMENT MAY CONFER WITH OR RECEIVE INFORMATION FROM THE RESIDENT, THE RESIDENCE, AND THE STATE LONG-TERM CARE OMBUDSMAN AND THE LOCAL OMBUDSMAN CONCERNING THE INVOLUNTARY DISCHARGE.

(4) (a) THE ASSISTED LIVING RESIDENCE SHALL NOT TAKE ANY

PUNITIVE OR RETALIATORY ACTION AGAINST A RESIDENT DUE TO THE RESIDENT FILING A GRIEVANCE OR APPEAL PURSUANT TO THIS SECTION AND SHALL CONTINUE TO ASSIST WITH PLANNING A DISCHARGE OR TRANSFER OF THE RESIDENT WHILE THE GRIEVANCE OR APPEAL TO THE DEPARTMENT IS PENDING.

(b) IF THE STATED REASON FOR THE INVOLUNTARY DISCHARGE IS FOR NONPAYMENT OF MONTHLY SERVICES OR ROOM AND BOARD, THE RESIDENCE MAY DISCHARGE THE RESIDENT ON THE THIRTY-FIRST DAY AFTER THE WRITTEN NOTICE OF DISCHARGE HAS BEEN PROVIDED TO THE RESIDENT. IF IT IS DETERMINED THROUGH THE GRIEVANCE AND APPEAL PROCESS THAT THE RESIDENT SUBSTANTIALLY COMPLIED WITH PAYMENTS DUE TO THE RESIDENCE, THE RESIDENCE SHALL ALLOW THE RESIDENT TO RETURN TO THE RESIDENCE.

(5) IF THE RESIDENT, THE PERSON FILING THE GRIEVANCE OR THE APPEAL, OR THE ASSISTED LIVING RESIDENCE IS DISSATISFIED WITH THE FINDINGS AND RECOMMENDATIONS OF THE DEPARTMENT, THAT RESIDENT, PERSON, OR RESIDENCE MAY REQUEST A HEARING CONDUCTED BY THE DEPARTMENT PURSUANT TO SECTION 24-4-105.

(6) (a) NO LATER THAN JANUARY 1, 2024, THE STATE BOARD SHALL PROMULGATE RULES NECESSARY TO IMPLEMENT THE GRIEVANCE PROCESS SET FORTH IN THIS SECTION.

(b) PRIOR TO THE BOARD'S ADOPTION OF RULES FOR THE IMPLEMENTATION OF THE GRIEVANCE PROCESS, THE DEPARTMENT SHALL CONFER WITH THE ADVISORY COMMITTEE ESTABLISHED IN SECTION 25-27-110 FOR THE PURPOSE OF MAKING RECOMMENDATIONS TO THE BOARD CONCERNING RULES RELATING TO THE GRIEVANCE PROCESS.

(7) AS USED IN THIS SECTION, "DESIGNEE" MEANS THE INDIVIDUAL DESIGNATED BY THE ASSISTED LIVING RESIDENCE TO RECEIVE GRIEVANCES RELATING TO AN INVOLUNTARY DISCHARGE OF A RESIDENT PURSUANT TO SUBSECTION (2)(a)(I) OF THIS SECTION.

SECTION 2. In Colorado Revised Statutes, 25-27-104, **amend** (2) introductory portion and (2)(g); and **add** (2)(l) and (2)(m) as follows:

25-27-104. Minimum standards for assisted living residences -

rules. (2) ~~Rules promulgated by the~~ State board RULES PROMULGATED pursuant to subsection (1) of this section ~~shall~~ MUST include, ~~as~~ AT a minimum, ~~provisions~~ RULES requiring the following:

(g) That the administrator and staff of a residence:

(I) (A) Meet minimum educational, training, and experience standards established by the state board. ~~including a requirement that such persons be~~

(B) ON AND AFTER JANUARY 1, 2024, THE STATE BOARD'S MINIMUM STANDARDS FOR ADMINISTRATORS MUST REQUIRE, AT A MINIMUM, THAT EACH ADMINISTRATOR, REGARDLESS OF THE ADMINISTRATOR'S HIRE DATE, HAVE AT LEAST ONE YEAR EXPERIENCE SUPERVISING THE DELIVERY OF PERSONAL CARE SERVICES THAT INCLUDES ACTIVITIES OF DAILY LIVING OR HAS ATTAINED THE EDUCATION OR EXPERIENCE ESTABLISHED BY THE STATE BOARD IN LIEU OF THAT SUPERVISORY EXPERIENCE.

(II) ARE of good, moral, and responsible character. In making ~~such a~~ THE determination, the owner or licensee of a residence ~~may~~ SHALL have access to and shall obtain any criminal history record information from a criminal justice agency, subject to any restrictions imposed by ~~such~~ THE agency for any person responsible for the care and welfare of residents of ~~such~~ THE residence AND SHALL OBTAIN A CHECK OF THE COLORADO ADULT PROTECTIVE SERVICES DATA SYSTEM PURSUANT TO SECTION 26-3.1-111 FOR ANY PERSON WHO IS AN EMPLOYEE OF THE RESIDENCE, AS DEFINED IN SECTION 26-3.1-111 (2), WHO WILL PROVIDE DIRECT CARE TO RESIDENTS.

(l) THAT THE ASSISTED LIVING RESIDENCE COMPLY WITH THE PROVISIONS OF SECTION 25-27-104.3 CONCERNING THE INVOLUNTARY DISCHARGE OF RESIDENTS; AND

(m) THAT THE STATE BOARD ESTABLISH, NOT LATER THAN JANUARY 1, 2024, A RANGE OF FINES FOR VIOLATIONS, WHICH AMOUNTS MAY VARY BASED ON THE SIZE OF THE ASSISTED LIVING RESIDENCE AND THE POTENTIAL FOR HARM TO ONE OR MORE PERSONS, AND SHALL PERMIT THE DEPARTMENT TO CONSIDER FACTORS SET FORTH IN SECTION 25-27-106 (4) IN DETERMINING THE AMOUNT OF THE FINE. PRIOR TO THE BOARD'S ADOPTION OF RULES CONCERNING THE RANGE OF FINES FOR VIOLATIONS, THE DEPARTMENT SHALL MAKE RECOMMENDATIONS TO THE BOARD, INCLUDING A PROPOSED

SCHEDULE OF FINES THAT VARY THE RANGE OF FINES BY THE SEVERITY AND FREQUENCY OF THE VIOLATIONS AND THAT MAY INCLUDE A DIFFERENT RANGE OF FINES BASED ON THE SIZE OF THE RESIDENCE. THE DEPARTMENT SHALL FIRST PRESENT THE RECOMMENDATIONS TO AND SEEK FEEDBACK FROM THE ADVISORY COMMITTEE ESTABLISHED IN SECTION 25-27-110.

SECTION 3. In Colorado Revised Statutes, 25-27-106, **amend** (2)(b)(I)(E) and (2)(b)(II); and **add** (4), (5), and (6) as follows:

25-27-106. License denial, suspension, or revocation. (2) (b) (I) The department may impose intermediate restrictions or conditions on a licensee that may include at least one of the following:

(E) Paying a civil fine not to exceed ~~two thousand dollars in a calendar year~~ TEN THOUSAND DOLLARS PER VIOLATION; EXCEPT THAT THE DEPARTMENT MAY EXCEED THE CAP FOR AN EGREGIOUS VIOLATION THAT RESULTS IN DEATH OR SERIOUS INJURY TO A RESIDENT AFTER CONSIDERING THE CIRCUMSTANCES SURROUNDING THE VIOLATION AND THE FACTORS SET FORTH IN SUBSECTION (4)(a) OF THIS SECTION.

(II) (A) If the department imposes an intermediate restriction or condition that is not a result of a life-threatening situation OR DUE TO SERIOUS INJURY OR HARM TO A RESIDENT, the licensee shall receive written notice of the restriction or condition. No later than ten days after the date the notice is received from the department, the licensee shall submit a written plan that includes the time frame for completing the plan and addresses the restriction or condition specified.

(B) If the department imposes an intermediate restriction or condition that is the result of a life-threatening situation OR IS DUE TO SERIOUS INJURY OR HARM TO A RESIDENT, the department shall notify the licensee in writing, by telephone, or in person during an on-site visit. The licensee shall implement the restriction or condition immediately upon receiving notice of the restriction or condition. If the department provides notice of a restriction or condition by telephone or in person, the department shall send written confirmation of the restriction or condition to the licensee within two business days.

(4) (a) (I) NOTWITHSTANDING THE DEPARTMENT'S DISCRETION PURSUANT TO SUBSECTION (2)(b)(I) OF THIS SECTION CONCERNING THE

IMPOSITION OF INTERMEDIATE RESTRICTIONS OR CONDITIONS ON A LICENSEE, THE DEPARTMENT SHALL IMPOSE A FINE, IN AN AMOUNT PER VIOLATION THAT IS CALCULATED TO DETER FURTHER VIOLATIONS, FOR ANY VIOLATION RESULTING IN ACTUAL HARM OR INJURY TO A RESIDENT. CONSISTENT WITH STATE BOARD RULES PURSUANT TO SECTION 25-27-104 (2), THE AMOUNT OF THE FINE MAY VARY DEPENDING ON THE SIZE OF THE RESIDENCE, THE POTENTIAL FOR HARM OR INJURY TO ONE OR MORE RESIDENTS, AND WHETHER THERE IS A PATTERN OF POTENTIAL OR ACTUAL HARM OR INJURY TO RESIDENTS.

(II) IN DETERMINING THE AMOUNT OF A FINE, THE DEPARTMENT SHALL CONSIDER:

(A) THE HISTORY OF HARM OR INJURY AT THE RESIDENCE;

(B) THE NUMBER OF INJURIES TO RESIDENTS FOR WHICH THE CAUSE OF THE INJURY IS UNKNOWN;

(C) THE ADEQUACY OF THE RESIDENCE'S OCCURRENCE INVESTIGATIONS AND REPORTING;

(D) THE ADEQUACY OF THE ADMINISTRATOR'S SUPERVISION OF EMPLOYEES TO ENSURE EMPLOYEES ARE KEEPING RESIDENTS SAFE FROM HARM OR INJURY; AND

(E) THE RESIDENCE'S COMPLIANCE WITH REQUIRED MANDATORY REPORTING OF THE MISTREATMENT OF RESIDENTS.

(b) NOTWITHSTANDING THE DEPARTMENT'S DISCRETION PURSUANT TO SUBSECTION (2)(b)(I) OF THIS SECTION, THE DEPARTMENT SHALL IMPOSE A FINE, IN AN AMOUNT DETERMINED BY THE DEPARTMENT, FOR ANY RESIDENCE THAT IS FOUND TO BE WITHOUT AN ADMINISTRATOR, OR AN INTERIM ADMINISTRATOR, AS DEFINED BY THE STATE BOARD BY RULE, ON OR AFTER JANUARY 1, 2024, WHO MEETS THE REQUIREMENTS ESTABLISHED BY THE STATE BOARD PURSUANT TO SECTION 25-27-104 (2)(g)(I)(B).

(5) EXCEPT AS PROVIDED IN SUBSECTION (2)(b)(III) OF THIS SECTION, THE DEPARTMENT MAY SUSPEND, REVOKE, OR REFUSE TO RENEW THE LICENSE OF A RESIDENCE IF:

(a) A RESIDENT IS SUBJECT TO MISTREATMENT, AS DEFINED IN SECTION 26-3.1-101 (7), THAT CAUSES INJURY TO THE RESIDENT;

(b) THE RESIDENCE'S OWNER OR ADMINISTRATOR DIRECTLY CAUSED THE MISTREATMENT OR THE MISTREATMENT RESULTED FROM THE ADMINISTRATOR'S FAILURE TO ADEQUATELY TRAIN OR SUPERVISE EMPLOYEES; AND

(c) A DIRECTED WRITTEN PLAN REQUIRED BY THE DEPARTMENT PURSUANT TO SUBSECTION (2)(b)(I)(D) OF THIS SECTION TO CORRECT THE VIOLATION, IN ADDITION TO THE ASSESSMENT OF CIVIL FINES, HAS NOT OR IS NOT REASONABLY EXPECTED TO CORRECT THE VIOLATIONS.

(6) ON AND AFTER JANUARY 1, 2024, THE DEPARTMENT MAY REFUSE TO RENEW THE LICENSE OF A RESIDENCE IF THE RESIDENCE'S ADMINISTRATOR DOES NOT MEET THE REQUIREMENTS ESTABLISHED BY THE STATE BOARD PURSUANT TO SECTION 25-27-104 (2)(g)(I)(B).

SECTION 4. In Colorado Revised Statutes, 25-27-102, **amend** the introductory portion; and **add** (6.5) and (12) as follows:

25-27-102. Definitions. As used in this ~~article~~ ARTICLE 27, unless the context otherwise requires:

(6.5) "LOCAL OMBUDSMAN" HAS THE SAME MEANING AS SET FORTH IN SECTION 26-11.5-103 (2).

(12) "STATE LONG-TERM CARE OMBUDSMAN" HAS THE SAME MEANING AS SET FORTH IN SECTION 26-11.5-103 (7).

SECTION 5. Appropriation. (1) For the 2022-23 state fiscal year, $74,509 is appropriated to the department of public health and environment. This appropriation is from the general fund. To implement this act, the department may use this appropriation as follows:

(a) $26,829 for use by the health facilities and emergency medical services division for administration and operations, which amount is based on an assumption that the division will require an additional 0.3 FTE; and

(b) $47,680 for the purchase of information technology services.

(2) For the 2022-23 state fiscal year, $47,680 is appropriated to the office of the governor for use by the office of information technology. This appropriation is from reappropriated funds received from the department of public health and environment under subsection (1)(b) of this section. To implement this act, the office may use this appropriation to provide information technology services for the department of public health and environment.

SECTION 6. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.

Steve Fenberg
PRESIDENT OF
THE SENATE

Alec Garnett
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED June 2, 2022 at 3:05pm
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

HOUSE BILL 22-1270

BY REPRESENTATIVE(S) Woodrow, Catlin, Esgar, Gray, Herod, Jodeh, Mullica, Pico, Ricks, Snyder;
also SENATOR(S) Priola, Moreno.

CONCERNING MEASURES RELATED TO CHANGING "NAME-BASED CRIMINAL HISTORY RECORD CHECK" TO "NAME-BASED JUDICIAL RECORD CHECK" IN THE COLORADO REVISED STATUTES.

Be it enacted by the General Assembly of the State of Colorado:

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

SECTION 42. In Colorado Revised Statutes, 25-27-105, **amend** (2.5)(a.7) as follows:

25-27-105. License - application - inspection - issuance. (2.5) (a.7) When the results of a fingerprint-based criminal history record check of an applicant performed pursuant to this section reveal a record of arrest without a disposition, the department shall require that applicant to submit to a name-based ~~criminal history~~ JUDICIAL record check, as defined in section 22-2-119.3 (6)(d).

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.

Alec Garnett
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Steve Fenberg
PRESIDENT OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

APPROVED April 21, 2022 at 11:59 am
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

SENATE BILL 22-079

BY SENATOR(S) Kolker and Ginal, Moreno;
also REPRESENTATIVE(S) Young and McLachlan, Bernett, Bird, Boesenecker, Cutter, Duran, Esgar, Exum, Froelich, Gonzales-Gutierrez, Herod, Hooton, Jodeh, Kennedy, Lindsay, Lontine, McCluskie, Sullivan.

CONCERNING REQUIRED DEMENTIA TRAINING FOR DIRECT-CARE STAFF OF SPECIFIED FACILITIES THAT PROVIDE SERVICES TO CLIENTS LIVING WITH DEMENTIA.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds that:

(a) In 2022, an estimated seventy-six thousand Coloradans are living with Alzheimer's disease, and that number is predicted to rise by more than twenty-one percent by 2025;

(b) As dementia progresses, individuals living with the disease increasingly rely on direct-care staff to help them with activities of daily living, such as bathing, dressing, and eating, among others, and are dependent on staff for their health, safety, and welfare;

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

(c) Direct-care staff in particular settings are more likely to encounter people with dementia, as evidenced by the following data:

(I) Forty-eight percent of nursing facility residents have dementia;

(II) Forty-two percent of residents in residential care facilities, including assisted living residences, have dementia; and

(III) Thirty-one percent of individuals using adult day care services have dementia;

(d) During the COVID-19 pandemic, when families were restricted from visiting their loved ones with dementia who live in nursing or other residential facilities, the critical need for direct-care staff to be adequately trained in dementia care was highlighted;

(e) Training has the dual benefit of supporting direct-care staff and increasing the quality of care provided to residents or program participants to whom they provide care;

(f) Staff turnover presents a major challenge to direct-care employers across the country, especially given that recruitment and training is often costly and time consuming;

(g) Dementia training can more adequately prepare direct-care staff for the responsibilities of these jobs, potentially reducing stress, staff burnout, and turnover; and

(h) The single most important determinant of quality dementia care across all care settings is direct-care staff.

SECTION 2. In Colorado Revised Statutes, **add** 25-1.5-118 as follows:

25-1.5-118. Training for staff providing direct-care services to residents with dementia - rules - definitions. (1) BY JANUARY 1, 2024, THE STATE BOARD OF HEALTH SHALL ADOPT RULES REQUIRING COVERED FACILITIES TO PROVIDE DEMENTIA TRAINING FOR DIRECT-CARE STAFF MEMBERS. THE RULES MUST SPECIFY THE FOLLOWING, AT A MINIMUM:

(a) THE DATE ON WHICH THE DEMENTIA TRAINING REQUIREMENT IS EFFECTIVE;

(b) THE LENGTH AND FREQUENCY OF THE DEMENTIA TRAINING, WHICH MUST BE COMPETENCY-BASED AND MUST REQUIRE A COVERED FACILITY TO PROVIDE:

(I) AT LEAST FOUR HOURS OF INITIAL DEMENTIA TRAINING FOR:

(A) ALL DIRECT-CARE STAFF MEMBERS HIRED BY OR WHO START PROVIDING DIRECT-CARE SERVICES AT A COVERED FACILITY ON OR AFTER THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES, UNLESS AN EXCEPTION ESTABLISHED PURSUANT TO SUBSECTION (1)(e) OF THIS SECTION APPLIES, WHICH TRAINING MUST BE COMPLETED WITHIN ONE HUNDRED TWENTY DAYS AFTER THE START OF EMPLOYMENT OR THE PROVISION OF DIRECT-CARE SERVICES, AS APPLICABLE; AND

(B) ALL DIRECT-CARE STAFF MEMBERS HIRED BY OR PROVIDING DIRECT-CARE SERVICES AT A COVERED FACILITY BEFORE THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES, UNLESS AN EXCEPTION ESTABLISHED PURSUANT TO SUBSECTION (1)(e) OF THIS SECTION APPLIES, WHICH TRAINING MUST BE COMPLETED WITHIN ONE HUNDRED TWENTY DAYS AFTER THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES; AND

(II) AT LEAST TWO HOURS OF CONTINUING EDUCATION ON DEMENTIA TOPICS FOR ALL DIRECT-CARE STAFF MEMBERS EVERY TWO YEARS. THE CONTINUING EDUCATION MUST INCLUDE CURRENT INFORMATION ON BEST PRACTICES IN THE TREATMENT AND CARE OF PERSONS LIVING WITH DEMENTIA DISEASES AND RELATED DISABILITIES.

(c) THE CONTENT OF THE INITIAL DEMENTIA TRAINING, WHICH MUST BE CULTURALLY COMPETENT AND INCLUDE THE FOLLOWING TOPICS:

(I) DEMENTIA DISEASES AND RELATED DISABILITIES;

(II) PERSON-CENTERED CARE;

(III) CARE PLANNING;

(IV) ACTIVITIES OF DAILY LIVING; AND

(V) DEMENTIA-RELATED BEHAVIORS AND COMMUNICATION;

(d) THE METHOD OF DEMONSTRATING COMPLETION OF THE REQUIRED DEMENTIA TRAINING AND CONTINUING EDUCATION AND OF EXEMPTING A DIRECT-CARE STAFF MEMBER FROM THE REQUIRED DEMENTIA TRAINING IF THE DIRECT-CARE STAFF MEMBER MOVES TO A DIFFERENT COVERED FACILITY THAN THE COVERED FACILITY THROUGH WHICH THE DIRECT-CARE STAFF MEMBER RECEIVED THE TRAINING. FOR PURPOSES OF THIS SUBSECTION (1)(d), "COVERED FACILITY" INCLUDES AN ADULT DAY CARE FACILITY AS DEFINED IN SECTION 25.5-6-303 (1).

(e) AN EXCEPTION TO THE INITIAL DEMENTIA TRAINING REQUIREMENTS FOR:

(I) A DIRECT-CARE STAFF MEMBER HIRED BY OR WHO STARTS PROVIDING DIRECT-CARE SERVICES AT A COVERED FACILITY ON OR AFTER THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES WHO HAS:

(A) COMPLETED AN EQUIVALENT DEMENTIA TRAINING PROGRAM WITHIN THE TWENTY-FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES; AND

(B) PROVIDED PROOF OF SATISFACTORY COMPLETION OF THE TRAINING PROGRAM; AND

(II) A DIRECT-CARE STAFF MEMBER HIRED BY OR PROVIDING DIRECT-CARE SERVICES AT A COVERED FACILITY BEFORE THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES WHO HAS:

(A) RECEIVED EQUIVALENT TRAINING, AS DEFINED IN THE RULES, WITHIN THE TWENTY-FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES; AND

(B) PROVIDED PROOF OF SATISFACTORY COMPLETION OF THE

TRAINING PROGRAM;

(f) MINIMUM REQUIREMENTS FOR INDIVIDUALS CONDUCTING THE DEMENTIA TRAINING;

(g) A PROCESS FOR THE DEPARTMENT TO VERIFY COMPLIANCE WITH THIS SECTION AND THE RULES ADOPTED BY THE STATE BOARD OF HEALTH PURSUANT TO THIS SECTION;

(h) A REQUIREMENT THAT COVERED FACILITIES PROVIDE THE DEMENTIA TRAINING AND CONTINUING EDUCATION PROGRAMS TO DIRECT-CARE STAFF MEMBERS AT NO COST TO THE STAFF MEMBERS; AND

(i) ANY OTHER MATTERS THE STATE BOARD OF HEALTH DEEMS NECESSARY TO IMPLEMENT THIS SECTION.

(2) THE DEPARTMENT SHALL ENCOURAGE COVERED FACILITIES AND DEMENTIA TRAINING PROVIDERS TO EXPLORE AND APPLY FOR AVAILABLE GIFTS, GRANTS, AND DONATIONS FROM STATE AND FEDERAL PUBLIC AND PRIVATE SOURCES TO SUPPORT THE DEVELOPMENT AND IMPLEMENTATION OF DEMENTIA TRAINING PROGRAMS.

(3) AS USED IN THIS SECTION:

(a) "COVERED FACILITY" MEANS A NURSING CARE FACILITY OR AN ASSISTED LIVING RESIDENCE LICENSED BY THE DEPARTMENT PURSUANT TO SECTION 25-1.5-103 (1)(a).

(b) "DEMENTIA DISEASES AND RELATED DISABILITIES" HAS THE SAME MEANING AS SET FORTH IN SECTION 25-1-502 (2.5).

(c) "DIRECT-CARE STAFF MEMBER" MEANS A STAFF MEMBER CARING FOR THE PHYSICAL, EMOTIONAL, OR MENTAL HEALTH NEEDS OF RESIDENTS IN A COVERED FACILITY AND WHOSE WORK INVOLVES REGULAR CONTACT WITH RESIDENTS WHO ARE LIVING WITH DEMENTIA DISEASES AND RELATED DISABILITIES.

(d) "STAFF MEMBER" MEANS AN INDIVIDUAL, OTHER THAN A VOLUNTEER, WHO IS EMPLOYED BY A COVERED FACILITY.

SECTION 3. In Colorado Revised Statutes, **add** 25.5-6-314 as follows:

25.5-6-314. Training for staff providing direct-care services to clients with dementia - rules - definitions. (1) AS USED IN THIS SECTION:

(a) "COVERED FACILITY" MEANS A NURSING CARE FACILITY OR AN ASSISTED LIVING RESIDENCE LICENSED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT PURSUANT TO SECTION 25-1.5-103 (1)(a).

(b) "DEMENTIA DISEASES AND RELATED DISABILITIES" HAS THE SAME MEANING AS SET FORTH IN SECTION 25-1-502 (2.5).

(c) "DIRECT-CARE STAFF MEMBER" MEANS A STAFF MEMBER CARING FOR THE PHYSICAL, EMOTIONAL, OR MENTAL HEALTH NEEDS OF CLIENTS OF AN ADULT DAY CARE FACILITY AND WHOSE WORK INVOLVES REGULAR CONTACT WITH CLIENTS WHO ARE LIVING WITH DEMENTIA DISEASES AND RELATED DISABILITIES.

(d) "STAFF MEMBER" MEANS AN INDIVIDUAL, OTHER THAN A VOLUNTEER, WHO IS EMPLOYED BY AN ADULT DAY CARE FACILITY.

(2) BY JULY 1, 2024, THE STATE BOARD SHALL ADOPT RULES REQUIRING ALL DIRECT-CARE STAFF MEMBERS TO OBTAIN DEMENTIA TRAINING PURSUANT TO CURRICULUM PRESCRIBED OR APPROVED BY THE STATE DEPARTMENT IN COLLABORATION WITH STAKEHOLDERS THAT IS CONSISTENT WITH THE RULES ADOPTED PURSUANT TO THIS SUBSECTION (2). THE RULES MUST SPECIFY THE FOLLOWING, AT A MINIMUM:

(a) THE DATE ON WHICH THE DEMENTIA TRAINING REQUIREMENT IS EFFECTIVE;

(b) THE LENGTH AND FREQUENCY OF THE DEMENTIA TRAINING, WHICH MUST BE COMPETENCY-BASED AND MUST REQUIRE ALL DIRECT-CARE STAFF TO OBTAIN:

(I) AT LEAST FOUR HOURS OF INITIAL DEMENTIA TRAINING, WHICH MUST BE COMPLETED AS FOLLOWS:

(A) FOR ALL DIRECT-CARE STAFF MEMBERS HIRED BY OR WHO START

PROVIDING DIRECT-CARE SERVICES AT AN ADULT DAY CARE FACILITY ON OR AFTER THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES, UNLESS AN EXCEPTION ESTABLISHED PURSUANT TO SUBSECTION (2)(e) OF THIS SECTION APPLIES, THE TRAINING MUST BE COMPLETED WITHIN ONE HUNDRED TWENTY DAYS AFTER THE START OF EMPLOYMENT OR THE PROVISION OF DIRECT-CARE SERVICES, AS APPLICABLE; AND

(B) FOR ALL DIRECT-CARE STAFF MEMBERS HIRED BY OR PROVIDING DIRECT-CARE SERVICES AT AN ADULT DAY CARE FACILITY BEFORE THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES, UNLESS AN EXCEPTION ESTABLISHED PURSUANT TO SUBSECTION (2)(e) OF THIS SECTION APPLIES, THE TRAINING MUST BE COMPLETED WITHIN ONE HUNDRED TWENTY DAYS AFTER THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES; AND

(II) AT LEAST TWO HOURS OF CONTINUING EDUCATION ON DEMENTIA TOPICS EVERY TWO YEARS. THE CONTINUING EDUCATION MUST INCLUDE CURRENT INFORMATION ON BEST PRACTICES IN THE TREATMENT AND CARE OF PERSONS LIVING WITH DEMENTIA DISEASES AND RELATED DISABILITIES.

(c) THE CONTENT OF THE INITIAL DEMENTIA TRAINING, WHICH MUST BE CULTURALLY COMPETENT AND INCLUDE THE FOLLOWING TOPICS:

(I) DEMENTIA DISEASES AND RELATED DISABILITIES;

(II) PERSON-CENTERED CARE;

(III) CARE PLANNING;

(IV) ACTIVITIES OF DAILY LIVING; AND

(V) DEMENTIA-RELATED BEHAVIORS AND COMMUNICATION;

(d) THE METHOD OF DEMONSTRATING COMPLETION OF THE REQUIRED DEMENTIA TRAINING AND CONTINUING EDUCATION AND OF EXEMPTING A DIRECT-CARE STAFF MEMBER FROM THE REQUIRED DEMENTIA TRAINING IF THE DIRECT-CARE STAFF MEMBER MOVES TO A DIFFERENT ADULT DAY CARE FACILITY THAN THE ADULT DAY CARE FACILITY THROUGH WHICH THE DIRECT-CARE STAFF MEMBER RECEIVED THE TRAINING OR MOVES TO A

COVERED FACILITY AFTER RECEIVING THE TRAINING THROUGH AN ADULT DAY CARE FACILITY;

(e) AN EXCEPTION TO THE INITIAL DEMENTIA TRAINING REQUIREMENTS FOR:

(I) A DIRECT-CARE STAFF MEMBER HIRED BY OR WHO STARTS PROVIDING DIRECT-CARE SERVICES AT AN ADULT DAY CARE FACILITY ON OR AFTER THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES WHO HAS:

(A) COMPLETED AN EQUIVALENT DEMENTIA TRAINING PROGRAM WITHIN THE TWENTY-FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES; AND

(B) PROVIDED PROOF OF SATISFACTORY COMPLETION OF THE TRAINING PROGRAM; AND

(II) A DIRECT-CARE STAFF MEMBER HIRED BY OR PROVIDING DIRECT-CARE SERVICES AT AN ADULT DAY CARE FACILITY BEFORE THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES WHO HAS:

(A) RECEIVED EQUIVALENT TRAINING, AS DEFINED IN THE RULES, WITHIN THE TWENTY-FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THE DEMENTIA TRAINING REQUIREMENT SPECIFIED IN THE RULES; AND

(B) PROVIDED PROOF OF SATISFACTORY COMPLETION OF THE TRAINING PROGRAM;

(f) MINIMUM REQUIREMENTS FOR INDIVIDUALS CONDUCTING THE DEMENTIA TRAINING;

(g) A PROCESS FOR THE STATE DEPARTMENT TO VERIFY COMPLIANCE WITH THIS SECTION AND THE RULES ADOPTED BY THE STATE BOARD PURSUANT TO THIS SECTION; AND

(h) ANY OTHER MATTERS THE STATE BOARD DEEMS NECESSARY TO

IMPLEMENT THIS SECTION.

SECTION 4. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in

November 2022 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

Steve Fenberg
PRESIDENT OF
THE SENATE

Alec Garnett
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED May 31, 2022 at 2:10 pm
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

SENATE BILL 22-053

BY SENATOR(S) Sonnenberg, Cooke, Donovan, Gardner, Holbert, Kirkmeyer, Lundeen, Moreno, Scott, Simpson, Smallwood, Woodward; also REPRESENTATIVE(S) McLachlan and Geitner, Pico, Van Beber, Van Winkle.

CONCERNING VISITATION RIGHTS AT HEALTH-CARE FACILITIES, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 25-1-120, **amend** (1)(b) as follows:

25-1-120. Nursing facilities - rights of patients. (1) The department shall require all skilled nursing facilities and intermediate care facilities to adopt and make public a statement of the rights and responsibilities of the patients who are receiving treatment in such facilities and to treat their patients in accordance with the provisions of said statement. The statement shall ensure each patient the following:

(b) The right to have private and unrestricted communications with any person of ~~his~~ THE PATIENT'S choice, EXCEPT AS SPECIFIED IN SECTION

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

25-3-125 (2) AND (3);

SECTION 2. In Colorado Revised Statutes, **recreate and reenact, with amendments,** 25-3-125 as follows:

25-3-125. Visitation rights - hospital patients - residents in nursing care facilities or assisted living residences - limitations during a pandemic - definitions - short title. (1) THE SHORT TITLE OF THIS SECTION IS THE "ELIZABETH'S NO PATIENT OR RESIDENT LEFT ALONE ACT".

(2) (a) SUBJECT TO THE RESTRICTIONS AND LIMITATIONS FOR SKILLED NURSING FACILITY AND NURSING FACILITY RESIDENTS' VISITATION RIGHTS SPECIFIED IN 42 U.S.C. 1396r (c)(3)(C); 42 U.S.C. 1395i (c)(3)(C); 42 CFR 483.10 (a), (b), AND (f); THE RIGHTS FOR ASSISTED LIVING RESIDENTS SPECIFIED IN RULE PURSUANT TO SECTION 25-27-104; THE RESTRICTIONS AND LIMITATIONS SPECIFIED BY A HEALTH-CARE FACILITY PURSUANT TO SUBSECTION (3) OF THIS SECTION; RESTRICTIONS AND LIMITATIONS SPECIFIED IN STATE OR LOCAL PUBLIC HEALTH ORDERS; AND THE COMMUNICATIONS EXCEPTION SPECIFIED IN SECTION 25-1-120, IN ADDITION TO HOSPITAL PATIENT VISITATION RIGHTS IN 42 CFR 482.13 (h), A PATIENT OR RESIDENT OF A HEALTH-CARE FACILITY MAY HAVE AT LEAST ONE VISITOR OF THE PATIENT'S OR RESIDENT'S CHOOSING DURING THE PATIENT'S STAY OR RESIDENCY AT THE HEALTH-CARE FACILITY, INCLUDING:

(I) A VISITOR TO PROVIDE A COMPASSIONATE CARE VISIT TO ALLEVIATE THE PATIENT'S OR RESIDENT'S PHYSICAL OR MENTAL DISTRESS;

(II) A VISITOR OR SUPPORT PERSON DESIGNATED PURSUANT TO SUBSECTION (2)(b) OF THIS SECTION FOR A PATIENT OR RESIDENT WITH A DISABILITY; AND

(III) FOR A PATIENT WHO IS UNDER EIGHTEEN YEARS OF AGE, THE PARENT OR LEGAL GUARDIAN OF, OR THE PERSON STANDING IN LOCO PARENTIS TO, THE PATIENT.

(b) (I) A PATIENT OR RESIDENT OF A HEALTH-CARE FACILITY MAY DESIGNATE, ORALLY OR IN WRITING, A SUPPORT PERSON WHO SUPPORTS THE PATIENT OR RESIDENT DURING THE COURSE OF THE PATIENT'S STAY OR RESIDENCY AT A HEALTH-CARE FACILITY AND WHO MAY VISIT THE PATIENT OR RESIDENT AND EXERCISE THE PATIENT'S OR RESIDENT'S VISITATION

RIGHTS ON BEHALF OF THE PATIENT OR RESIDENT WHEN THE PATIENT OR RESIDENT IS INCAPACITATED OR OTHERWISE UNABLE TO COMMUNICATE.

(II) WHEN A PATIENT OR RESIDENT HAS NOT DESIGNATED A SUPPORT PERSON PURSUANT TO SUBSECTION (2)(b)(I) OF THIS SECTION AND IS INCAPACITATED OR OTHERWISE UNABLE TO COMMUNICATE THE PATIENT'S OR RESIDENT'S WISHES AND AN INDIVIDUAL PROVIDES AN ADVANCE MEDICAL DIRECTIVE DESIGNATING THE INDIVIDUAL AS THE PATIENT'S OR RESIDENT'S SUPPORT PERSON OR OTHER TERM INDICATING THE INDIVIDUAL IS AUTHORIZED TO EXERCISE RIGHTS COVERED BY THIS SECTION ON BEHALF OF THE PATIENT OR RESIDENT, THE HEALTH-CARE FACILITY SHALL ACCEPT THIS DESIGNATION AND ALLOW THE INDIVIDUAL TO EXERCISE THE PATIENT'S OR RESIDENT'S VISITATION RIGHTS ON THE PATIENT'S OR RESIDENT'S BEHALF.

(3) (a) CONSISTENT WITH 42 CFR 482.13 (h); 42 U.S.C. 1396r (c)(3)(C); 42 U.S.C. 1395i (c)(3)(C); 42 CFR 483.10 (a), (b), AND (f); AND SECTION 25-27-104, A HEALTH-CARE FACILITY SHALL HAVE WRITTEN POLICIES AND PROCEDURES REGARDING THE VISITATION RIGHTS OF PATIENTS AND RESIDENTS, INCLUDING POLICIES AND PROCEDURES SETTING FORTH ANY NECESSARY OR REASONABLE RESTRICTION OR LIMITATION TO ENSURE HEALTH AND SAFETY OF PATIENTS, STAFF, OR VISITORS THAT THE HEALTH-CARE FACILITY MAY NEED TO PLACE ON PATIENT OR RESIDENT VISITATION RIGHTS AND THE REASONS FOR THE RESTRICTION OR LIMITATION.

(b) (I) DURING A PERIOD WHEN THE RISK OF TRANSMISSION OF A COMMUNICABLE DISEASE IS HEIGHTENED, A HEALTH-CARE FACILITY MAY:

(A) REQUIRE VISITORS TO ENTER THE HEALTH-CARE FACILITY THROUGH A SINGLE, DESIGNATED ENTRANCE;

(B) DENY ENTRANCE TO A VISITOR WHO HAS KNOWN SYMPTOMS OF THE COMMUNICABLE DISEASE AND SHOULD ENCOURAGE THE VISITOR TO SEEK CARE;

(C) REQUIRE VISITORS TO USE MEDICAL MASKS, FACE COVERINGS, OR OTHER PERSONAL PROTECTIVE EQUIPMENT WHILE ON THE HEALTH-CARE FACILITY PREMISES OR IN SPECIFIC AREAS OF THE HEALTH-CARE FACILITY;

(D) FOR A HOSPITAL, REQUIRE VISITORS TO SIGN A WAIVER ACKNOWLEDGING THE RISKS OF ENTERING THE HEALTH-CARE FACILITY,

WAIVING ANY CLAIMS AGAINST THE HEALTH-CARE FACILITY IF THE VISITOR CONTRACTS THE COMMUNICABLE DISEASE WHILE ON THE HEALTH-CARE FACILITY PREMISES, AND ACKNOWLEDGING THAT MENACING AND PHYSICAL ASSAULTS ON HEALTH-CARE WORKERS AND OTHER EMPLOYEES OF THE HEALTH-CARE FACILITY WILL NOT BE TOLERATED, AND, IF SUCH ABUSE OCCURS, A HOSPITAL MAY RESTRICT THE VISITOR'S CURRENT OR FUTURE ACCESS;

(E) FOR ALL OTHER HEALTH-CARE FACILITIES, REQUIRE VISITORS TO SIGN A DOCUMENT ACKNOWLEDGING THE RISKS OF ENTERING THE HEALTH-CARE FACILITY AND ACKNOWLEDGING THAT MENACING AND PHYSICAL ASSAULTS ON HEALTH-CARE WORKERS AND OTHER EMPLOYEES OF THE HEALTH-CARE FACILITY WILL NOT BE TOLERATED;

(F) REQUIRE ALL VISITORS, BEFORE ENTERING THE HEALTH-CARE FACILITY, TO BE SCREENED FOR SYMPTOMS OF THE COMMUNICABLE DISEASE AND DENY ENTRANCE TO ANY VISITOR WHO HAS SYMPTOMS OF THE COMMUNICABLE DISEASE;

(G) REQUIRE ALL VISITORS TO THE HEALTH-CARE FACILITY TO BE TESTED FOR THE COMMUNICABLE DISEASE AND DENY ENTRY FOR THOSE WHO HAVE A POSITIVE TEST RESULT; AND

(H) RESTRICT THE MOVEMENT OF VISITORS WITHIN THE HEALTH-CARE FACILITY, INCLUDING RESTRICTING ACCESS TO WHERE IMMUNOCOMPROMISED OR OTHERWISE VULNERABLE POPULATIONS ARE AT GREATER RISK OF BEING HARMED BY A COMMUNICABLE DISEASE.

(II) FOR VISITATION OF A PATIENT OR RESIDENT WITH A COMMUNICABLE DISEASE WHO IS ISOLATED, THE HEALTH-CARE FACILITY MAY:

(A) LIMIT VISITATION TO ESSENTIAL CAREGIVERS WHO ARE HELPING TO PROVIDE CARE TO THE PATIENT OR RESIDENT;

(B) LIMIT VISITATION TO ONE CAREGIVER AT A TIME PER PATIENT OR RESIDENT WITH A COMMUNICABLE DISEASE;

(C) SCHEDULE VISITORS TO ALLOW ADEQUATE TIME FOR SCREENING, EDUCATION, AND TRAINING OF VISITORS AND TO COMPLY WITH ANY LIMITS

ON THE NUMBER OF VISITORS PERMITTED IN THE ISOLATED AREA AT ONE TIME; AND

(D) PROHIBIT THE PRESENCE OF VISITORS DURING AEROSOL-GENERATING PROCEDURES OR DURING COLLECTION OF RESPIRATORY SPECIMENS.

(4) IF A HEALTH-CARE FACILITY REQUIRES, PURSUANT TO SUBSECTION (3) OF THIS SECTION, THAT A VISITOR USE A MEDICAL MASK, FACE COVERING, OR OTHER PERSONAL PROTECTIVE EQUIPMENT, OR TAKE A TEST FOR A COMMUNICABLE DISEASE, IN ORDER TO VISIT A PATIENT OR RESIDENT AT THE HEALTH-CARE FACILITY, NOTHING IN THIS SECTION:

(a) REQUIRES THE HEALTH-CARE FACILITY, IF THE REQUIRED EQUIPMENT OR TEST IS NOT AVAILABLE DUE TO LACK OF SUPPLY, TO ALLOW A VISITOR TO ENTER THE FACILITY;

(b) REQUIRES THE HEALTH-CARE FACILITY TO SUPPLY THE REQUIRED EQUIPMENT OR TEST TO THE VISITOR OR BEAR THE COST OF THE EQUIPMENT FOR THE VISITOR; OR

(c) PRECLUDES THE HEALTH-CARE FACILITY FROM SUPPLYING THE REQUIRED EQUIPMENT OR TEST TO THE VISITOR.

(5) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "ADVANCE MEDICAL DIRECTIVE" HAS THE SAME MEANING AS SET FORTH IN SECTION 15-18.7-102 (2).

(b) "CAREGIVER" MEANS A PARENT, SPOUSE, OR OTHER FAMILY MEMBER OR FRIEND OF A PATIENT WHO PROVIDES CARE TO THE PATIENT.

(c) "COMMUNICABLE DISEASE" HAS THE SAME MEANING AS SET FORTH IN SECTION 25-1.5-102 (1)(a)(IV).

(d) (I) "COMPASSIONATE CARE VISIT" MEANS A VISIT WITH A FRIEND OR FAMILY MEMBER THAT IS NECESSARY TO MEET THE PHYSICAL OR MENTAL NEEDS OF A PATIENT OR RESIDENT WHEN THE PATIENT OR RESIDENT IS EXHIBITING SIGNS OF PHYSICAL OR MENTAL DISTRESS, INCLUDING:

(A) END-OF-LIFE SITUATIONS;

(B) ADJUSTMENT SUPPORT AFTER MOVING TO A NEW FACILITY OR ENVIRONMENT;

(C) EMOTIONAL SUPPORT AFTER THE LOSS OF A FRIEND OR FAMILY MEMBER;

(D) PHYSICAL SUPPORT AFTER EATING OR DRINKING ISSUES, INCLUDING WEIGHT LOSS OR DEHYDRATION; OR

(E) SOCIAL SUPPORT AFTER FREQUENT CRYING, DISTRESS, OR DEPRESSION.

(II) "COMPASSIONATE CARE VISIT" INCLUDES A VISIT FROM:

(A) A CLERGY MEMBER OR LAYPERSON OFFERING RELIGIOUS OR SPIRITUAL SUPPORT; OR

(B) OTHER PERSONS REQUESTED BY THE PATIENT OR RESIDENT FOR THE PURPOSE OF A COMPASSIONATE CARE VISIT.

(e) "HEALTH-CARE FACILITY" MEANS A HOSPITAL, NURSING CARE FACILITY, OR ASSISTED LIVING RESIDENCE LICENSED OR CERTIFIED BY THE DEPARTMENT PURSUANT TO SECTION 25-3-101.

(f) "PATIENT OR RESIDENT WITH A DISABILITY" MEANS A PATIENT OR RESIDENT WHO NEEDS ASSISTANCE TO EFFECTIVELY COMMUNICATE WITH HEALTH-CARE FACILITY STAFF, MAKE HEALTH-CARE DECISIONS, OR ENGAGE IN ACTIVITIES OF DAILY LIVING DUE TO A DISABILITY SUCH AS:

(I) A PHYSICAL, INTELLECTUAL, BEHAVIORAL, OR COGNITIVE DISABILITY;

(II) DEAFNESS, BEING HARD OF HEARING, OR OTHER COMMUNICATION BARRIERS;

(III) BLINDNESS;

(IV) AUTISM SPECTRUM DISORDER; OR

(V) DEMENTIA.

SECTION 3. Appropriation. For the 2022-23 state fiscal year, $45,409 is appropriated to the department of public health and environment for use by the health facilities and emergency medical services division. This appropriation is from the general fund and is based on an assumption that the division will require an additional 0.6 FTE. To implement this act, the division may use this appropriation for the nursing and acute care facility survey.

SECTION 4. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.

Steve Fenberg
PRESIDENT OF
THE SENATE

Alec Garnett
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED June 8th at 9:00 a.m.
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

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 Chapter 7

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

Adopted by the Board of Health on ~~June 21, 2023~~_____. Effective ~~June 14, 2021~~_____.

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PART 1 – STATUTORY AUTHORITY AND APPLICABILITY

1.1 Authority to establish minimum standards through regulation and to administer and enforce such regulations is provided by Sections 25-1.5-103, 25-1.5-118, 25-3-125, 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, General Licensure Standards;

(C) 6 CCR 1011-1, Chapter 24, Medication Administration Regulations, and Sections 25-1.5-301 through 25-1.5-303 C.R.S, pertaining to medication administration;

(D) 6 CCR 1010-2, Colorado Retail Food Establishment Regulations, pertaining to food safety, for residences licensed for 20 or more beds;

(E) 6 CCR 1009-1, Epidemic and Communicable Disease Control;

(F) 6 CCR 1007-2, Part 1, Regulations Pertaining to Solid Waste Disposal Sites and Facilities, Section 13, Medical Waste; and

(G) 6 CCR 1007-3, Part 262, Standards Applicable to Generators of Hazardous Waste.

PART 2 – DEFINITIONS

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

2.1 "Abuse" means any of the following acts or omissions:

(A) The non-accidental infliction of bodily injury, serious bodily injury or death,

(B) Confinement or restraint that is unreasonable under generally accepted caretaking standards, or

(C) Subjection to sexual conduct or contact that is classified as a crime.

2.2 "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. THE TERM "ADMINISTRATOR" INCLUDES INDIVIDUALS APPOINTED AS AN INTERIM ADMINISTRATOR IN ACCORDANCE WITH PART 4.5(A) UNLESS OTHERWISE INDICATED.

2.3 "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.

2.4 "ADVANCE MEDICAL DIRECTIVE" MEANS A WRITTEN INSTRUCTION, AS DEFINED IN SECTION 15-18.7-102(2), C.R.S., CONCERNING MEDICAL TREATMENT DECISIONS TO BE MADE ON BEHALF OF THE RESIDENT WHO PROVIDED THE INSTRUCTION IN THE EVENT THAT THE INDIVIDUAL BECOMES INCAPACITATED.

Commented [BF1]: All highlighted passages have been re-characterized from being current rules to new rules so that the rules related to Senate Bills 22-079 and 22-053, as heard and adopted by the Board of Health on June 21, 2023, may be re-adopted after a technical error with the Administrative Procedure Act rendered them ineffective.

Commented [BF2]: Added for re-adoption of rules related to Senate Bills 22-079 and 22-053, as heard and adopted by the Board of Health on June 21, 2023

2.45 "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.

2.~~5~~6 "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.

2.~~6~~7 "Assisted living residence" or "ALR" means:

(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, or

(B) A Supportive Living Program residence that, in addition to the criteria specified in the above paragraph, 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.

(C) 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.

2.~~7~~8 "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:

(A) 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;

(B) Is unable to walk, see, hear or speak;

(C) Is unable to breathe without mechanical assistance;

(D) Is a person with an intellectual and developmental disability as defined in Section 25.5-10-202, C.R.S.;

(E) Is a person with a mental health disorder as defined in Section 27-65-102(11.5), C.R.S.;

(F) Is mentally impaired as defined in Section 24-34-501(1.3)(b)(II), C.R.S.;

(G) Is blind as defined in Section 26-2-103(3), C.R.S.; or

(H) Is receiving care and treatment for a developmental disability under Article 10.5 of Title 27, C.R.S.

2.~~8~~9 "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.

2.~~9~~10 "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.

2.11 "CAREGIVER" MEANS A PARENT, SPOUSE, OR OTHER FAMILY MEMBER OR FRIEND OF A RESIDENT WHO PROVIDES CARE TO THE RESIDENT.

2.102 "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.

2.113 "Certified nurse medication aide (CNA-Med)" means a certified nurse aide who meets the qualifications specified in 3 CCR 716-1, Rule 1.19, and who is currently certified as a nurse aide with medication aide authority by the State Board of Nursing.

2.14 "COMMUNICABLE DISEASE" MEANS THE SAME AS THE DEFINITION SET FORTH IN SECTION 25-1.5-102(L)(A)(IV), C.R.S.

2.15 "COMPASSIONATE CARE VISIT" MEANS A VISIT WITH A FRIEND OR FAMILY MEMBER THAT IS NECESSARY TO MEET THE PHYSICAL OR MENTAL NEEDS OF A RESIDENT WHEN THE RESIDENT IS EXHIBITING SIGNS OF PHYSICAL OR MENTAL DISTRESS, INCLUDING:

(A) END-OF-LIFE SITUATIONS;

(B) ADJUSTMENT SUPPORT AFTER MOVING TO A NEW FACILITY OR ENVIRONMENT;

(C) EMOTIONAL SUPPORT AFTER THE LOSS OF A FRIEND OR FAMILY MEMBER;

(D) PHYSICAL SUPPORT AFTER EATING OR DRINKING ISSUES, INCLUDING WEIGHT LOSS OR DEHYDRATION; OR

(E) SOCIAL SUPPORT AFTER FREQUENT CRYING, DISTRESS, OR DEPRESSION.

A COMPASSIONATE CARE VISIT INCLUDES A VISIT FROM A CLERGY MEMBER OR LAYPERSON OFFERING RELIGIOUS OR SPIRITUAL SUPPORT OR OTHER PERSONS REQUESTED BY THE RESIDENT FOR THE PURPOSE OF A COMPASSIONATE CARE VISIT.

2.126 "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.

2.137 "Deficiency" means a failure to fully comply with any statutory and/or regulatory requirements applicable to a licensed assisted living residence.

2.148 "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.

2.19 "DEMENTIA DISEASES AND RELATED DISABILITIES" MEANS A CONDITION WHERE MENTAL ABILITY DECLINES AND IS SEVERE ENOUGH TO INTERFERE WITH AN INDIVIDUAL'S ABILITY TO PERFORM EVERYDAY TASKS.

DEMENTIA DISEASES AND RELATED DISABILITIES INCLUDES ALZHEIMER'S DISEASE, MIXED DEMENTIA, LEWY BODY DEMENTIA, VASCULAR DEMENTIA, FRONTOTEMPORAL DEMENTIA, AND OTHER TYPES OF DEMENTIA.

2.~~15~~20 "Department" means the Colorado Department of Public Health and Environment or its designee.

2.~~16~~21 "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.

2.~~17~~22 "Discharge" means termination of the resident agreement and the resident's permanent departure from the facility.

2.~~18~~23 "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.

2.~~19~~24 "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.

2.25 "ESSENTIAL CAREGIVER" MEANS A DESIGNATED INDIVIDUAL THAT MEETS AN ESSENTIAL NEED FOR THE RESIDENT BY ASSISTING WITH ACTIVITIES OF DAILY LIVING OR POSITIVELY INFLUENCING THE BEHAVIOR OF THE RESIDENT. THE GOAL OF SUCH A DESIGNATION IS TO HELP ENSURE RESIDENTS CONTINUE TO RECEIVE INDIVIDUALIZED, PERSON-CENTERED CARE WHEN LIMITATIONS ON GENERAL VISITORS ARE IN PLACE. EACH RESIDENT'S CARE PLAN SHOULD INCLUDE SERVICES PROVIDED BY THE ESSENTIAL CAREGIVER.

2.2~~0~~6 "Exploitation" means an act or omission committed by a person who:

(A) 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;

(B) 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;

(C) 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

(D) 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.

2.2~~1~~7 "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~~ CARE PROVIDERS, CAREGIVERS AS DEFINED IN PART 2.11, AND ESSENTIAL CAREGIVERS AS DEFINED IN PART 2.25. ~~and family~~ members.

Commented [BF3]: Change required due to new definition of "caregiver"

2.2~~2~~8 "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.

2.239 "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.

2.30 "INTERIM ADMINISTRATOR" MEANS AN INDIVIDUAL MEETING THE REQUIREMENTS AT PARTS 6.3 AND 6.5(A), WHO IS APPOINTED IN ACCORDANCE WITH PART 4.5(A) TO FULFILL THE RESPONSIBILITIES OF THE ADMINISTRATOR POSITION WHILE THE ASSISTED LIVING RESIDENCE DOES NOT HAVE AN INDIVIDUAL IN THE ADMINISTRATOR POSITION.

2.31 "INVOLUNTARY DISCHARGE" MEANS ANY DISCHARGE INITIATED BY THE ASSISTED LIVING RESIDENCE.

2.2432 "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 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."

2.33 "LOCAL OMBUDSMAN" MEANS THE SAME AS THE DEFINITION SET FORTH IN SECTION 25-27-102(6.5), C.R.S.

Commented [BF4]: Statutory definition added in SB22-154

2.2534 "Medical waste" means waste that may contain disease causing organisms or chemicals that present potential health hazards such as discarded surgical gloves, sharps, blood, human tissue, prescription or over-the-counter pharmaceutical waste, and laboratory waste.

2.2635 "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.

(A) Medication administration does not include:

(1) Medication monitoring; or

(2) Self-administration of prescription drugs or the self-injection of medication by a resident.

(B) Medication administration by a qualified medication administration person (QMAP) does not include judgement, evaluation, assessments, or injecting medication (unless otherwise authorized by law in response to an emergent situation.)

2.2736 "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.

2.~~28~~37 "Mistreatment" means abuse, caretaker neglect, or exploitation.

2.38 "NAME-BASED JUDICIAL RECORD CHECK" MEANS A BACKGROUND CHECK PERFORMED USING JUDICIAL DEPARTMENT RECORDS THAT INCLUDES AN INDIVIDUAL'S CONVICTION AND FINAL DISPOSITION OF CASE RECORDS.

Commented [BF5]: HB22-1270 changed Section 25-27-105(2.5)(a.7) to specify name-based judicial record checks, as defined in Section 22-2-119.3(6)(d), C.R.S. The definition added here is that statutory definition.

2.~~29~~39 "Nurse" means an individual who holds a current unrestricted license to practice pursuant to Article 255 of Title 12, C.R.S., and is acting within the scope of such authority.

2.~~30~~40 "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.

2.~~31~~41 "Owner" means the person or business entity that applies for assisted living residence licensure and/or in whose name the license is issued.

2.~~32~~42 "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.

2.43 "PATIENT OR RESIDENT WITH A DISABILITY" MEANS AN INDIVIDUAL WHO NEEDS ASSISTANCE TO EFFECTIVELY COMMUNICATE WITH ASSISTED LIVING RESIDENCE STAFF, MAKE HEALTH-CARE DECISIONS, OR ENGAGE IN ACTIVITIES OF DAILY LIVING DUE TO A DISABILITY SUCH AS:

(A) A PHYSICAL, INTELLECTUAL, BEHAVIORAL, OR COGNITIVE DISABILITY;

(B) DEAFNESS, BEING HARD OF HEARING, OR OTHER COMMUNICATION BARRIERS;

(C) BLINDNESS;

(D) AUTISM SPECTRUM DISORDER; OR

(E) DEMENTIA.

2.~~33~~44 "Personal care worker" means an individual who:

(A) Provides personal services for any resident; and

(B) Is not acting in his or her capacity as a health care professional under Articles 240, 255, 270, or 285 of Title 12 of the Colorado Revised Statutes.

2.~~34~~45 "Personal services" means those services that an assisted living residence and its staff provide for each resident including, but not limited to:

(A) An environment that is sanitary and safe from physical harm,

(B) Individualized social supervision,

(C) Assistance with transportation, and

(D) Assistance with activities of daily living.

2.~~35~~46 "Plan of correction" means a written plan to be submitted by an assisted living residence to the Department for approval, detailing the measures that shall be taken to correct all cited deficiencies.

2.~~36~~47 "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.

2.~~37~~48 "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.

(A) 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.

(B) 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.

(C) 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.

(D) 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.

2.~~38~~49 "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:

(A) Being aware of a resident's general whereabouts, although the resident may travel independently in the community; and

(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.

2.~~39~~50 "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.

2.~~40~~51 "Renovation" means the moving of walls and reconfiguring of existing floor plans. It includes the rebuilding or upgrading of major systems, including but not limited to: heating, ventilation, and electrical systems. It also means the changing of the functional operation of the space.

(A) Renovations do not include "minor alterations," which are building construction projects which are not additions, which do not affect the structural integrity of the building, which do not change functional operation, and/or which do not add beds or capacity above what the facility is limited to under the existing license.

2.~~41~~52 "Resident's legal representative" means one of the following:

(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;

(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;

(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

(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.

2.~~42~~53 "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.

2.~~43~~54 "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.

2.~~44~~55 "Self-administration" means the ability of a resident to take medication independently without any assistance from another person.

2.~~45~~56 "Staff" means employees and contracted individuals intended to substitute for or supplement employees who provide personal services. "Staff" does not include individuals providing external services, as defined herein.

2.57 "STATE LONG-TERM CARE OMBUDSMAN" MEANS THE SAME AS THE DEFINITION SET FORTH IN SECTION 25-27-102(12), C.R.S.

Commented [BF6]: Statutory definition added by SB22-154

2.~~46~~58 "Therapeutic diet" means a diet ordered by a practitioner or registered dietician 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.

2.~~47~~59 "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.

2.~~48~~60 "Volunteer" means an unpaid individual providing personal services on behalf of and/or under the control of the assisted living residence. "Volunteer" does not include individuals visiting the assisted living residence for the purposes of resident engagement.

PART 3 – DEPARTMENT OVERSIGHT

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3.3 Each owner or applicant shall request a criminal history record check.

(A) If an owner or applicant for an initial assisted living residence license has lived in Colorado for more than three (3) years at the time of the initial application, said individual shall request from the Colorado Bureau of Investigation (CBI) a state fingerprint-based 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 (3) years or less at the time of the initial application, said individual shall:

(1) Request from the Colorado Bureau of Investigation (CBI) a state fingerprint-based criminal history record check with notification of future arrests; and

(2) Obtain a name-based criminal history report for each additional 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 name-based report as determined by the Department.

(C) The cost of obtaining such information shall be borne by the individual or individuals who are the subject of such check.

(D) The results of the check shall be forwarded to the Department as follows:

(1) For results from CBI, the information shall be forwarded by CBI to the Department.

(2) For equivalent agencies in other states, the information shall be forwarded by the agency to the Department if authorized by such state. If such authorization does not exist, the results shall be forwarded to the Department by the individual.

(E) When the results of a fingerprint-based criminal history record check of an applicant reveal a record of arrest without a disposition, the applicant shall submit to a name-based~~criminal history~~ JUDICIAL record check.

Commented [BF7]: Change required by HB22-1270, Section 43, which changes Section 25-27-105(2.5)(a.7), C.R.S.

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.

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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 subpart, 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.

(1) IF THE CHANGE OF ADMINISTRATOR APPLICATION IS DUE TO THE APPOINTMENT OF AN INTERIM ADMINISTRATOR, THE FACILITY SHALL PAY THE FEE NO LATER THAN 90 DAYS AFTER THE APPOINTMENT.

(A) IF AN ADMINISTRATOR IS APPOINTED DURING THE 90 DAYS AND THE REQUIRED CHANGE OF ADMINISTRATOR APPLICATION IS SUBMITTED DURING THAT TIME, THE FACILITY SHALL OWE A SINGLE PAYMENT OF $500.

(B) IF AN ADMINISTRATOR IS APPOINTED MORE THAN 90 DAYS AFTER THE APPOINTMENT OF THE INTERIM ADMINISTRATOR, THE FACILITY SHALL PAY SEPARATE FEES FOR EACH CHANGE OF ADMINISTRATOR 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.

FINE FOR LACK OF ADMINISTRATOR

Commented [BF8]: Section 25-27106((4)(b)

3.11 ANY ASSISTED LIVING RESIDENCE FOUND TO BE WITHOUT AN ADMINISTRATOR OR INTERIM ADMINISTRATOR COMPLIANT WITH THE REQUIREMENTS IN PART 4.5 SHALL BE FINED $1,000.

Citing Deficiencies

3.~~11~~12 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.

IN DETERMINING THE LEVEL OF DEFICIENCY TO BE CITED, POTENTIAL FOR HARM SHALL MEAN THERE IS A REASONABLE EXPECTATION THAT THE NONCOMPLIANCE WILL RESULT IN AN ADVERSE OUTCOME.

3.12~~3~~ 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~~4~~ Pursuant to Section 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 to the requirements set forth in 6 CCR 1011-1, Chapter 2, Part 2.10.4(B);

(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 2.10.4(B).

Intermediate Restrictions or Conditions

3.14~~5~~ 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; AND/or

(E) Paying a civil fine not to exceed ~~two thousand dollars ($2,000) in a calendar year.~~TEN THOUSAND DOLLARS PER VIOLATION; EXCEPT THE CAP MAY BE EXCEEDED AT THE DEPARTMENT'S DISCRETION FOR AN EGREGIOUS VIOLATION THAT RESULTS IN DEATH OR SERIOUS INJURY TO A RESIDENT AFTER CONSIDERING THE CIRCUMSTANCES AROUND THE VIOLATION. IN DETERMINING THE AMOUNT OF THE FINE, IN ACCORDANCE WITH SECTION 25-27-106(4)(A), C.R.S.:

Commented [BF9]: Section 25-27-106(2)(b)(I)(E), C.R.S.

(1) THE DEPARTMENT SHALL CONSIDER:

(A) THE HISTORY OF HARM OR INJURY AT THE RESIDENCE;

(B) THE NUMBER OF INJURIES TO RESIDENTS FOR WHICH THE CAUSE OF THE INJURY IS UNKNOWN;

(C) THE ADEQUACY OF THE RESIDENCE'S OCCURRENCE INVESTIGATIONS AND REPORTING;

(D) THE ADEQUACY OF THE ADMINISTRATOR'S SUPERVISION OF EMPLOYEES TO ENSURE EMPLOYEES ARE KEEPING RESIDENTS SAFE FROM HARM OR INJURY; AND

(E) THE RESIDENCE'S COMPLIANCE WITH REQUIRED MANDATORY REPORTING OF THE MISTREATMENT OF RESIDENTS, IN ACCORDANCE WITH PART 13.11(A).

(2) THE DEPARTMENT MAY VARY THE AMOUNT OF THE FINE DEPENDING ON THE SIZE OF THE RESIDENCE, THE POTENTIAL FOR HARM OR INJURY TO ONE OR MORE RESIDENTS, AND WHETHER THERE IS A PATTERN OF POTENTIAL OR ACTUAL HARM OR INJURY TO RESIDENTS. FOR THESE VARIATIONS, POTENTIAL FOR HARM SHALL MEAN THERE IS A REASONABLE EXPECTATION THAT THE ASSISTED LIVING RESIDENCE'S NONCOMPLIANCE WILL RESULT IN AN ADVERSE OUTCOME.

3.156 Intermediate restrictions or conditions may be imposed for Level A~~,~~ AND 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.~~

3.17 FOR ALL CASES WHERE THE DEFICIENCY LIST INCLUDES LEVEL C, D, OR E DEFICIENCIES, THE ASSISTED LIVING RESIDENCE MAY BE REQUIRED TO COMPLY WITH ONE OR MORE OF THE INTERMEDIATE RESTRICTIONS OR CONDITIONS IN PART 3.15(A) THROUGH (D), AND SHALL BE ASSESSED A CIVIL FINE IN ACCORDANCE WITH PART 3.15(E), WITHIN THE FOLLOWING RANGES:

(A) FOR EACH LEVEL C DEFICIENCY, THE FINE SHALL BE BETWEEN $100 AND $5,000.

(B) FOR EACH LEVEL D DEFICIENCY, THE FINE SHALL BE BETWEEN $500 AND $7,500.

(C) FOR EACH LEVEL E DEFICIENCY THAT IS CITED BASED ON THE LIKELIHOOD OF SERIOUS INJURY, SERIOUS HARM, SERIOUS IMPAIRMENT, OR DEATH, THE FINE SHALL BE BETWEEN $1,000 AND $10,000.

(D) FOR EACH LEVEL E DEFICIENCY THAT IS CITED BASED ON ACTUAL SERIOUS INJURY, SERIOUS HARM, SERIOUS IMPAIRMENT, OR DEATH, THE FINE SHALL BE BETWEEN $2,000 AND $10,000, EXCEPT THAT THE DEPARTMENT MAY EXCEED $10,000 FOR ANY EGREGIOUS VIOLATION(S) OR ONGOING PATTERN OF EGREGIOUS VIOLATIONS RESULTING IN SERIOUS INJURY OR DEATH.

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PART 4 – LICENSEE RESPONSIBILITIES

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4.5 The licensee shall appoint an administrator who meets the minimum qualifications set forth in these regulations and delegate to that individual the executive authority and responsibility for the administration of the assisted living residence.

(A) IF THE ASSISTED LIVING RESIDENCE DOES NOT HAVE AN ADMINISTRATOR, THE LICENSEE SHALL APPOINT AN INTERIM ADMINISTRATOR AND DELEGATE TO THAT INDIVIDUAL THE EXECUTIVE

Commented [BF10]: Fines "shall be assessed" for actual harm per Section 25-27-106(4)(a)(I), C.R.S.

Commented [BF11]: SB22-154 modified statutory requirements by adding the following at Section 25-27-106(4)(b), C.R.S., as follows:

"Notwithstanding the department's discretion pursuant to subsection (2)(b)(I) of this section, the department shall impose a fine, in an amount to be determined by the department, for any residence that is found to be without an administrator, or interim administrator, as defined by the state board by rule, on or after January 1, 2024, who meets the requirements established by the state board pursuant to Section 25-27-104(2)(g)(I)(B)." Note that 104(2)(g)(I)(B) is the section requiring that all administrators meet the same education and experience requirement.

AUTHORITY AND RESPONSIBILITY FOR THE ADMINISTRATION OF THE ASSISTED LIVING RESIDENCE, UNTIL SUCH TIME THAT THE FACILITY HAS AN ADMINISTRATOR.

(1) THE LICENSEE SHALL NOTIFY THE DEPARTMENT OF THE INTERIM ADMINISTRATOR APPOINTMENT WITHIN 24 HOURS OF THE APPOINTMENT IN ACCORDANCE WITH 6 CCR 1011-1, CHAPTER 2 – GENERAL LICENSURE, PART 2.9.6.

(2) THE INTERIM ADMINISTRATOR SHALL MEET THE ADMINISTRATOR QUALIFICATIONS IN PART 6.3.

(3) THE INTERIM ADMINISTRATOR SHALL MEET THE TRAINING REQUIREMENTS AT PART 6.5(A).

(4) THE INTERIM ADMINISTRATOR SHALL BE RESPONSIBLE FOR ENSURING COMPLIANCE WITH THESE RULES AS IF THEY WERE THE ADMINISTRATOR. WHEREVER THE TERM "ADMINISTRATOR" APPEARS IN THESE RULES, THE REQUIREMENTS ALSO APPLY TO INTERIM ADMINISTRATORS, UNLESS OTHERWISE INDICATED.

(B) IN ACCORDANCE WITH SECTION 25-27-106(4)(B), C.R.S., ANY ASSISTED LIVING RESIDENCE FOUND TO BE WITHOUT AN ADMINISTRATOR OR AN INTERIM ADMINISTRATOR MEETING THE REQUIREMENTS OF 4.5 SHALL BE ASSESSED A FINE, AS INCLUDED IN PART 3.11 OF THESE RULES.

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PART 6 – ADMINISTRATOR

Criminal H~~h~~istory AND ADULT PROTECTIVE SERVICES R~~r~~ecord C~~c~~hecks

6.1 In order to ensure that the administrator OR INDIVIDUAL APPOINTED AS AN INTERIM 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, OR WITHIN 10 DAYS OF APPOINTMENT FOR AN INTERIM ADMINISTRATOR.

(A) If an administrator applicant has lived in Colorado for more than three (3) years at the time of application, the assisted living residence 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 administrator applicant has lived in Colorado for less than three (3) years at the time of application, the assisted living residence shall:

(1) Request from the CBI a state fingerprint-based criminal history record check with notification of future arrests; and

(2) Obtain a name-based criminal history report for each additional state in which the applicant has lived for the past three (3) years, conducted by the respective states' bureaus of investigation or equivalent state-level law enforcement agency or other name-based report as determined by the Department.

(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 to the department in accordance with Part 3.3(D) of these rules.

(D) When the results of a fingerprint-based criminal history record check of an administrator applicant reveal a record of arrest without a disposition, the administrator applicant shall submit to a name-based ~~criminal history~~ JUDICIAL record check.

6.2 IN ORDER TO ENSURE THAT THE ADMINISTRATOR OR INDIVIDUAL APPOINTED AS AN INTERIM ADMINISTRATOR IS OF GOOD, MORAL, AND RESPONSIBLE CHARACTER, THE ASSISTED LIVING RESIDENCE SHALL OBTAIN A CHECK OF THE COLORADO ADULT PROTECTIVE SERVICES DATA SYSTEM PURSUANT TO SECTION 26-3.1-111, C.R.S. BASED ON THE RESULTS OF THE CHECK, THE ASSISTED LIVING RESIDENCE SHALL ENSURE IT FOLLOWS ITS POLICY REGARDING THE HIRING OR CONTINUED SERVICE OF ANY ADMINISTRATOR OR INDIVIDUAL APPOINTED AS AN INTERIM ADMINISTRATOR, AS REQUIRED BY PART 7.4.

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 Part 6.3.~~

6.3 Each ~~newly hired~~ administrator OR INDIVIDUAL APPOINTED AS AN INTERIM ADMINISTRATOR ~~who does not qualify under Part 6.2,~~ shall be at least 21 years of age, possess a high school diploma or equivalent, and HAVE at least one year of experience supervising the delivery of personal care services that include activities of daily living. If the administrator OR INTERIM ADMINISTRATOR does not have the required one year of experience supervising the delivery of personal care services including activities of daily living, they shall ~~demonstrate~~ DOCUMENT they have one or more of the following:

(A) An active, unrestricted Colorado nursing home administrator license;

(B) An active, unrestricted Colorado registered nurse license plus at least six (6) months of work experience in health care during the previous ten (10)-year period;

(C) An active, unrestricted Colorado licensed practical nurse license plus at least one year of work experience in health care during the previous ten (10)-year period;

(D) A bachelor's degree with emphasis in health care or human services plus at least one year of work experience in health care during the previous ten (10)-year period;

(E) An associate's degree with emphasis in health care or human services plus at least two (2) years of work experience in health care during the previous ten (10)-year period;

(F) Thirty (30) credit hours from an accredited college or university with an emphasis in health care or human services plus three (3) years of work experience in health care during the previous ten (10)-year period;

(G) Five (5) or more years of management or supervisory work in the field of geriatrics, human services, or providing care for the physically and/or cognitively disabled during the previous ten (10)-year period; or

(H) A college degree in any field plus two (2) years of health care experience during the previous ten (10)-year period.

6.4 Each administrator OR INDIVIDUAL APPOINTED AS AN INTERIM ADMINISTRATOR of an assisted living residence shall ensure that qualified medication administration persons (QMAPs) comply with the medication administration requirements and limitations in 6 CCR 1011-1, Chapter 24, and Sections 25-1.5-301 through 25-1.5-303, C.R.S.

Commented [BF12]: Change required by HB22-1270

Commented [BF13]: While language in 6 CCR 1011-1, Chapter 2 requires these checks, SB22-154 added language specifically to the ALR statutes at Section 25-27-104(g)(II), C.R.S.

Commented [BF14]: Sections 25-27-104(2)(g)(I)(A) and (B), C.R.S. as modified/added by SB22-154.

Commented [BF15]: SB22-154 (Section 25-27-106(4)(b), C.R.S.)

Training

6.5 Each administrator shall have completed ~~an~~ 40 HOURS OF administrator training ~~program~~ before assuming an administrator position. INDIVIDUALS APPOINTED AS AN INTERIM ADMINISTRATOR SHALL HAVE COMPLETED 40 HOURS OF ADMINISTRATOR TRAINING WITHIN 30 DAYS OF APPOINTMENT. Written proof regarding the successful completion of such training program shall be maintained in the administrator's personnel file. THE 40 HOURS SHALL BE MET BY ONE OF THE FOLLOWING:

(A) COMPLETING AN ADMINISTRATOR TRAINING PROGRAM THAT MEETS THE REQUIREMENTS OF PART 6.6, BELOW.

(B) COMPLETING A 30-HOUR ADMINISTRATOR TRAINING PROGRAM ON OR BEFORE DECEMBER 31, 2018, AND DOCUMENTING AN ADDITIONAL 10 HOURS OF TRAINING IN TOPICS RELATED TO THE ASSISTED LIVING ADMINISTRATOR'S RESPONSIBILITIES, REGULATORY UPDATES, AND/OR BEST PRACTICES BEFORE JUNE 30, 2024.

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Duties

6.8 The administrator, OR INDIVIDUAL APPOINTED AS AN INTERIM ADMINISTRATOR, shall be responsible for the overall day-to-day 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 Part 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) ENSURING THE ASSISTED LIVING RESIDENCE'S COMPLIANCE WITH THE INVOLUNTARY DISCHARGE REQUIREMENTS IN SECTION 25-27-104.3 C.R.S., AND THESE RULES; AND

(~~K~~L) 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.

PART 7 – PERSONNEL

Criminal History AND ADULT PROTECTIVE SERVICES Record 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 staff hire or volunteer on-boarding, a name-based criminal history record check for each prospective staff member and volunteer.

(A) If the applicant has lived in Colorado for more than three (3) years at the time of application, the assisted living residence shall obtain a name-based criminal history report conducted by the Colorado Bureau of Investigation (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 name-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.

7.2 IN ORDER TO ENSURE THAT STAFF MEMBERS AND VOLUNTEERS ARE OF GOOD, MORAL, AND RESPONSIBLE CHARACTER, THE ASSISTED LIVING RESIDENCE SHALL OBTAIN A CHECK OF THE COLORADO ADULT PROTECTIVE SERVICES DATA SYSTEM PURSUANT TO SECTION 26-3.1-111, C.R.S. BASED ON THE RESULTS OF THE CHECK, THE ASSISTED LIVING RESIDENCE SHALL ENSURE IT FOLLOWS ITS POLICY REGARDING THE HIRING OR CONTINUED SERVICE OF ANY STAFF MEMBER OR VOLUNTEER, AS REQUIRED BY PART 7.4.

Commented [BF16]: While language in 6 CCR 1011-1, Chapter 2 requires these checks, SB22-154 added language specifically to the ALR statutes at Section 25-27-104(g)(II), C.R.S.

Background Check Policies and Procedures

7.~~2~~3 If the assisted living residence becomes aware of information that indicates a current administrator, INDIVIDUAL APPOINTED AS AN INTERIM ADMINISTRATOR, staff member, or volunteer 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 AND ADULT PROTECTIVE SERVICES record check for such individual from the CBI and/or other relevant law enforcement agency.

7.~~3~~4 The assisted living residence shall develop and implement policies and procedures regarding the hiring or continued service of any administrator, INDIVIDUAL APPOINTED AS AN INTERIM ADMINISTRATOR, staff member, or volunteer whose criminal history OR ADULT PROTECTIVE SERVICES

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.

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Staff and Volunteer Orientation and Training

7.8 The assisted living residence shall ensure that each staff member and volunteer receives orientation and training, as follows:

(A) The assisted living residence shall ensure each staff member or volunteer completes an initial orientation prior to providing any care or services to a resident. Such orientation shall include, at a minimum, all of the following topics:

(1) The care and services provided by the assisted living residence;

(2) Assignment of duties and responsibilities, specific to the staff member or volunteer;

(3) Hand Hygiene and infection control;

(4) Emergency response policies and procedures, including:

(a) Recognizing emergencies,

(b) Relevant emergency contact numbers,

(c) Fire response, including facility evacuation procedures

(d) Basic first aid,

(e) Automated external defibrillator (AED) use, if applicable,

(f) Practitioner assessment, and

(g) Serious illness injury, and/or death of a resident.

(5) Reporting requirements, including occurrence reporting procedures within the facility;

(6) Resident rights;

(7) House rules;

(8) Where to immediately locate a resident's advance directive; and

(9) An overview of the assisted living residence's policies and procedures and how to access them for reference.

(B) DEMENTIA TRAINING REQUIREMENTS

(1) AS OF JANUARY 1, 2024, EACH ASSISTED LIVING RESIDENCE SHALL ENSURE THAT ITS DIRECT-CARE STAFF MEMBERS MEET THE DEMENTIA TRAINING REQUIREMENTS IN THIS PART 7.8(B).

(2) DEFINITIONS: FOR THE PURPOSES OF DEMENTIA TRAINING AS REQUIRED BY SECTION 25-1.5-118, C.R.S.

(A) "DIRECT-CARE STAFF MEMBER" MEANS A STAFF MEMBER CARING FOR THE PHYSICAL, EMOTIONAL, OR MENTAL HEALTH NEEDS OF RESIDENTS IN A COVERED FACILITY AND WHOSE WORK INVOLVES REGULAR CONTACT WITH RESIDENTS WHO ARE LIVING WITH DEMENTIA DISEASES AND RELATED DISABILITIES.

(B) "EQUIVALENT TRAINING" IN THIS SUB-PART SHALL MEAN ANY INITIAL TRAINING PROVIDED BY A COVERED FACILITY MEETING THE REQUIREMENTS OF THIS SUB-PART 7.8(B)(3).

(3) INITIAL TRAINING: EACH ASSISTED LIVING RESIDENCE IS RESPONSIBLE FOR ENSURING THAT ALL DIRECT-CARE STAFF MEMBERS ARE TRAINED IN DEMENTIA DISEASES AND RELATED DISABILITIES.

(A) INITIAL TRAINING SHALL BE AVAILABLE TO DIRECT-CARE STAFF AT NO COST TO THEM.

(B) THE TRAINING SHALL BE COMPETENCY-BASED AND CULTURALLY-COMPETENT AND SHALL INCLUDE A MINIMUM OF FOUR HOURS OF TRAINING IN DEMENTIA TOPICS INCLUDING THE FOLLOWING CONTENT:

(I) DEMENTIA DISEASES AND RELATED DISABILITIES;

(II) PERSON-CENTERED CARE OF RESIDENTS WITH DEMENTIA;

(III) CARE PLANNING FOR RESIDENTS WITH DEMENTIA;

(IV) ACTIVITIES OF DAILY LIVING FOR RESIDENTS WITH DEMENTIA; AND

(V) DEMENTIA-RELATED BEHAVIORS AND COMMUNICATION.

(C) FOR DIRECT-CARE STAFF MEMBERS ALREADY EMPLOYED PRIOR TO JANUARY 1, 2024, THE INITIAL TRAINING MUST BE COMPLETED AS SOON AS PRACTICAL, BUT NO LATER THAN 120 DAYS AFTER JANUARY 1, 2024, UNLESS AN EXCEPTION, AS DESCRIBED IN SUB-PART 7.8(B)(4)(A), APPLIES.

(D) FOR DIRECT-CARE STAFF MEMBERS HIRED OR PROVIDING CARE ON OR AFTER JANUARY 1, 2024, THE INITIAL TRAINING MUST BE COMPLETED AS SOON AS PRACTICAL, BUT NO LATER THAN 120 DAYS AFTER THE START OF EMPLOYMENT OR THE PROVISION OF

DIRECT-CARE SERVICES, UNLESS AN EXCEPTION, AS DESCRIBED IN SUB-PART 7.8(B)(4)(B), APPLIES.

(4) EXCEPTION TO INITIAL DEMENTIA TRAINING REQUIREMENT

(A) ANY DIRECT-CARE STAFF MEMBER WHO IS EMPLOYED BY OR PROVIDING DIRECT-CARE SERVICES PRIOR TO THE JANUARY 1, 2024, MAY BE EXEMPTED FROM THE RESIDENCE'S INITIAL TRAINING REQUIREMENT IF SUB-PARTS I AND II BELOW ARE MET:

(I) THE DIRECT-CARE STAFF MEMBER HAS COMPLETED AN EQUIVALENT TRAINING, AS DEFINED IN THESE RULES, WITHIN THE 24 MONTHS IMMEDIATELY PRECEDING JANUARY 1, 2024; AND

(II) THE DIRECT-CARE STAFF MEMBER CAN PROVIDE DOCUMENTATION OF THE SATISFACTORY COMPLETION OF THE EQUIVALENT TRAINING; AND

(III) IF THE EQUIVALENT TRAINING WAS PROVIDED MORE THAN 24 MONTHS PRIOR TO THE DATE OF HIRE AS ALLOWED IN THIS EXCEPTION, THE INDIVIDUAL MUST DOCUMENT PARTICIPATION IN BOTH THE EQUIVALENT TRAINING AND ALL REQUIRED CONTINUING EDUCATION SUBSEQUENT TO THE INITIAL TRAINING.

(B) ANY DIRECT-CARE STAFF MEMBER WHO IS HIRED BY OR BEGINS PROVIDING DIRECT-CARE SERVICES ON OR AFTER JANUARY 1, 2024, MAY BE EXEMPTED FROM THE RESIDENCE'S INITIAL TRAINING REQUIREMENT IF THE DIRECT-CARE STAFF MEMBER:

(I) HAS COMPLETED AN EQUIVALENT TRAINING, AS DEFINED IN THESE RULES, EITHER:

(A) WITHIN THE 24 MONTHS IMMEDIATELY PRECEDING JANUARY 1, 2024; OR

(B) WITHIN THE 24 MONTHS IMMEDIATELY PRECEDING THE DATE OF HIRE OR THE DATE OF PROVIDING DIRECT-CARE SERVICES; AND

(II) PROVIDES DOCUMENTATION OF THE SATISFACTORY COMPLETION OF THE INITIAL TRAINING; AND

(III) PROVIDES DOCUMENTATION OF ALL REQUIRED CONTINUING EDUCATION SUBSEQUENT TO THE INITIAL TRAINING.

(C) SUCH EXCEPTIONS SHALL NOT NEGATE THE REQUIREMENT FOR DEMENTIA TRAINING CONTINUING EDUCATION AS DESCRIBED IN SUB-PART 7.8(B)(5).

(5) DEMENTIA TRAINING: CONTINUING EDUCATION

(A) AFTER COMPLETING THE REQUIRED INITIAL TRAINING, ALL DIRECT-CARE STAFF MEMBERS SHALL HAVE DOCUMENTED A MINIMUM OF TWO HOURS OF CONTINUING EDUCATION ON DEMENTIA TOPICS EVERY TWO YEARS.

(B) CONTINUING EDUCATION ON THIS TOPIC MUST BE AVAILABLE TO DIRECT-CARE STAFF MEMBERS AT NO COST TO THEM.

(C) THIS CONTINUING EDUCATION SHALL BE CULTURALLY COMPETENT; INCLUDE CURRENT INFORMATION PROVIDED BY RECOGNIZED EXPERTS, AGENCIES, OR ACADEMIC INSTITUTIONS; AND INCLUDE BEST PRACTICES IN THE TREATMENT AND CARE OF PERSONS LIVING WITH DEMENTIA DISEASES AND RELATED DISABILITIES.

(6) MINIMUM REQUIREMENTS FOR INDIVIDUALS CONDUCTING DEMENTIA TRAINING

(A) SPECIALIZED TRAINING FROM RECOGNIZED EXPERTS, AGENCIES, OR ACADEMIC INSTITUTIONS IN DEMENTIA DISEASE;

(B) SUCCESSFUL COMPLETION OF THE TRAINING BEING OFFERED OR OTHER SIMILAR INITIAL TRAINING WHICH MEETS THE MINIMUM STANDARDS DESCRIBED HEREIN; AND

(C) TWO OR MORE YEARS OF EXPERIENCE IN WORKING WITH PERSONS LIVING WITH DEMENTIA DISEASES AND RELATED DISABILITIES.

(~~B~~C) The assisted living residence shall provide each staff member or volunteer with training relevant to their specific duties and responsibilities prior to that staff member or volunteer working independently. This training may be provided through formal instruction, self-study courses, or on-the-job training, and shall include, but is not limited to, the following topics:

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Personnel Files

7.10 The assisted living residence shall maintain a personnel file for each of its employees and volunteers.

7.11 Personnel files for current employees and volunteers shall be readily available onsite for Department review.

7.12 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, or other state agency, 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.

(G) DOCUMENTATION OF INITIAL DEMENTIA TRAINING AND CONTINUING EDUCATION FOR DIRECT-CARE STAFF MEMBERS:

(1) THE RESIDENCE SHALL MAINTAIN DOCUMENTATION OF EACH EMPLOYEE'S COMPLETION OF INITIAL DEMENTIA TRAINING AND CONTINUING EDUCATION.

SUCH RECORDS SHALL BE AVAILABLE FOR INSPECTION BY REPRESENTATIVES OF THE DEPARTMENT.

(2) COMPLETION SHALL BE DEMONSTRATED BY A CERTIFICATE, ATTENDANCE ROSTER, OR OTHER DOCUMENTATION.

(3) DOCUMENTATION SHALL INCLUDE THE NUMBER OF HOURS OF TRAINING, THE DATE ON WHICH IT WAS RECEIVED, AND THE NAME OF THE INSTRUCTOR AND/OR TRAINING ENTITY.

(4) DOCUMENTATION OF THE SATISFACTORY COMPLETION OF AN EQUIVALENT TRAINING AS DEFINED IN SUB-PART 7.8(B)(2)(B) AND AS REQUIRED IN THE CRITERIA FOR AN EXCEPTION DISCUSSED IN SUB-PART 7.8(B)(4), SHALL INCLUDE THE INFORMATION REQUIRED IN THIS SUB-PART 7.12 (G)(2) AND (3).

(5) AFTER THE COMPLETION OF TRAINING AND UPON REQUEST, SUCH DOCUMENTATION SHALL BE PROVIDED TO THE STAFF MEMBER FOR THE PURPOSE OF EMPLOYMENT AT ANOTHER COVERED FACILITY. FOR THE PURPOSE OF DEMENTIA TRAINING DOCUMENTATION, COVERED FACILITIES SHALL INCLUDE ASSISTED LIVING RESIDENCES, NURSING CARE FACILITIES, AND ADULT DAY CARE FACILITIES AS DEFINED IN SECTION 25.5-6-303(1), C.R.S.

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PART 8 – STAFFING REQUIREMENTS

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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 part.

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~~ (E.G., the American Red Cross, the American Heart Association, the National Safety Council or the American Safety and Health Institute) OR A TRAINING CURRICULUM THAT MEETS THE AMERICAN HEART ASSOCIATION'S EMERGENCY CARDIOVASCULAR CARE (ECC) OR INTERNATIONAL CONSENSUS ON CARDIO-PULMONARY RESUSCITATION (ILCOR) GUIDELINES. THE CERTIFICATION SHALL EITHER BE IN ADULT CPR OR INCLUDE ADULT CPR IN ITS CURRICULUM, AND SHALL INCLUDE A SKILLS ASSESSMENT OBSERVED AND EVALUATED BY AN INSTRUCTOR. ~~The certification shall either be in Adult CPR or include Adult CPR~~

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PART 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 Parts 11 and 25, if applicable, INCLUDING, BUT NOT LIMITED TO CRITERIA FOR INVOLUNTARY DISCHARGE AS LISTED IN PARTS 11.11 THROUGH 11.12;

(B) Resident rights;

(C) Grievance procedure and complaint resolution, INCLUDING A GRIEVANCE PROCEDURE FOR INVOLUNTARY DISCHARGE IN ACCORDANCE WITH PART 9.3;

(D) Investigation of abuse, neglect, and exploitation allegations;

(E) Investigation of injuries of known or unknown source/origin;

(F) House rules;

(G) Emergency preparedness;

(H) Fall management;

(I) Provision of lift assistance, first aid, obstructed airway technique, and cardiopulmonary resuscitation;

(J) Unanticipated illness, injury, significant change of status from baseline, or death of resident;

(K) Infection control;

(L) Practitioner assessment;

(M) Health information management;

(N) Personnel POLICIES AS REQUIRED IN BOTH PART 6 AND PART 7 OF THESE RULES;

(O) Staff Training;

(P) Environmental pest control;

(Q) Medication errors and medication destruction and disposal;

(R) Management of resident funds, if applicable;

(S) Policies and procedures related to secure environment, if applicable; ~~and~~

(T) Provision of palliative care in accordance with 6 CCR 1011-1, Chapter 2, Part 4.3, if applicable~~.~~; and

(U) VISITATION IN ACCORDANCE WITH PART 9.2.

9.2 THE ASSISTED LIVING RESIDENCE SHALL HAVE WRITTEN POLICIES AND PROCEDURES REGARDING THE VISITATION RIGHTS DETAILED IN SECTION 25-3-125(3)(A), C.R.S. SUCH POLICIES AND PROCEDURES SHALL:

(A) SET FORTH THE VISITATION RIGHTS OF THE RESIDENT, CONSISTENT WITH 42 CFR 482.13(H); 42 U.S.C. 1396R(C)(3)(C); 42 U.S.C. 1395I(C)(3)(C); 42 CFR483.10(A), (B), AND (F); AND SECTION 25-27-104, C.R.S., AS APPLICABLE TO THE FACILITY TYPE;

(B) DESCRIBE ANY RESTRICTION OR LIMITATION NECESSARY TO ENSURE THE HEALTH AND SAFETY OF RESIDENTS, STAFF, OR VISITORS AND THE REASONS FOR SUCH RESTRICTION OR LIMITATION;

(C) BE AVAILABLE FOR INSPECTION AT THE REQUEST OF THE DEPARTMENT;

(D) BE PROVIDED TO RESIDENTS AND/OR FAMILY MEMBERS UPON REQUEST; AND

(E) INCLUDE THE RIGHT OF EACH RESIDENT OF AN ASSISTED LIVING RESIDENCE TO HAVE AT LEAST ONE VISITOR OF THE RESIDENT'S CHOOSING DURING THEIR STAY AT THE RESIDENCE, UNLESS RESTRICTIONS OR LIMITATIONS UNDER FEDERAL LAW OR REGULATION, OTHER STATE STATUTE, OR STATE OR LOCAL PUBLIC HEALTH ORDER APPLY. THIS VISITATION RIGHT SHALL BE EXERCISED IN ACCORDANCE WITH THE FOLLOWING:

(1) A VISITOR TO PROVIDE A COMPASSIONATE CARE VISIT TO ALLEVIATE THE RESIDENT'S PHYSICAL OR MENTAL DISTRESS.

(2) FOR A RESIDENT WITH A DISABILITY:

(A) A VISITOR OR SUPPORT PERSON, DESIGNATED BY THE RESIDENT, ORALLY OR IN WRITING, TO SUPPORT THE RESIDENT DURING THE COURSE OF THEIR RESIDENCY. THE SUPPORT PERSON MAY VISIT THE RESIDENT AND MAY EXERCISE THE RESIDENT'S VISITATION RIGHTS EVEN WHEN THE RESIDENT IS INCAPACITATED OR OTHERWISE UNABLE TO COMMUNICATE.

(B) WHEN THE RESIDENT HAS NOT OTHERWISE DESIGNATED A SUPPORT PERSON AND THE RESIDENT IS INCAPACITATED OR OTHERWISE UNABLE TO COMMUNICATE THEIR WISHES, AN INDIVIDUAL MAY PROVIDE AN ADVANCE MEDICAL DIRECTIVE DESIGNATING THE INDIVIDUAL AS THE RESIDENT'S SUPPORT PERSON OR ANOTHER TERM INDICATING THAT THE INDIVIDUAL IS AUTHORIZED TO EXERCISE VISITATION RIGHTS ON BEHALF OF THE RESIDENT.

PURSUANT TO SECTION 15-18.7-102(2), C.R.S., "(2) 'ADVANCE MEDICAL DIRECTIVE' MEANS A WRITTEN INSTRUCTION CONCERNING MEDICAL TREATMENT DECISIONS TO BE MADE ON BEHALF OF THE ADULT WHO PROVIDED THE INSTRUCTION IN THE EVENT THAT HE OR SHE BECOMES INCAPACITATED. AN ADVANCE MEDICAL DIRECTIVE INCLUDES, BUT NEED NOT BE LIMITED TO: (A) A MEDICAL DURABLE POWER OF ATTORNEY EXECUTED PURSUANT TO SECTION 15-14-506; (B) A DECLARATION EXECUTED PURSUANT TO THE "COLORADO MEDICAL TREATMENT DECISION ACT", ARTICLE 18 OF THIS TITLE; (C) A POWER OF ATTORNEY GRANTING MEDICAL TREATMENT AUTHORITY EXECUTED PRIOR TO JULY 1, 1992, PURSUANT TO SECTION 15-14-501, AS IT EXISTED PRIOR TO THAT DATE; OR (D) A CPR DIRECTIVE OR DECLARATION EXECUTED PURSUANT TO ARTICLE 18.6 OF THIS TITLE."

(3) FOR A RESIDENT WHO IS UNDER EIGHTEEN YEARS OF AGE, THE PARENT, LEGAL GUARDIAN, OR PERSON STANDING IN LOCO PARENTIS TO THE RESIDENT IS ALLOWED TO EXERCISE THESE VISITATION RIGHTS PURSUANT TO ANY LIMITATIONS DESCRIBED IN PARTS 9.2(F) AND (G).

(F) THE POLICIES AND PROCEDURES MAY IMPOSE LIMITATIONS ON VISITATION RIGHTS. DURING A PERIOD WHEN THE RISK OF TRANSMISSION OF A COMMUNICABLE DISEASE IS HEIGHTENED, AN ASSISTED LIVING RESIDENCE MAY:

(1) REQUIRE VISITORS TO ENTER THE RESIDENCE THROUGH A SINGLE, DESIGNATED ENTRANCE;

(2) DENY ENTRANCE TO A VISITOR WHO HAS KNOWN SYMPTOMS OF THE COMMUNICABLE DISEASE;

(3) REQUIRE VISITORS TO USE MEDICAL MASKS, FACE-COVERINGS, OR OTHER PERSONAL PROTECTIVE EQUIPMENT WHILE ON THE ASSISTED LIVING RESIDENCE PREMISES OR IN SPECIFIC AREAS OF THE RESIDENCE;

(4) REQUIRE VISITORS TO SIGN A DOCUMENT ACKNOWLEDGING:

(A) THE RISKS OF ENTERING THE RESIDENCE WHILE THE RISK OF TRANSMISSION OF A COMMUNICABLE DISEASE IS HEIGHTENED; AND

(B) THAT MENACING AND PHYSICAL ASSAULTS ON HEALTH-CARE WORKERS AND OTHER EMPLOYEES OF THE RESIDENCE WILL NOT BE TOLERATED;

(5) REQUIRE ALL VISITORS, BEFORE ENTERING THE RESIDENCE, TO BE SCREENED FOR SYMPTOMS OF THE COMMUNICABLE DISEASE AND DENY ENTRANCE TO ANY VISITOR WHO HAS SYMPTOMS OF THE COMMUNICABLE DISEASE;

(6) REQUIRE ALL VISITORS TO THE RESIDENCE TO BE TESTED FOR THE COMMUNICABLE DISEASE AND DENY ENTRY FOR THOSE WHO HAVE A POSITIVE TEST RESULT; AND

(7) RESTRICT THE MOVEMENT OF VISITORS WITHIN THE RESIDENCE, INCLUDING RESTRICTING ACCESS TO WHERE IMMUNOCOMPROMISED OR OTHERWISE VULNERABLE POPULATIONS ARE AT GREATER RISK OF BEING HARMED BY A COMMUNICABLE DISEASE.

(8) IF AN ASSISTED LIVING RESIDENCE REQUIRES THAT A VISITOR USE A MEDICAL MASK, FACE COVERING, OR OTHER PERSONAL PROTECTIVE EQUIPMENT OR TO TAKE A TEST FOR A COMMUNICABLE DISEASE IN ORDER TO VISIT A RESIDENT AT THE ASSISTED LIVING RESIDENCE, NOTHING IN THESE REGULATIONS:

(A) REQUIRES THE RESIDENCE ALLOW A VISITOR TO ENTER, IF THE REQUIRED EQUIPMENT OR TEST IS NOT AVAILABLE DUE TO LACK OF SUPPLY;

(B) REQUIRES THE RESIDENCE TO SUPPLY THE REQUIRED EQUIPMENT OR TEST TO THE VISITOR, OR BEAR THE COST OF THE EQUIPMENT FOR THE VISITOR; OR

(C) PRECLUDES THE HEALTH-CARE RESIDENCE FROM SUPPLYING THE REQUIRED EQUIPMENT OR TEST TO THE VISITOR.

(G) THE POLICIES AND PROCEDURES MAY IMPOSE ADDITIONAL LIMITATIONS FOR THE VISITORS OF A RESIDENT WITH A COMMUNICABLE DISEASE WHO IS ISOLATED. IN THIS CASE, THE RESIDENCE MAY IMPOSE ADDITIONAL RESTRICTIONS INCLUDING:

(1) LIMITING VISITATION TO ESSENTIAL CAREGIVERS WHO ARE HELPING TO PROVIDE CARE TO THE RESIDENT;

(2) LIMITING VISITATION TO ONE CAREGIVER AT A TIME PER RESIDENT WITH A COMMUNICABLE DISEASE;

(3) SCHEDULING VISITORS TO ALLOW FOR ADEQUATE TIME FOR SCREENING, EDUCATION, AND TRAINING OF VISITORS AND TO COMPLY WITH ANY LIMITS ON THE NUMBER OF VISITORS PERMITTED IN THE ISOLATED AREA AT THE TIME; AND

(4) PROHIBITING THE PRESENCE OF VISITORS DURING AEROSOL-GENERATING PROCEDURES OR DURING COLLECTION OF RESPIRATORY SPECIMENS.

(H) ANY LIMITATIONS IMPOSED SHALL BE CONSISTENT WITH APPLICABLE FEDERAL LAW AND REGULATION AND OTHER STATE STATUTE.

9.3 THE ASSISTED LIVING RESIDENCE SHALL HAVE AN INVOLUNTARY DISCHARGE GRIEVANCE POLICY THAT COMPLIES WITH SECTION 25-27-104.3, C.R.S., AND INCLUDES, AT A MINIMUM:

(A) THE INDIVIDUAL DESIGNATED BY THE ASSISTED LIVING RESIDENCE TO RECEIVE INVOLUNTARY DISCHARGE GRIEVANCES.

Commented [BF17]: Section 25-27-104.3(2)(a)(I), C.R.S.

(B) THE ABILITY FOR ANY OF THE PERSONS THE ASSISTED LIVING RESIDENCE IS REQUIRED TO NOTIFY IN ACCORDANCE WITH PART 11.16 TO FILE A GRIEVANCE CHALLENGING THE INVOLUNTARY DISCHARGE AND/OR REASONS FOR THE DISCHARGE WITH THE INDIVIDUAL DESIGNATED IN SUBPART (A), ABOVE, WITHIN 14 CALENDAR DAYS AFTER WRITTEN NOTICE OF THE INVOLUNTARY DISCHARGE IS PROVIDED BY THE ASSISTED LIVING RESIDENCE.

Commented [BF18]: Section 25-27-104.3(2)(a)(II), C.R.S.

(C) THE ABILITY FOR THE RESIDENT, OR OTHER PERSON ALLOWED TO FILE A GRIEVANCE TO RECEIVE ASSISTANCE IN PREPARING AND FILING A GRIEVANCE WITHOUT INTERFERENCE FROM THE ASSISTED LIVING RESIDENCE.

Commented [BF19]: Based in Section 25-27-104.3(2)(c), C.R.S. which allows ombudsmen to help prepare the grievance

(D) A REQUIREMENT THAT GRIEVANCES RELATED TO INVOLUNTARY DISCHARGE BE SUBMITTED TO THE INDIVIDUAL DESIGNATED BY THE FACILITY IN ACCORDANCE WITH SUBPART (A) AS FOLLOWS:

Commented [BF20]: Section 25-27-104.3(2)(a)(III), C.R.S.

(1) IN WRITING, OR

(2) ORALLY SUBMITTED TO THE INDIVIDUAL DESIGNATED IN ACCORDANCE WITH SUBPART (A), ABOVE. IN THE CASE OF AN ORAL SUBMISSION, THE ASSISTED LIVING RESIDENCE SHALL ENSURE THE INDIVIDUAL SUBMITTING THE GRIEVANCE RETAINS PROOF OF THE ORAL SUBMISSION THROUGH A WITNESS OR OTHER EVIDENCE.

(A) IF THE GRIEVANCE IS ORALLY SUBMITTED AND WITNESSED, THE ASSISTED LIVING RESIDENCE SHALL ENSURE THAT THE RESIDENT OR OTHER PERSON FILING THE GRIEVANCE HAS THE WITNESS'S NAME AND CONTACT INFORMATION, AND SHALL KEEP THAT INFORMATION AS PART OF THE GRIEVANCE DOCUMENTATION.

(E) A REQUIREMENT THAT NO LATER THAN 5 BUSINESS DAYS AFTER THE SUBMISSION OF A GRIEVANCE IN ACCORDANCE WITH SUBPART (D), ABOVE, THE INDIVIDUAL DESIGNATED BY THE ASSISTED LIVING RESIDENCE TO RECEIVE INVOLUNTARY DISCHARGE GRIEVANCES SHALL PROVIDE A RESPONSE TO THE GRIEVANCE AS FOLLOWS:

Commented [BF21]: First sentence of Section 25-27-104.3(2)(b), C.R.S.

(1) A WRITTEN RESPONSE SHALL BE PROVIDED TO THE INDIVIDUALS REQUIRED TO RECEIVE NOTICE IN PART 11.16, THE STATE LONG-TERM CARE OMBUDSMAN, AND THE DESIGNATED LOCAL OMBUDSMAN.

(2) AN ORAL EXPLANATION OF THE WRITTEN RESPONSE SHALL BE PROVIDED TO THE RESIDENT AND/OR PERSON FILING THE GRIEVANCE, AS APPROPRIATE.

Commented [BF22]: Second sentence of Section 25-27-104.3(2)(b), C.R.S.

(3) THE WRITTEN RESPONSE SHALL INCLUDE THE FOLLOWING STATEMENT REGARDING THE FILING OF AN APPEAL:

Commented [BF23]: Section 25-27-104.3(3), C.R.S., modified for clarity.

"IF THE RESIDENT, OR OTHER PERSON THAT SUBMITTED THIS GRIEVANCE IS DISSATISFIED WITH THIS RESPONSE, THEY MAY FILE AN APPEAL TO THE EXECUTIVE DIRECTOR OF THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT WITHIN 5 BUSINESS DAYS AFTER RECEIVING THIS WRITTEN RESPONSE. THE APPEAL MUST INCLUDE THE ORIGINAL GRIEVANCE, THE ORIGINAL NOTICE OF INVOLUNTARY DISCHARGE AND SUPPORTING DOCUMENTATION GIVEN TO THE RESIDENT AS PART OF THAT NOTIFICATION, AND ANY ADDITIONAL INFORMATION OR DOCUMENTATION."

(F) ACKNOWLEDGEMENT THAT IF THE RESIDENT, THE INDIVIDUAL FILING THE GRIEVANCE, OR THE ASSISTED LIVING RESIDENCE IS DISSATISFIED WITH THE FINDINGS AND RECOMMENDATIONS OF THE DEPARTMENT RELATED TO AN APPEAL, THEY MAY REQUEST A HEARING CONDUCTED BY THE DEPARTMENT PURSUANT TO SECTION 24-4-105, C.R.S.

Commented [BF24]: Section 25-27-104.3(5), C.R.S.

(G) A REQUIREMENT THAT THE ASSISTED LIVING RESIDENCE NOT TAKE ANY PUNITIVE OR RETALIATORY ACTION AGAINST A RESIDENT DUE TO THE RESIDENT FILING A GRIEVANCE OR APPEAL PURSUANT TO THIS PART.

Commented [BF25]: First half of Section 25-27-104.3(4)(a), C.R.S.

(H) A REQUIREMENT THAT THE ASSISTED LIVING RESIDENCE CONTINUE TO ASSIST WITH PLANNING A DISCHARGE OR TRANSFER OF THE RESIDENT WHILE THE GRIEVANCE OR APPEAL TO THE DEPARTMENT IS PENDING.

Commented [BF26]: Second half of Section 25-27-104.3(4)(a), C.R.S.

(I) A REQUIREMENT THAT THE RESIDENT BE ALLOWED TO RETURN TO THE ASSISTED LIVING RESIDENCE IF ALL OF THE FOLLOWING APPLY:

Commented [BF27]: Section 25-27-104.3(4)(b), C.R.S.

(1) THE STATED REASON FOR THE INVOLUNTARY DISCHARGE IN THE NOTICE OF INVOLUNTARY DISCHARGE PROVIDED IN ACCORDANCE WITH PART 11.17 IS NONPAYMENT OF MONTHLY SERVICES OR ROOM AND BOARD,

(2) THE ASSISTED LIVING RESIDENCE DISCHARGED THE RESIDENT ON OR AFTER THE 31ST DAY AFTER THE WRITTEN NOTICE OF INVOLUNTARY DISCHARGE WAS PROVIDED TO THE RESIDENT, AND

(3) THE RESIDENT SUBSTANTIALLY COMPLIED WITH PAYMENTS DUE TO THE RESIDENCE, AS DETERMINED THROUGH THE GRIEVANCE AND APPEAL PROCESS.

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PART 11 – RESIDENT ADMISSION AND DISCHARGE

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Resident Agreement

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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 thirty (30) calendar days before such closure~~.~~,

(G) REASONS THAT THE ASSISTED LIVING RESIDENCE COULD PURSUE AN INVOLUNTARY DISCHARGE OF THE RESIDENT, AS LISTED IN PARTS 11.11 AND 11.12,

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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 Part 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 IN WHICH THE RESIDENT REQUIRES A LEVEL OF CARE THAT CANNOT BE MET BY THE RESIDENCE OR THE RESIDENT HAS DEMONSTRATED THAT THEY ARE A DANGER TO THEMSELVES OR OTHERS, ~~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~~PROVIDE WRITTEN NOTIFICATION WITH AS MUCH ADVANCE NOTICE AS IS REASONABLE UNDER THE CIRCUMSTANCES PRIOR TO THE REMOVAL FROM THE RESIDENCE. SUCH WRITTEN NOTICE SHALL BE PROVIDED TO:

(A) THE RESIDENT,

(B) THE RESIDENT'S LEGAL REPRESENTATIVE, AND

(C) ANY RELATIVE OR OTHER PERSON THE RESIDENT HAS DESIGNATED TO RECEIVE NOTICE OF A DISCHARGE, AS LISTED ON THE RESIDENT'S FACE SHEET IN ACCORDANCE WITH PART 18.9(G).

11.17 WRITTEN NOTICE OF INVOLUNTARY DISCHARGE MUST INCLUDE THE FOLLOWING:

(A) A DETAILED EXPLANATION OF THE REASON OR REASONS FOR THE DISCHARGE, INCLUDING, AT A MINIMUM:

(1) FACTS AND EVIDENCE SUPPORTING EACH REASON GIVEN BY THE RESIDENCE, AND

(2) A RECOUNTING OF EVENTS LEADING TO THE INVOLUNTARY DISCHARGE, INCLUDING INTERACTIONS WITH THE RESIDENT OVER A PERIOD OF TIME PRIOR TO THE NOTICE AND ACTIONS TAKEN TO AVOID DISCHARGE, SPECIFYING THE TIMING OF THE EVENTS AND ACTIONS.

(B) STATEMENTS CONVEYING THE FOLLOWING INFORMATION:

(1) THAT THE INDIVIDUAL RECEIVING THE NOTICE HAS THE RIGHT TO FILE A GRIEVANCE WITH THE RESIDENCE CHALLENGING THE INVOLUNTARY DISCHARGE WITHIN 14 DAYS OF THE WRITTEN NOTICE, REGARDLESS OF WHETHER THE RESIDENT HAS ALREADY BEEN REMOVED FROM THE ASSISTED LIVING RESIDENCE,

Commented [BF28]: Modifications to Part 11.6 header language is statutory language at Section 26-27-104.3(1)(c), C.R.S.

Commented [BF29]: (A) through (C) from Section 25-27-104.3(1)(a)(I), C.R.S.

Commented [BF30]: Section 25-27-104.3(1)(b), C.R.S.

Commented [BF31]: Section 25-27-104.3(1)(b)(I)(A), C.R.S.

Commented [BF32]: Section 25-27-104.3(1)(b)(I)(B), C.R.S.

Commented [BF33]: Section 25-27-104.3(1)(b)(I)(C), C.R.S.

(2) THAT IF A GRIEVANCE IS FILED, THE ASSISTED LIVING RESIDENCE MUST PROVIDE A RESPONSE TO THE GRIEVANCE WITHIN FIVE BUSINESS DAYS, AND

(3) IF THE RESIDENT OR PERSON FILING THE GRIEVANCE IS DISSATISFIED WITH THE RESPONSE, THAT THE RESIDENT OR PERSON FILING THE GRIEVANCE MAY APPEAL TO THE EXECUTIVE DIRECTOR OF THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT OR THEIR DESIGNEE.

(C) NAMES AND CONTACT INFORMATION, INCLUDING PHONE NUMBERS, PHYSICAL ADDRESSES, AND EMAIL ADDRESSES, FOR THE STATE LONG-TERM CARE OMBUDSMAN, THE DESIGNATED LOCAL OMBUDSMAN, AND THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT.

(D) IF THE INVOLUNTARY DISCHARGE IS INITIATED DUE TO A MEDICAL OR PHYSICAL CONDITION RESULTING IN A REQUIRED LEVEL OF CARE THAT CANNOT BE TREATED WITH MEDICATION OR SERVICES ROUTINELY PROVIDED BY THE RESIDENCE'S STAFF OR AN EXTERNAL SERVICE PROVIDER, THE NOTICE MUST ALSO INCLUDE AN ASSESSMENT BY THE RESIDENT'S APPLICABLE HEALTH-CARE OR BEHAVIORAL HEALTH PROVIDER OF THE RESIDENT'S CURRENT NEEDS IN RELATION TO THE RESIDENT'S MEDICAL AND PHYSICAL CONDITION.

11.1~~7~~8 A copy of any involuntary discharge notice shall be sent to the state LONG-TERM CARE ombudsman and the designated local ~~long-term~~ care ombudsman, within five (5) calendar days of the date that it is provided to the resident ~~or~~ AND the resident's legal representative.

~~.~~PART 12 – RESIDENT CARE SERVICES

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Resident Care Plan

12.10 Each resident care plan shall:

(A) Be developed with input from the resident and the resident's 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, INCLUDING ESSENTIAL CAREGIVERS FOR THE PURPOSES OF THE ASSISTED LIVING RESIDENCE'S VISITATION POLICY AS REQUIRED BY PART 9.2, along with care coordination arrangements; and

(F) Identify formal, planned, and informal spontaneous engagement opportunities that match the resident's personal choices and needs.

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PART 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:

Commented [BF34]: Section 25-27-104.3(1)(b)(I)(D), C.R.S.

Commented [BF35]: Section 25-27-104.3(1)(b)(II), C.R.S.

Commented [BF36]: Change for consistency with statutory definitions

Commented [BF37]: Section 25-27-104.3(1)(a)(II) requires this notice within 5 days after providing notice to the resident. It does not include language regarding the legal representative, thus making this an "and" rather than an or.

(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 thirty (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.

(10) THE RIGHT TO DESIGNATE THE INDIVIDUALS TO BE NOTIFIED IN CASES OF EMERGENCY OR INVOLUNTARY DISCHARGE.

(E) THE RIGHT TO VISITATION IN COMPLIANCE WITH FACILITY POLICY AS SET FORTH IN PART 9.2.

Ombudsman Access

13.2 In accordance with the Supporting Older Americans Act of 2020 (P.L. 116-131), and Sections 26-11.5-108 and 25-27-104(2)(d), C.R.S., an assisted living residence shall permit access to the premises and residents by the state LONG-TERM CARE 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.

(A) For the purposes of complying with this Part 13.2, access to residents shall include access to the assisted living residence's contact information for the resident and the resident's representative.

Commented [BF38]: Change for consistency with new statutory definitions

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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 AND LOCAL OMBUDSMAN;

Commented [BF39]: Change for consistency with new statutory definitions

(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.

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PART 18 – RESIDENT HEALTH INFORMATION RECORDS

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Confidentiality and Access

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18.7 Each resident or legal representative of a resident shall be allowed to inspect that resident's own record in accordance with Section 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 AND LOCAL OMBUDSMAN pursuant to Section 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~~CAREGIVERS, ESSENTIAL CAREGIVERS, aides, podiatrists, physical therapists, hospice and home care services, and other practitioners, assistants, and care~~givers~~ PROVIDERS;

(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, CONTACT INFORMATION, AND MAILING ADDRESS, IF AVAILABLE, ~~address and contact information~~ for family members, legal representatives, and/or other persons to be notified SPECIFICALLY in case of emergency;

(G) NAME, CONTACT INFORMATION, AND MAILING ADDRESS, IF AVAILABLE, FOR THE LEGAL REPRESENTATIVE AND ALL RELATIVES OR OTHER PERSONS THE RESIDENT AND/OR LEGAL REPRESENTATIVE SPECIFICALLY DESIGNATES TO RECEIVE A NOTICE OF DISCHARGE IN ACCORDANCE WITH PART 11.16.

(~~G~~H) Name, address, and contact information for resident's practitioner and case manager, if applicable;

(~~H~~I) Resident's primary spoken language and any issues with oral communication;

(~~I~~J) Indication of resident's religious preference, if any;

(~~J~~K) Resident's current diagnoses; and

(~~K~~L) Notation of resident's allergies, if any.

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PART 25 – SECURE ENVIRONMENT

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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 local~~ long-term care ombudsman AND LOCAL OMBUDSMAN, when appropriate;

Commented [BF40]: Change for consistency with new statutory definitions

(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.

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