COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

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

Through: Elaine McManis, Division Director, Health Facilities and Emergency Medical Services Division *EM*

Date: November 20, 2024

Subject: Request for a Rulemaking Hearing concerning 6 CCR 1011-1, Chapter 7 - Assisted Living Residences, and for conforming amendments to 6 CCR 1011-1, Chapter 24 - Medication Administration Regulations

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The Division requests that the Board of Health set a rulemaking hearing for revisions to 6 CCR 1011-1, Chapter 7 – Assisted Living Residences with conforming amendments to 6 CCR 1011-1, Chapter 24 – Medication Administration Regulations. These revisions are due to the passage of Senate Bill (SB) 24-167, which makes certain trainings and tests performed by individual assisted living residences (ALR) "portable," meaning that an employee can carry it from one ALR employer to another without a need for retraining or retesting on the portable topic.

Due to the prescriptive nature of the bill, the proposed rule language was developed through a stakeholder process involving two stand-alone stakeholder meetings and two meetings with the Assisted Living Advisory Committee (ALAC), the statutory committee created in Section 25-17-110, C.R.S., which is tasked with making recommendations to the Department concerning ALR-related rules promulgated by the Board of Health. The limited schedule, while abbreviated compared to the Division's typical stakeholder process, was appropriate for the minimal flexibility allowed by the bill.

Senate Bill 24-167 added a statutory definition of qualified medication administration personnel (QMAP) to the ALR statutes at Section 25-27-102(10.5), C.R.S. The Chapter 7 regulatory definition is being updated to reference the statutory definition as part of this rulemaking effort. For these reasons, the Division is also proposing a conforming amendment to Chapter 24 – Medication Administration Regulations to ensure clarity about which definition applies, based on the license type of the facility.

This request also includes some citation updates and a correction to rule numbering.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 CCR 1011-1, Chapter 7 – Assisted Living Residences,
And Conforming Amendments to
6 CCR 1011-1, Chapter 24 – Medication Administration Regulation

Basis and Purpose

The Department is proposing rules to implement Senate Bill 24-167 (SB24-167), concerning "portable requirements for direct-care health-care workers in assisted living residences." This bill makes certain trainings and tests for workers in assisted living residences (ALRs) "portable," meaning that, under certain conditions, an ALR can rely on an employee's test or training provided by a previous ALR employer, rather than providing the test or training upon hire.

The language of the bill is generally prescriptive with regard to definitions, applicability, and the processes for ALRs as far as providing and accepting portable tests and/or training. However, the Department has worked with stakeholders to offer implementation flexibility where possible, and ensure the requirements in statute are clear in the regulations. The proposed rules include:

- New statutory definitions of direct-care worker, qualified medication administration personnel in ALR's, portable test, and portable training.
- Required processes for ALRs providing or accepting portable tests or training.
- Incorporation of the testing/training requirements in cross-referenced or similar rules.
- Citation and numbering updates.

SB24-167 adds a statutory definition of qualified medication administration personnel (QMAPs) to the ALR statutes at Section 25-27-102(10.5), C.R.S. As part of this rulemaking, the rule-based definition is being replaced by a definition that refers to the statutory definition. A conforming amendment is being made to 6 CCR 1011-1, Chapter 24 – Medication Administration to reflect the statutory definition of QMAP now in effect for ALRs.

The bill's requirements and the proposed rule language were presented and discussed with stakeholders over a four-month process, culminating in the draft rules being reviewed by the statutory Assisted Living Advisory Committee (ALAC), which recommended the draft rules be presented to the Board of Health.

Specific Statutory Authority
Statutes that require or authorize rulemaking:
Section 25-27-104, C.R.S.
Section 25-27-114, C.R.S.
Section 25-1.5-302, C.R.S.

Other relevant statutes:
Section 25-27-102, C.R.S.

Is this rulemaking due to a change in state statute?

__X___ Yes, the bill number is SB24-167. Rules are _X__ authorized ___ required.

_____ No

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

_____ Yes ___ URL

__X___ No

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

_____ Yes

__X___ No

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

__X_ 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,
And Conforming Amendments to
6 CCR 1011-1, Chapter 24 – Medication Administration Regulation

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**
Licensed Assisted Living Residences (ALRs)	677	C
ALR employees	unknown	S
Advocates, ombudsmen, residents' family members, friends, or legal representatives	unknown	S
ALR residents	Unknown	B

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.

C: The proposed rule allows ALRs to accept a new employee's prior training in certain topics, or certain tests, rather than providing that training or test once the person is hired. It is anticipated that this could reduce the cost and time needed to onboard new staff. It is also possible that, by not having to repeat training a new hire already has, ALRs could redirect training resources previously dedicated to the portable topics to more advanced skill development, resulting in a better-trained workforce across the industry.

S: ALR direct-care workers may benefit from the proposed rules by differentiating themselves among the workforce with proof of existing skills and training, making them more attractive to employers. For advocates, ombudsmen, and those with ties to ALR residents, the rule

enables ALRs to document new workers' existing abilities, potentially resulting in better care for residents.

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 acceptance of proof of portable training is optional for licensed assisted living residences. This means that each ALR can determine whether the economic benefits (e.g., reduced costs or time for onboarding new staff) outweigh the costs of developing and following a policy for the acceptance of such training. In contrast, all ALRs must provide certificates to direct-care workers for training they have provided or paid for in portable topics; however, the costs associated with doing so are expected to be minimal and were not brought up as a concern during any of the stakeholder meetings regarding these rules.

Please describe any anticipated financial costs or benefits to these individuals/ entities.

S: N/A

B: N/A

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.

C and B: Over time, recognizing, and potentially building upon, the training workers have previously received is expected to result in a higher level of consistently trained workers and competent care for residents of ALRs. This, in turn, may help with workforce shortages, employee morale, and retention.

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. It is anticipated that any regulatory oversight of the new rules will be absorbed as part of existing assisted living residence licensing and oversight functions.

Anticipated CDPHE Revenues:

N/A

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

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 rules:

_x_ Comply with a statutory mandate to promulgate rules.
___ 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
___ Improve public and environmental health practice.
_x_ Implement stakeholder feedback.
___ Advance the following CDPHE Strategic Plan priorities (select all that apply):
___ Improve outcomes in public health and environmental protection for all people of Colorado.
___ Realize a human-first, progress-forward culture
___ Accomplish bold and Wildly Important Goals (WIGs) with an annual focus on a few key issues.
___ Continuously pursue operational excellence in support of our programs.
___ Strengthen Colorado's governmental public health system and promote effective public health practice.
__ Advance CDPHE Division-level strategic priorities.

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

Though not a financial cost, inaction would have left assisted living residences to interpret and implement the requirements of Senate Bill 24-167 on their own without the regulatory framework of 6 CCR 1011-1, Chapter 7. Given that there are more than 700 licensed assisted living residences in Colorado, a lack of regulatory language could result in statutory requirements not being met, or applied inconsistently from facility to facility.

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

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

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

The passage of Senate Bill 24-167 created the concept of training portability for assisted living residence workers. With the prescriptive nature of the bill, the Department considered not including the requirements in rule, but instead relying on assisted living residences to implement training portability based on the statutory requirements. However, doing so would

result in an inconsistent implementation between facilities, increasing the difficulty of the Department's oversight of staff training in assisted living residences as part of licensing oversight. Therefore, the Department pursued rulemaking, hewing close to the statutory language, but allowing assisted living residences as much flexibility as possible.

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- and medication administration-related statutes and existing regulatory language regarding training requirements for individuals providing care in assisted living residences.

STAKEHOLDER ENGAGEMENT
for Amendments to
6 CCR 1011-1, Chapter 7 – Assisted Living Residences,
And Conforming Amendments to
6 CCR 1011-1, Chapter 24 – Medication Administration Regulation

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:

The Division held two stand-alone stakeholder meetings in August 2024 and September 2024 and also presented proposed rule language to two meetings of the statutorily-created Assisted Living Advisory Committee (ALAC) in July 2024 and October 2024 to seek feedback regarding the implementation of SB24-167. All meetings were open to the public and available via a Zoom online platform. The September 2024 stakeholder meeting was held in a hybrid format, allowing participants to attend in person at the Department.

Notice of the opportunity to participate in the stakeholder process related to SB24-167 was provided to individual contacts roughly two weeks in advance of each meeting, including the following:

- Assisted Living Advisory Committee (ALAC) members
- All individuals expressing interest in being included in the stakeholder process, as gathered through the interested parties Google Form link in the public Google folder for the stakeholder process
- Provider Messaging System from the Department to all Assisted Living Residences

Roughly one week in advance of each meeting, a public link to the Google folder containing the signed statute, proposed draft rule language, meeting agenda, and other meeting materials was made available to stakeholders. Meeting participants had the opportunity to use the chat or raise hand function in Zoom to participate during meetings. Attendance ranged from 15 to 25 participants, with 45 distinct stakeholders taking part in at least one meeting. Outside of the meetings, stakeholders were encouraged to send written comments to Department staff via email. Once meetings concluded, audio and video recordings were published in the public Google folder alongside the Zoom meeting chat record.

The following individuals attended at least one meeting as part of the stakeholder process:

Representative Name	**Organization (if known)**
Andrea Sanchez	Belmont Senior Care Assisted Living
Ashley Gainer	Senior Care Compliance Solutions
Ashley Reese	Boulder County Area Agency on Aging, Assisted Living Advisory Committee (ALAC)
Becky Parry	Aspen Ridge Alzheimer's Special Care Center

Ben Besrat Bejiga	
Beth Williams	
Carrie Olenick	Adeo-Stephans Farm
David Lewis	Rocky Mountain Assisted Living, Assisted Living Advisory Committee (ALAC)
Deborah Lively	LeadingAge Colorado, Assisted Living Advisory Committee (ALAC)
Eileen Doherty	
Emily Bloom Cortez	Fort Collins Good Samaritan
Gemma Wilson	
Grant Reefer	HCBS Benefits Specialist, Community Living, Health Care Policy and Financing (HCPF)
Janet Cornell	Colorado Assisted Living Association (CALA), Assisted Living Advisory Committee (ALAC)
Jason Davis	Family Health West, Assisted Living Advisory Committee (ALAC)
Jami Molencamp	OZ Architecture
Jeff Ippen	Stage Management, Assisted Living Advisory Committee (ALAC)
Jenny Albertson	
Julie Lee	Provider Representative, Good Samaritan Society Estes Park Village, Assisted Living Advisory Committee (ALAC)
Kara Harvey	Kavod Senior Life
Kassy Trujillo	Belmont Senior Care Assisted Living
Kristie Ashby	
Lesley Reeder	Colorado Gerontological Society
Linda Berens	AltaVita Senior Residences
Lindsay Matkin	Wellage Senior Living
Lisa Anderson	Assured Senior Living, Assisted Living Advisory Committee (ALAC)
Mandi Mouw	
Maggie Gerardi	Whitcomb Terrace Assisted Living
Meg Janeba	HCBS Benefits Supervisor, Community Living, Health Care Policy and Financing (HCPF)
Megan Hart	
Melissa Clement	Morningstar Senior Living
Meredith Steffan-Gardens	Care Senior Living
Mike O'Donnell	Clinical Manager, LPC, Thomas and Mrachek Houses, Aurora Mental Health
Phi Nguyen	
Phyllis Sanchez	Belmont Senior Care Assisted Living
Sara Taylor	Montage Creek
Sara Wright	Assisted Living Consultants of Denver
Shannon Gimbel	Denver Regional Council of Governments, Assisted Living Advisory Committee (ALAC)
Shelly Fitzgerald	Aurora Mental Health and Recovery
Sherrie Bonham	Applewood Our House, Colorado Assisted Living Association (CALA)

Teresa Fleischli	
Terry Zamell	LeadingAge Colorado
In addition to the participants listed above, there were 3 unnamed participants.	

During the July 2024 presentation to ALAC, participants were informed of the requirements set forth in SB24-167 and presented with ways to participate in the upcoming stakeholder process. Stakeholder meetings in August 2024 and September 2024 focused on reviewing and modifying proposed draft rule language to incorporate new portable training requirements in Chapter 7. In October 2024, the Department sought final feedback about proposed modifications to the rule language from ALAC and took final comment regarding the provision of SB24-167, resulting in the ALAC's recommendation to take the proposed rules forward for presentation to the Board of Health.

Stakeholder communication and meetings for the implementation of Senate Bill 24-167 (SB24-167) occurred in the following manner:

- July 3, 2024 – Message regarding the rulemaking process and the new statutory definition of qualified medication administration person (QMAP) sent to all assisted living residences (ALRs) through the Department's provider messaging system, as well as posted to the Department's website.
- July 18, 2024 – SB24-167 presentation to the statutorily-created ALAC, including the details of the legislation and the upcoming stakeholder process.
- August 15, 2024 – Initial stakeholder meeting to discuss proposed draft language implementing the provisions of SB24-167. Notice of this meeting was sent via email, posted to the Department's website, and sent to ALRs directly through the Department's provider messaging system on July 28, 2024.
- September 26, 2024 – Additional stakeholder meeting to discuss modifications to draft rule language based on stakeholder feedback. Notice of this meeting was sent via email, posted to the Department's website, and sent to ALRs directly through the Department's provider messaging system on September 20, 2024.
- October 24, 2024 – Presentation of draft language to the ALAC.

Additional communication regarding the new statutory definition of qualified medication administration person (QMAP) was sent via the Department's provider messaging system, posted on the Department's website, and sent to all assisted living residences in July 2024 and August 2024.

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).

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

____ 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.

- **Applicability of portable training and testing requirements.** Senate Bill 24-167 limits portable training to qualified medication administration personnel and "direct-care workers," so, in its initial proposed rule language, the Department referred to both qualified medication administration personnel and direct-care workers in each requirement. Stakeholders pointed out that referring to both might be redundant and unnecessary because any qualified medication administration person working in an assisted living residence would also be considered a direct-care worker. As a result, the reference to qualified medication personnel was removed from the rules regarding acceptance of proof of portable training.
- **Information to be included on certificates issued for use as proof of portable training.** The Department initially proposed that the certificates include both the worker's name and date of birth in order to provide assurance that, in the case of common names, the individual named on the certificate is the person presenting the certificate. However, stakeholders raised legitimate concerns regarding the potential for age discrimination, and voiced the concern that the inclusion of a date of birth may not truly provide the assurance it is intended to provide. After reviewing other, similar types of certificates and professional documentation, the Department found that dates of birth are typically not included in certificates of this type. It will be the responsibility of the assisted living residence to verify that the individual presenting the certificate is the person who received the training, and to determine that the individual is competent in the specified portable skills prior to providing care. After discussing other, similar certificates with stakeholders, the Department decided to require that the portable training certificate include information about the date and length of an individuals' training. Stakeholders approved the inclusion of the date and length of training on the certificate and consensus was reached.

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

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

Select all that apply.

___ Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.

_x__ Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.

___ Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.

_x__ 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.

___ 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

SENATE BILL 24-167

BY SENATOR(S) Ginal and Smallwood, Bridges, Buckner, Cutter, Jaquez Lewis, Michaelson Jenet, Mullica, Priola, Sullivan, Will, Zenzinger; also REPRESENTATIVE(S) McCormick, Amabile, Bacon, Bird, Boesenecker, Brown, Clifford, Daugherty, English, Hamrick, Herod, Jodeh, Joseph, Lieder, Lindsay, McLachlan, Ortiz, Ricks, Sirota, Snyder, Story, Valdez, Woodrow, Young, McCluskie.

CONCERNING PORTABLE REQUIREMENTS FOR DIRECT-CARE HEALTH-CARE WORKERS 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, 25-27-102, **add** (2.5), (2.7), (9.3), (9.5), and (10.5) as follows:

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

(2.5) "DIRECT CARE WORKER" MEANS AN EMPLOYEE WHO PROVIDES HANDS-ON CARE, SERVICES, AND SUPPORT TO RESIDENTS OF AN ASSISTED LIVING RESIDENCE.

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.

(2.7) "FIT TEST" MEANS A TEST PROTOCOL CONDUCTED TO VERIFY THAT A RESPIRATOR OR MASK IS BOTH COMFORTABLE AND PROVIDES THE WEARER WITH THE EXPECTED PROTECTION.

(9.3) "PORTABLE TEST" MEANS THE FOLLOWING TESTS FOR WHICH, WHEN SUCCESSFULLY COMPLETED BY AN INDIVIDUAL, THE INDIVIDUAL IS PROVIDED A CERTIFICATION OF COMPLETION THAT MAY BE TRANSFERRED FROM ONE ASSISTED LIVING RESIDENCE TO ANOTHER IN ACCORDANCE WITH THIS SECTION:

(a) A FIT TEST; AND

(b) A TUBERCULOSIS TEST.

(9.5) "PORTABLE TRAINING" MEANS THE FOLLOWING TRAINING FOR WHICH, WHEN SUCCESSFULLY COMPLETED BY AN INDIVIDUAL, THE INDIVIDUAL IS PROVIDED A CERTIFICATION OF COMPLETION THAT MAY BE TRANSFERRED FROM ONE ASSISTED LIVING RESIDENCE TO ANOTHER IN ACCORDANCE WITH THIS SECTION:

(a) HAND HYGIENE AND INFECTION CONTROL;

(b) BASIC FIRST AID;

(c) RESIDENT RIGHTS;

(d) PERSON-CENTERED CARE;

(e) FALL PREVENTION;

(f) LIFT ASSISTANCE; AND

(g) FOOD SAFETY.

(10.5) "QUALIFIED MEDICATION ADMINISTRATION PERSONNEL" MEANS AN INDIVIDUAL WHO HAS 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 INDIVIDUALS WHO HAVE PASSED THE REQUISITE COMPETENCY EVALUATION.

SECTION 2. In Colorado Revised Statutes, **add** 25-27-114 as follows:

25-27-114. Direct care workers in assisted living residences - training - portability - rules. (1) (a) IF AN OPERATOR OF AN ASSISTED LIVING RESIDENCE PROVIDES OR PAYS FOR A PORTABLE TEST FOR A DIRECT CARE WORKER OR FOR QUALIFIED MEDICATION ADMINISTRATION PERSONNEL EMPLOYED BY THE ASSISTED LIVING RESIDENCE, THE OPERATOR SHALL MAKE THE RESULTS OF THE TEST AVAILABLE TO THE DIRECT CARE WORKER OR QUALIFIED MEDICATION ADMINISTRATION PERSONNEL UPON COMPLETION OF THE TEST.

(b) IF, UPON HIRE BY AN ASSISTED LIVING RESIDENCE, A NEW EMPLOYEE PROVIDES PROOF OF COMPLETION OF A PORTABLE TEST, THE OPERATOR OF THE ASSISTED LIVING RESIDENCE MAY DETERMINE THAT THE INDIVIDUAL HAS SATISFIED RELATED TESTING REQUIREMENTS OR REQUIRE THE INDIVIDUAL TO COMPLETE NEW TESTING.

(c) THE RESULTS OF A TUBERCULOSIS TEST MAY BE ACCEPTED FOR PURPOSES OF NEW EMPLOYMENT RECORDS IF PRESENTED TO THE NEW EMPLOYER WITHIN TWO YEARS AFTER THE TESTING DATE. NOTWITHSTANDING ANY PROVISION OF THIS SECTION, THE DEPARTMENT MAY REQUIRE ADDITIONAL TESTING AS DETERMINED THROUGH ADMINISTRATIVE ACTION, NOTICE, RULE, OR STATE LAW.

(2) IF AN OPERATOR OF AN ASSISTED LIVING RESIDENCE PROVIDES OR PAYS FOR PORTABLE TRAINING FOR A DIRECT CARE WORKER OR QUALIFIED MEDICATION ADMINISTRATION PERSONNEL EMPLOYED BY THE OPERATOR, UPON COMPLETION OF THE PORTABLE TRAINING, THE OPERATOR OR THE ENTITY THAT PROVIDES THE PORTABLE TRAINING SHALL PROVIDE THE INDIVIDUAL WHO COMPLETES THE PORTABLE TRAINING WITH A CERTIFICATE OF COMPLETION. THE CERTIFICATE OF COMPLETION MUST INCLUDE:

(a) THE PORTABLE TOPIC COVERED;

(b) THE DATE OF THE PORTABLE TRAINING;

(c) THE INDIVIDUAL OR ENTITY THAT PROVIDED THE PORTABLE TRAINING;

(d) DOCUMENTATION OF COMPETENCY IN THE SPECIFIC PORTABLE TOPIC OF THE PORTABLE TRAINING; AND

(e) ADDITIONAL ELEMENTS AS DETERMINED BY RULE.

(3) (a) IF, UPON HIRE BY AN ASSISTED LIVING RESIDENCE, A NEW DIRECT CARE WORKER PROVIDES PROOF OF COMPLETION OF PORTABLE TRAINING, THE ASSISTED LIVING RESIDENCE SHALL ENSURE, IN A FORM AND MANNER DETERMINED BY THE OPERATOR, THAT THE DIRECT CARE WORKER HAS SATISFIED THE RELATED PORTABLE TRAINING REQUIREMENTS IN ORDER TO ENSURE THAT EACH DIRECT CARE WORKER CAN SAFELY CARRY OUT THE DUTIES AND RESPONSIBILITIES FOR THE CARE AND PROVISION OF SERVICES TO RESIDENTS.

(b) IN ADDITION TO PORTABLE TRAINING, THE OPERATOR OF AN ASSISTED LIVING RESIDENCE SHALL ENSURE THAT EACH DIRECT CARE WORKER RECEIVES ANY TRAINING REQUIRED BY RULES ADOPTED BY THE STATE BOARD, OR AS SET FORTH IN STATE LAW, WITHIN THE TIMELINES SET BY STATE LAW OR RULE.

(4) THE STATE BOARD SHALL ACCEPT PROOF OF A PORTABLE TEST OR A CERTIFICATE FOR PORTABLE TRAINING THAT IS DEEMED SUFFICIENT BY AN ASSISTED LIVING RESIDENCE OPERATOR AS PROOF OF COMPLETION OF A PORTABLE TEST OR PORTABLE TRAINING. THE STATE BOARD MAY, BUT IS NOT REQUIRED TO, PROMULGATES RULES TO DEFINE OTHER PORTABLE TESTS OR PORTABLE TRAININGS AS PORTABLE.

(5) IF AN ASSISTED LIVING RESIDENCE OPERATOR ACCEPTS PROOF OF PORTABLE TRAINING CONDUCTED BY ANOTHER ENTITY, THE ASSISTED LIVING RESIDENCE OPERATOR SHALL ENSURE COMPETENCY IN A FORM AND MANNER TO BE DETERMINED BY THE OPERATOR IN ORDER TO ENSURE PRIOR EDUCATION AND PORTABLE TRAINING ARE SUFFICIENT FOR THE DIRECT CARE WORKER TO SAFELY CARRY OUT THE DIRECT CARE WORKER'S DUTIES AND RESPONSIBILITIES. AN ASSISTED LIVING RESIDENCE THAT CURRENTLY EMPLOYS A DIRECT CARE WORKER IS LIABLE FOR ANY ACTS OR OMISSIONS BY THE DIRECT CARE WORKER EMPLOYEE THAT ARE DIRECTLY RELATED TO THE EMPLOYEE'S PREVIOUS PORTABLE TRAINING AND THE ACCEPTANCE OF THE CERTIFICATION OF COMPLETION OF THAT TRAINING BY THE ASSISTED LIVING RESIDENCE.

SECTION 3. Appropriation. For the 2024-25 state fiscal year, $30,152 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 0.3 FTE. To implement this act, the division may use this appropriation for administration and operations.

SECTION 4. Act subject to petition - effective date. This act takes effect January 1, 2025; 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 the ninety-day period after final adjournment of the general assembly, 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 2024 and, in such case, will take effect January 1, 2025, or on the date of the official declaration of the vote thereon by the governor, whichever is later.

Steve Fenberg
PRESIDENT OF
THE SENATE

Julie McCluskie
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED Thursday June 6th 2024 at 4:00 pm
(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 ~~November 15, 2023~~_____. Effective ~~January 14, 2024~~_____.

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PART 2 – DEFINITIONS

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2.47 MEANS A TUBERCULOSIS TEST FOR WHICH, WHEN SUCCESSFULLY COMPLETED BY AN INDIVIDUAL, THE INDIVIDUAL IS PROVIDED A CERTIFICATION OF COMPLETION THAT MAY BE TRANSFERRED FROM ONE ASSISTED LIVING RESIDENCE TO ANOTHER IN ACCORDANCE WITH THE RULES IN PART 7.7(A)(2).

Commented [BF1]: Definition from Section 25-27-102(9.3), C.R.S., as added by SB24-167. Though the statutory definition includes fit testing and tuberculosis testing, this definition only refers to tuberculosis testing, since fit testing is not referenced in Chapter 7

2.48 MEANS TRAINING IN HAND HYGIENE AND INFECTION CONTROL, BASIC FIRST AID, RESIDENT RIGHTS, PERSON-CENTERED CARE, FALL PREVENTION, LIFT ASSISTANCE, AND FOOD SAFETY FOR WHICH, WHEN SUCCESSFULLY COMPLETED BY AN INDIVIDUAL, THE INDIVIDUAL IS PROVIDED A CERTIFICATION OF COMPLETION THAT MAY BE TRANSFERRED FROM ONE ASSISTED LIVING RESIDENCE TO ANOTHER IN ACCORDANCE WITH THE RULES IN PART 7.9(D).

Commented [BF2]: Definition from Section 25-27-102(9.5), C.R.S., as added by SB24-167

2.4~~7~~9 "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.

2.4~~8~~50 "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.

2.4951 "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.

2.502 "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.~~ MEETS THE DEFINITION OF "QUALIFIED MEDICATION ADMINISTRATION PERSONNEL" AT SECTION 25-27-102(10.5), C.R.S.

2.513 "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.

2.524 "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.

2.535 "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.

2.546 "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.

2.5~~5~~7 “Self-administration” means the ability of a resident to take medication independently without any assistance from another person.

2.5~~6~~8 “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

2.5~~7~~9 "State long-term care ombudsman" means the same as the definition set forth in Section 25-27-102(12), C.R.S.

2.~~58~~60 “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.~~59~~61 “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.

2.6~~0~~2 “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.

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PART 7 – PERSONNEL

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Ability to Perform Job Functions

7.5 Each staff member and volunteer shall be physically and mentally able to adequately and safely perform all functions essential to resident care.

7.6 The assisted living residence shall select direct care staff based on such factors as the ability to read, write, carry out directions, communicate, and demonstrate competency to safely and effectively provide care and services.

7.7 The assisted living residence shall establish written policies concerning pre-employment physical evaluations and employee health. Those policies shall include, at a minimum:

(A) Tuberculin skin testing of each staff member and volunteer prior to direct contact with residents, AS FOLLOWS: ~~; and~~

(1) FOR STAFF MEMBERS WHO ARE EMPLOYEES MEETING THE DEFINITION OF DIRECT-CARE WORKER, AS DEFINED AT PART 7.9(D)(1) OF THESE RULES:

(A) THE ASSISTED LIVING RESIDENCE MAY:

(I) REQUIRE THE INDIVIDUAL TO COMPLETE A NEW TUBERCULIN SKIN TEST, OR

(II) ACCEPT PROOF OF A PORTABLE TEST IN LIEU OF REQUIRING A NEW TEST, IF SUCH PROOF IS PRESENTED TO THE ASSISTED LIVING RESIDENCE WITHIN TWO (2) YEARS OF THE TESTING DATE.

(B) IF THE ASSISTED LIVING RESIDENCE PROVIDES OR PAYS FOR TUBERCULIN SKIN TESTING FOR AN EMPLOYEE WHO IS A DIRECT-CARE WORKER, AS DEFINED AT PART 7.9(D)(1) OF THESE RULES, IT SHALL MAKE THE RESULTS OF THE TEST AVAILABLE TO THE DIRECT-CARE WORKER OR QMAP UPON COMPLETION OF THE TEST.

(2) FOR STAFF MEMBERS AND VOLUNTEERS WHO DO NOT MEET THE DEFINITION OF DIRECT-CARE WORKER, AS DEFINED AT PART 7.9(D)(1) OF THESE RULES, THE ASSISTED LIVING RESIDENCE SHALL ENSURE THE STAFF MEMBER OR VOLUNTEER HAS A TUBERCULIN SKIN TEST PRIOR TO DIRECT CONTACT WITH RESIDENTS.

(B) The imposition of work restrictions on ~~direct care staff~~ STAFF AND VOLUNTEERS who are known to be affected with any illness in a communicable stage. At a minimum, such ~~staff~~ INDIVIDUALS shall be barred from direct contact with residents or resident food.

7.8 The assisted living residence shall have policies and procedures restricting on-site access by staff or volunteers with drug or alcohol use that would adversely impact their ability to provide resident care and services.

Staff and Volunteer Orientation and Training

7.9 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, OR ACCEPT PROOF OF PORTABLE TRAINING IN ACCORDANCE WITH PART 7.9(D);

Commented [BF3]: Section 25-27-102(9.5)(a), C.R.S.

(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, OR ACCEPT PROOF OF PORTABLE TRAINING IN ACCORDANCE WITH PART 7.9(D),

Commented [BF4]: Section 25-27-102(9.5)(b), C.R.S.

(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, OR ACCEPT PROOF OF PORTABLE TRAINING IN ACCORDANCE WITH PART 7.9(D);

(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 Ppart 7.89(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 7.89(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 7.89(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

Commented [BF5]: Section 25-27-102(9.5)(c), C.R.S.

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~~9(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) W~~w~~ithin 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~~9(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.

(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:

(1) Overview of state regulatory oversight applicable to the assisted living residence;

(2) Person-centered care, OR ACCEPT PROOF OF PORTABLE TRAINING IN ACCORDANCE WITH PART 7.9(D);

(3) The role of and communication with external service providers;

(4) Recognizing behavioral expression and management techniques, as appropriate for the population being served;

(5) How to effectively communicate with residents that have hearing loss, limited English proficiency, dementia, or other conditions that impair communication, as appropriate for the population being served;

(6) Training related to fall prevention, OR ACCEPT PROOF OF PORTABLE TRAINING IN ACCORDANCE WITH PART 7.9(D);

(7) TRAINING RELATED TO ways to monitor residents for signs of heightened fall potential such as deteriorating eyesight, unsteady gait, and increasing limitations that restrict mobility;

(~~7~~8) How to safely provide lift assistance, OR ACCEPT PROOF OF PORTABLE TRAINING IN ACCORDANCE WITH PART 7.9(D);

(9) HOW TO SAFELY PROVIDE accompaniment, and transport of residents;

(~~8~~10) Maintenance of a clean, safe and healthy environment including appropriate cleaning techniques;

(~~9~~11) Food safety, OR ACCEPT PROOF OF PORTABLE TRAINING IN ACCORDANCE WITH PART 7.9(D); and

Commented [BF6]: Section 25-27-102(9.5)(d), C.R.S.

Commented [BF7]: Section 25-27-102(9.5)(e), C.R.S.

Commented [BF8]: Separation necessary as topics are not included as portable topics

Commented [BF9]: Section 25-27-102(9.5)(f), C.R.S.

Commented [BF10]: Separation necessary as topics are not included as portable topics

Commented [BF11]: Section 25-27-102(9.5)(g), C.R.S.

(~~10~~12) Understanding the staff or volunteer's role in end of life care including hospice and palliative care.

(D) THE ASSISTED LIVING RESIDENCE MAY ACCEPT PROOF OF PORTABLE TRAINING FOR IDENTIFIED TOPICS IN SUBPARTS (A) AND (C) OF THIS PART 7.9 IN LIEU OF MEETING THE REQUIREMENT FOR THE ASSISTED LIVING RESIDENCE TO PROVIDE THE TRAINING ONLY IF ALL OF THE FOLLOWING CONDITIONS ARE MET:

(1) THE PERSON PRESENTING PROOF OF PORTABLE TRAINING IS A DIRECT-CARE WORKER, DEFINED FOR THE PURPOSES OF PORTABLE TRAINING AND PORTABLE TESTS AT SECTION 25-27-102(2.5), C.R.S., AS AN EMPLOYEE WHO PROVIDES HANDS-ON CARE, SERVICES, AND SUPPORT TO RESIDENTS OF AN ASSISTED LIVING RESIDENCE.

(A) NON-EMPLOYEES, INCLUDING VOLUNTEERS AND CONTRACTED INDIVIDUALS MEETING THE DEFINITION OF STAFF MEMBER AT PART 2.58 ARE NOT DIRECT CARE WORKERS FOR THE PURPOSES OF AN ASSISTED LIVING RESIDENCE'S ACCEPTANCE OF PORTABLE TRAINING OR PORTABLE TESTS.

(2) THE DIRECT-CARE WORKER IS A NEW EMPLOYEE OF THE ASSISTED LIVING RESIDENCE.

(3) THE PROOF OF PORTABLE TRAINING IS PROVIDED BY THE DIRECT-CARE WORKER UPON HIRE BY THE ASSISTED LIVING RESIDENCE AND NOT AT A LATER DATE.

(4) THE ASSISTED LIVING RESIDENCE DEVELOPS AND FOLLOWS A POLICY TO ENSURE THE DIRECT CARE WORKER HAS SATISFIED THE RELATED PORTABLE TRAINING REQUIREMENT AND CAN SAFELY CARRY OUT THE DUTIES AND RESPONSIBILITIES FOR THE CARE AND PROVISION OF SERVICES TO RESIDENTS.

(E) WHEN PROVIDING OR PAYING FOR PORTABLE TRAINING FOR EITHER A QUALIFIED MEDICATION ADMINISTRATION PERSON OR AN EMPLOYEE MEETING THE DEFINITION OF DIRECT-CARE WORKER AT PART 7.9(D)(1), ABOVE, THE ASSISTED LIVING RESIDENCE SHALL ENSURE IT OR THE ENTITY PROVIDING THE PORTABLE TRAINING PROVIDES THE PERSON A CERTIFICATE OF COMPLETION THAT MUST INCLUDE:

(1) THE QUALIFIED MEDICATION ADMINISTRATION PERSON OR DIRECT-CARE WORKER'S NAME;

(2) THE PORTABLE TOPIC COVERED;

(3) THE DATE OF THE PORTABLE TRAINING;

(4) THE INDIVIDUAL OR ENTITY THAT PROVIDED THE PORTABLE TRAINING;

(5) THE LENGTH OF TRAINING TIME IN HOURS AND/OR MINUTES; AND

(6) DOCUMENTATION OF COMPETENCY IN THE SPECIFIC PORTABLE TOPIC OF THE PORTABLE TRAINING.

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Personnel Files

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

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

7.13 Each personnel file shall include, but not be limited to, written documentation regarding the following items:

(A) A description of the employee or volunteer duties;

(B) Date of hire or acceptance of volunteer service and date duties commenced;

(C) Orientation and training, including, BUT NOT LIMITED TO THE FOLLOWING, AS APPLICABLE:

(1) F~~f~~irst aid and CPR certification, ~~if applicable;~~

(2) PROOF OF PORTABLE TRAINING(S) ACCEPTED BY THE ASSISTED LIVING RESIDENCE, INCLUDING DOCUMENTATION OF THE ACCEPTANCE CONDITIONS AT PART 7.9(D) BEING MET.

(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 OR PROOF OF A PORTABLE TEST COMPLIANT WITH PART 7.7, 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~~9~~(B)(2)(b) and as required in the criteria for an exception discussed in sub-part 7.8~~9~~(B)(4), shall include the information required in this sub-part 7.12~~3~~ (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.

7.14 If the employee or volunteer is a qualified medication administration person, the following shall also be retained in the employee's or volunteer's personnel file:

(A) Documentation that the ~~individual's name appears on the Department's list of individuals who have successfully completed the medication administration competency evaluation~~

INDIVIDUAL MEETS THE DEFINITION OF QUALIFIED MEDICATION ADMINISTRATION PERSON AT PART 2.52 OF THESE RULES; and

(B) A signed disclosure that the individual has not had a professional medical, nursing, or pharmacy license revoked in this or any other state for reasons directly related to the administration of medications.

7.15 Personnel files shall be retained for three years following an employee's separation from employment or a volunteer's separation from service and include the reason(s) for the separation.

Personal Care Worker

7.16 The assisted living residence shall ensure that each personal care worker ~~attends~~ FULFILLS the initial orientation required~~s~~MENTS in Part 7.8~~x~~9(A)~~xx~~. The assisted living residence shall also require that each personal care worker receives additional orientation on the following topics before providing care and services to a resident:

(A) Personal care worker duties and responsibilities;

(B) The differences between personal services and skilled care; and

(C) Observation, reporting and documentation regarding a resident's change in functional status along with the assisted living residence's response requirements.

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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, INCLUDING BUT NOT LIMITED TO POLICIES RELATED TO PORTABLE 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;

(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.

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PART 12 – RESIDENT CARE SERVICES

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Fall Management Program

12.15 The assisted living residence shall develop policies and procedures to establish a fall management program. The program shall include the following:

(A) Providing fall management education and materials to residents and family members;

(B) Detailing in each resident's care plan the individualized approach necessary to address fall risk related to deficits in strength, balance, and eyesight, or effects of medication as identified during the comprehensive resident assessment;

(C) Providing resident engagement activities to improve strength and balance as specified in Part 12.22(C);

(D) Routinely inspecting and maintaining a safe exterior and interior environment as specified in Parts 21 and 22; and

(E) Providing staff training related to fall prevention as specified in Part 7.~~8~~9(B)(6).

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PART 14 – MEDICATION AND MEDICATION ADMINISTRATION

General Requirements:

14.1 An assisted living residence shall not allow an employee or volunteer to administer or assist with administering medication to a resident unless such individual is a practitioner, nurse, qualified medication administration person (QMAP), or certified nurse medication aide (CNA-Med) acting within his or her scope of practice.

14.2 For purposes of this Part 14, a practitioner is "authorized" if state law allows the practitioner to prescribe treatment, medication, or medical devices.

14.3 An assisted living residence shall not allow a QMAP or a CNA-Med to assist a resident with medication administration unless the resident is able to consent and participate in the consumption of the medication.

14.4 If a CNA-Med is used to administer or assist with administering medication to a resident, the assisted living residence shall ensure that the CNA-Med complies with the medication administration procedures listed in this Part 14, except that a CNA-Med may perform additional tasks associated with medication administration as authorized by his or her certification.

14.5 An assisted living residence that utilizes qualified medication administration persons shall ENSURE THE QUALIFIED MEDICATION ADMINISTRATION PERSONS MEET THE DEFINITION AT PART 2.52, AND comply with the requirements of 6 CCR 1011-1, Chapter 24, Medication Administration Regulations, in addition to the requirements set forth in this Part 14.

14.6 The assisted living residence shall comply with all federal and state laws and regulations relating to procurement, storage, administration, and disposal of controlled substances.

14.7 The assisted living residence shall ensure that each resident receives proper administration and/or monitoring of medications.

14.8 The assisted living residence shall be responsible for ensuring compliance with all safety requirements regarding oxygen use, handling, and storage as set forth in Parts 22.29 through 22.34 of this chapter.

14.9 No medication shall be administered by a qualified medication administration person on a pro re nata (PRN) or "as needed" basis except:

(A) In a residential treatment facility that is licensed to provide services for the mentally ill;

(B) Where the resident understands the purpose of the medication, is capable of voluntarily requesting the medication, and the assisted living residence has documentation from an authorized practitioner that the use of such medication in this manner is appropriate; or

(C) Where specifically allowed by statute.

14.10 Unless otherwise allowed by statute, the assisted living residence shall not permit a qualified medication administration person to perform any of the following tasks:

(A) Intravenous, intramuscular, or subcutaneous injections;

(B) Gastrostomy or jejunostomy tube feeding;

(C) Chemical debridement;

(D) Administration of medication for purposes of restraint;

(E) Titration of oxygen;

(F) Decision making regarding PRN or “as needed” medication administration;

(G) Assessment of residents or use of judgment including, but not limited to, medication effect;

(H) Pre-pouring of medication; or

(I) Masking or deceiving administration of medication including, but not limited to, concealing in food or liquid.

14.11 Only medication that has been ordered by an authorized practitioner shall be prepared for or administered to residents.

Training, Competency and Supervision

14.12 The assisted living residence shall ensure that all qualified medication administration persons are trained in and adhere to the following medication administration procedures:

(A) Identification of the right resident for each medication administration or monitoring by asking for the resident’s name or comparing the resident to a photograph maintained specifically for medication administration identification;

(B) Providing the correct medication by the correct route at the correct time and in the correct dose as ordered by the authorized practitioner; and

(C) Implementing any changes in medication orders upon receipt.

14.13 The assisted living residence shall designate a QMAP supervisor who is a nurse, practitioner, or meets the ~~requirements~~ DEFINITION of a qualified medication administration person AT PART 2.52.

(A) The QMAP supervisor shall, before initial assignment of each qualified medication administration person, conduct a competency assessment with direct observation of all medication administration tasks that the QMAP will be assigned to perform.

(1) Whenever a QMAP is assigned additional medication administration tasks, the QMAP supervisor shall conduct a competency assessment with direct observation of each new task that the QMAP will be assigned.

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PART 16 – FOOD SAFETY

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19 or Fewer Beds

16.4 An assisted living residence that is licensed for 19 beds or fewer shall comply with all of the requirements in Parts 16.5 through 16.37. A commercial kitchen is not a requirement for an assisted living residence with fewer than 20 beds.

Employee Training

16.5 Staff preparing or serving food shall complete recognized food safety training and maintain evidence of completion on site. Food safety training shall be provided by recognized food safety experts or agencies, such as the Department's Division of Environmental Health and Sustainability, local public health agencies, or Colorado State University Extension Services. At a minimum, a certificate of completion of the available online modules is sufficient to comply with this part. The successful completion of other accredited food safety courses is also acceptable.

(A) THE ASSISTED LIVING RESIDENCE MAY ACCEPT PROOF OF PORTABLE TRAINING IN ACCORDANCE WITH PART 7.9(D) OF THESE RULES TO FULFILL THIS TRAINING REQUIREMENT ONLY IF THE ACCEPTED PORTABLE TRAINING COMPLIES WITH THE REQUIREMENTS OF THIS PART 16.5, INCLUDING THE REQUIREMENT THAT THE TRAINING WAS PROVIDED BY RECOGNIZED FOOD SAFETY EXPERTS OR AGENCIES, OR OTHER ACCREDITED FOOD SAFETY COURSES.

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Staffing

25.17 The assisted living residence shall have a sufficient number of trained staff members on duty in the secure environment to ensure each resident's physical, social, and emotional health care and safety needs are met in accordance with their individualized care plan.

25.18 The assisted living residence shall consider the day to day resident needs and activity, including the intensity of staff assistance, on an individual resident basis to determine the appropriate level of staffing. At a minimum, there shall be one trained, awake staff member on duty at all times.

25.19 Staff members shall be familiar with each resident's specific care-planned needs and the unique approaches for assisting with care and safety.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 24 - MEDICATION ADMINISTRATION REGULATIONS

6 CCR 1011-1 Chapter 24

ADOPTED BY THE BOARD OF HEALTH ON ~~APRIL 17, 2017~~ _____. EFFECTIVE ~~JULY 1, 2017~~ _____.

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SECTION 2 – DEFINITIONS

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2.18 "Qualified medication administration person" or "QMAP" means:

(A) A~~a~~n 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, UNLESS OTHERWISE DEFINED IN STATUTE OR THE FACILITY-SPECIFIC CHAPTER OF 6 CCR 1011-1.

(B) FOR ASSISTED LIVING RESIDENCES, AN INDIVIDUAL WHO MEETS THE DEFINITION OF "QUALIFIED MEDICATION ADMINISTRATION PERSONNEL" AT SECTION 25-27-102(10.5), C.R.S.

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