STANDARDS FOR HOSPITALS AND HEALTH FACILITIES

CHAPTER XXI - HOSPICES

6 CCR 1011-1 Chap 21

~~1. DEFINITIONS~~

~~1.1 A hospice is a centrally administrated program of palliative, supportive and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient and home care available 24 hours, 7 days a week. Hospice services shall be provided in the home, residential facility, and/or licensed health care facility. Hospice services include but shall not necessarily be limited to the following: nursing, physician, home health aide, homemaker, physical therapy, pastoral counseling, trained volunteer and social services.~~

~~1.2 A patient is an individual in the terminal stage of illness who has an anticipated life expectancy of days, weeks or months and who, alone or in conjunction with a family member or members, has voluntarily requested admission and been accepted into a hospice.~~

~~1.3 A patient/family is one unit of care consisting of those individuals who are closely linked with the patient including the immediate family, the primary care giver and individuals with significant personal ties.~~

~~1.4 Palliative Services are those services and/or interventions which are not curative but which produce the greatest degree of relief from symptoms of the terminal illness.~~

~~1.5 The interdisciplinary team is a group of qualified individuals, consisting of at least a physician, registered nurse, clergy/counselors, volunteer director and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of hospice patient/families.~~

~~1.6 Core Services are physician service's, nursing services, pastoral counseling, trained volunteers, and social/counseling services routinely provided by hospice employees.~~

~~1.7 Bereavement is that period of time during which survivors mourn a death and experience grief. Bereavement services means support services to be offered during the bereavement period.~~

~~1.8 Social/counseling services are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience.~~

~~1.9 The governing body is the group in which ultimate authority and legal responsibility is vested for the conduct of the hospice.~~

~~1.10 Informed consent requires that the patient/family giving consent has been informed of the type of care and services which may be provided as part of hospice care and has been given:~~

~~1) an explanation of the procedures to be followed.~~

~~2) a description of the benefits to be expected.~~

~~3) a disclosure of alternative services that could be advantageous to the patient.~~

~~4) an offer to answer any inquiries concerning procedures.~~

~~5) instruction that the patient or other person giving consent is free to withdraw his consent and to discontinue participation in the program.~~

~~1.11 Personal care means services provided to a patient in his or her home to meet the patient's physical requirements and/or to accommodate a patient's maintenance or supportive needs.~~

~~1.12 Homemaker services means services provided the patient which include:~~

~~1) general household activities including the preparation of meals and routine household care, and~~

~~2) teaching, demonstrating and providing patient/family with household management techniques that promote self-care, independent living and good nutrition.~~

~~1.13 Respite care means hospice services provided in a patient's home or in a licensed health care facility to relieve temporarily the patient's family or other care providers for unforeseen emergencies or the daily demands of care for the patient.~~

~~1.14 Hospice staff shall consist of paid or unpaid persons and shall include volunteers.~~

~~1.15 Evaluation means an objective, formal and cyclical assessment of the functioning of the organization and of the provision of hospice care.~~

~~1.16 Home care services are hospice services which are provided in the place the patient designates as his/her primary residence.~~

~~1.17 Inpatient services are hospice services provided to patient/families who require 24-hour nursing supervision in a licensed health care facility. The hospice shall maintain administrative control of and responsibility for the provision of all services.~~

~~1.18 Hospice day care means health and social services provided on a regularly scheduled basis in a day care center governed by the licensed hospice to insure the overall continuum of patient care.~~

~~1.19 A hospice residential facility is an optional part of the home care or respite services provided by the hospice. The facility is one which houses no more than eight hospice patients and is located in a residential area. The facility shall approximate a normal home and directly provides 24 hour home care services.~~

~~1.20 An inpatient hospice facility is one which shall directly provide inpatient services and may provide any or all of the continuum of hospice services. These services are provided 24 hours a day and, to the extent possible, in a homelike setting.~~

~~1.21 Plan review means the review by the Department, or its designee, of new construction, previously unlicensed space, or remodeling to ensure compliance by the facility with the National Fire Protection Association (NFPA) Life Safety Code and with this Chapter XXI. Plan review consists of the analysis of construction plans/documents and onsite inspections, where warranted. For the purposes of the National Fire Protection Association requirements, the Department is the authority having jurisdiction for state licensure. [Eff. 04/30/2009]~~

~~1.22 Structural element for the purposes of plan review, means an element relating to load bearing or to the scheme (layout) of a building as opposed to a screening or ornamental element. Structural elements of a building include but are not limited to: floor joists, rafters, wall and partition studs, supporting columns and foundations. [Eff. 04/30/2009]~~

~~2. GOVERNING BODY~~

~~2.1 The Governing Body shall be organized formally with written by-laws, shall meet no less often than quarterly and shall maintain records in the hospice available for review.~~

~~2.2 The Governing Body shall consist of no fewer than seven members, at least two-thirds of whom shall have no financial interest in the hospice and who shall be representative of the geographic area in which the hospice is located.~~

~~2.3 The Governing Body shall appoint an administrator qualified by training and/or experience in hospice administration and to whom the responsibility for the management of the hospice on a day-to-day basis shall be delegated.~~

~~2.4 The Governing Body shall promulgate a written philosophy and objectives for the hospice.~~

~~2.5 The Governing Body shall provide for medical direction by a licensed physician.~~

~~2.6 The Governing Body shall provide for qualified nursing personnel in sufficient quantity to ensure nursing care 24 hours a day, 7 days a week.~~

~~2.7 The Governing Body shall ensure the provision of both home care and in-patient services.~~

~~3. ADMINISTRATION~~

~~3.1 The hospice shall have an administrator who:~~

~~1) is a physician licensed in Colorado, or~~

~~2) is a registered nurse, or~~

~~3) has training and experience in health service administration and at least 1 year of supervisory or administrative experience in related health programs.~~

~~3.2 The administrator shall be responsible for the management of the hospice and shall maintain liaison between the Governing Body and the hospice staff. If the administrator delegates specific duties, the person responsible shall be clearly identified.~~

~~3.3 The duties of the administrator shall include but not be limited to:~~

~~1) directing the hospice and ensuring implementation of policies and procedures regarding all activities and patient/family care services provided in the hospice, whether provided through staff employed directly by the hospice, by volunteers or through contract arrangement.~~

~~2) designation an alternate to act in his or her absence.~~

~~3) implementing administrative policies and procedures which include personnel policies and which are applicable to all hospice staff.~~

~~4) implementing financial policies and procedures, approved by the Governing Body, according to sound business practice. Such policies and procedures shall include at least the following: a) payroll (if applicable). b) accepting and accounting for gifts and donations. c) keeping and submitting such reports and records as required by the Department in these regulations and other authorized agencies.~~

~~4. QUALITY MANAGEMENT~~

~~4.1 The hospice shall have a quality management program to evaluate and report to the governing body on the 1) organization or method of operations and 2) patient care services. A summary of the outcomes of this program shall be available to the public on an annual basis.~~

~~4.1.1 The hospice shall evaluate its:~~

~~1) Goals and objectives.~~

~~2) Patient care policies and procedures.~~

~~3) Administrative policies and procedures.~~

~~4) Staff and volunteer performance.~~

~~5) On-going education and training.~~

~~6) Financial reporting.~~

~~7) Board performance.~~

~~4.1.2 There shall be a quality assurance program to guide evaluation of the care provided and include at least:~~

~~1) The desired outcomes of hospice care.~~

~~2) Criteria for determining appropriate length of stay.~~

~~3) Criteria for determining level, location, and intensity of care for continuing, respite, and bereavement care, and for discharge.~~

~~4) Provision for responding to consumer complaints.~~

~~5) Provision for review of service providers.~~

~~6) A patient care plan which directly relates to the identified physical and psychosocial needs of the patient and family.~~

~~7) A determination that the services, medications and treatments prescribed were in accordance with the current hospice plan of care.~~

~~8) A determination that the hospice program of care appropriately utilized inpatient hospice care.~~

~~9) A determination the R.N. staffing ratios are consistent with quality hospice care.~~

~~4.1.3 The hospice shall appoint a clinical record review committee, composed of appropriately selected members, including at least one member not affiliated with the hospice. The committee shall meet at least twice yearly. Dated and signed minutes of these meetings shall be maintained.~~

~~1) The committee's function shall be to provide ongoing evaluation and review of hospice utilization and to make recommendations to the administrator.~~

~~2) The administrator shall report such findings and recommendations to the governing body and staff.~~

~~3) All incident reports shall be reviewed by this committee.~~

~~5. PATIENT RIGHTS AND RESPONSIBILITIES~~

~~5.1 Each hospice patient/family shall receive a copy of the Hospice Patient's Bill of Rights and Responsibilities.~~

~~5.1.1 There shall be written documentation of receipt of the copy of the patient rights and responsibilities.~~

~~5.1.2 By written declaration the hospice shall affirm the following patient rights and responsibilities:~~

~~1) the right to be informed of the hospice concept, admission criteria, services to be provided, options available, and any charges which may be incurred.~~

~~2) the right to participate in developing the patient plan of care.~~

~~3) the right to expect that all records be confidential.~~

~~4) the right to refuse service or withdraw from the program at any time.~~

~~5) the responsibility to provide accurate information which may be useful to the hospice in delivering appropriate care.~~

~~6) The right to express a grievance without fear of reprisal.~~

~~5.1.3 Hospice responsibilities shall include but not be limited to:~~

~~1) the responsibility to provide quality care to individuals regardless of race, religion, sex, age, and/or physical or mental disabilities or ability to pay.~~

~~2) the responsibility to train all professional staff and volunteers adequately for the level of service they provide.~~

~~3) the responsibility to provide care which is ethical, is in the best interest of the patient, and is respectful of the patient/family life values, religious preference, dignity, individuality, privacy in treatment and personal needs.~~

~~4) special attention, in regard to their right to privacy, choice and dignity shall be given to infants, small children and adolescents.~~

~~6. POLICIES AND PROCEDURES~~

~~6.1 Under the supervision and direction of the Governing Body, the hospice shall develop and implement written policies to coordinate a program for home and inpatient hospice care services.~~

~~6.1.1 These policies and procedures shall be reviewed and approved by the Governing Body annually.~~

~~6.1.2 The policies and procedures shall include but not be limited to:~~

~~1) medical direction.~~

~~2) admission and termination of care.~~

~~3) physician services.~~

~~4) nursing services.~~

~~5) nutrition services.~~

~~6) pharmacy services.~~

~~7) bereavement services.~~

~~8) social services.~~

~~9) volunteer services.~~

~~10) spiritual services.~~

~~11) special needs of infants, children and adolescents.~~

~~12) management of: a) pain and other symptoms. b) physical components of care. c) financial needs. d) contractual services.~~

~~13) patient/family education.~~

~~14) death at home and in facilities.~~

~~15) coordination and communication between all agencies serving the patient/family.~~

~~16) referral to hospice, response to requests and referral to other appropriate agencies.~~

~~17) community education.~~

~~6.1.3 Prior to admission to the hospice the patient/family shall be apprised of all options provided by the hospice to meet their needs.~~

~~6.1.4 There shall be an admission agreement which includes but is not limited to:~~

~~1) information regarding charges for services, materials and equipment available to the patient/family.~~

~~2) a statement of patient/family financial responsibility.~~

~~3) any existing pre-payment, refund and sliding scale fee policies.~~

~~4) a copy of the patient's rights and responsibilities.~~

~~6.1.5 Admission policies shall indicate that admission to a hospice shall be limited to the following:~~

~~1) patients in the terminal stage of illness whose survival is defined in terms of days, weeks or months.~~

~~2) the patient/family and attending physician agree that palliative care is appropriate.~~

~~3) persons shall not be admitted without a signed parent/guardian consent.~~

~~4) a patient/family must be under the care of a physician who shall be responsible for medical care.~~

~~6.1.6 Admission to a home care hospice program may be limited to those patients who have a primary care giver.~~

~~6.1.7 The hospice shall have a written policy regarding the admission of patients who do not have a primary care giver.~~

~~6.2 Transfers: To facilitate continuity of care, when transferring within the hospice, to another hospice, or to another provider, the patient/family plan of care shall be immediately forwarded to the receiving provider of care.~~

~~6.3 Termination of Care: The hospice shall establish specific criteria for termination of care.~~

~~6.3.1 There shall be policies and procedures related to termination of care and/or referral.~~

~~6.3.2 The patient/family record shall contain documentation of the reason care has been terminated.~~

~~6.4 There shall be policies and procedures related to provision of bereavement services for individuals who have not previously received hospice services.~~

~~7. PATIENT CARE SERVICES~~

~~7.1 The hospice shall establish an interdisciplinary team whose responsibility shall include but not be limited to:~~

~~1) establishment of a plan of care.~~

~~2) provision and/or supervision of hospice care and services.~~

~~3) review and/or revision, at least twice monthly, of the plan of care for each patient/family receiving hospice care.~~

~~4) implementation of written policies governing the day-to-day provision of hospice care and services.~~

~~7.1.1 On admission to the hospice there shall be an assessment of the patient/family physical, emotional, psychosocial and spiritual needs, including any environmental or financial considerations and an initial plan of care developed by the physician and one member of the interdisciplinary team.~~

~~7.1.2 Based upon the assessment and admission findings, there shall be prepared, within 5 working days of admission, an interdisciplinary team plan of care which shall include but not be limited to:~~

~~1) plans to meet the identified needs.~~

~~2) a mechanism for initial and on-going liaison with the patient's attending physician.~~

~~3) designation of the primary care giver or alternate plan.~~

~~4) identification of the team members who will provide care.~~

~~5) identification of the anticipated frequency of services needed.~~

~~6) plans instructing the patient/family in patient care.~~

~~7) when applicable, plans to meet the special needs of infants, children and adolescents.~~

~~7.1.3 The hospice shall designate a registered nurse to coordinate the overall plan of care for each patient.~~

~~7.1.4 Progress notes shall demonstrate the implementation and evaluation of the plan of care.~~

~~7.1.5 There shall be on-going assessment of patient/family needs, and revision of plan of care as appropriate.~~

~~7.1.6 There shall be documentation of coordination and continuity of care to include:~~

~~1) on-going liaison with the primary or attending physician.~~

~~2) communication among team members.~~

~~3) communication between inpatient and home care teams.~~

~~4) instruction of patient/family in care needed.~~

~~7.1.7 The interdisciplinary team shall ensure that the patient/family shall be actively involved in hospice care including but not limited to:~~

~~1) participating in designating the primary care giver or alternate plan.~~

~~2) assisting the interdisciplinary team to identify and meet needs.~~

~~3) receiving instruction and participating in care.~~

~~4) participating in care and care decisions.~~

~~7.1.8 The interdisciplinary team shall make use of consultants and community resources as necessary.~~

~~7.1.9 Any unusual change in the patient's physical, mental, spiritual or emotional status shall be reported to the interdisciplinary team and next of kin or significant other.~~

~~7.2 Medical Direction: The hospice shall have a physician who shall act as medical director who is currently licensed to practice in the State of Colorado.~~

~~7.2.1 The medical director shall be a member of the interdisciplinary care team and shall be responsible for the direction and quality of the medical care rendered to the patient/family by the interdisciplinary team.~~

~~7.2.2 The responsibility of the medical director shall include but not be limited to:~~

~~1) reviewing appropriate clinical material from the referring physician to validate the prognosis as anticipated by the patient's attending physician.~~

~~2) assisting in developing and medically validating the interdisciplinary plan of care for each patient/family with the coordination of the patient's primary or attending physician.~~

~~3) rendering, as necessary, or supervising active medical care in the patient's home, in the inpatient hospice unit or outpatient hospice service; and maintaining a record of such care.~~

~~4) maintaining a regular schedule of participation in all components of the hospice care program.~~

~~5) being readily available to the hospice program personally or naming a qualified physician designee.~~

~~6) acting as a consultant to and maintaining liaison with the attending physicians and other members of the interdisciplinary care team.~~

~~7) helping to develop and review patient/family care policies and procedures.~~

~~8) serving on appropriate committees.~~

~~9) reporting regularly to the administrator regarding medical care delivered to the hospice patients.~~

~~10) approving written protocols for symptom control, i.e., pain, nausea, vomiting, or other symptoms.~~

~~7.3 Physician Services: The hospice shall ensure that each patient has a primary physician. If a patient has no primary physician, there shall be a mechanism for assuring the availability of one.~~

~~7.3.1 The primary and/or attending physician shall:~~

~~1) approve and sign the plan of care for the patient/family.~~

~~2) be available to the interdisciplinary team as necessary.~~

~~3) provide information to the interdisciplinary team in developing the plan of care.~~

~~4) review the plan of care at least every 60 days.~~

~~7.4 Nursing Services: The hospice shall have an organized nursing service under the direction and supervision of a registered nurse qualified by training and experience to direct hospice nursing care.~~

~~7.4.1 The responsibilities of the aforementioned registered nurse shall include but not be limited to:~~

~~1) developing and implementing nursing objectives, policies and procedures.~~

~~2) developing job descriptions for all nursing personnel.~~

~~3) establishing staffing schedules to meet patient/family needs.~~

~~4) developing and implementing orientation and training programs.~~

~~5) developing and implementing a program of performance evaluation.~~

~~7.4.2 A registered nurse shall assess the patient/family and identify nursing needs.~~

~~7.4.3 A registered nurse shall plan, supervise and evaluate the nursing care for each patient/family.~~

~~7.4.4 Nursing care of each patient/family shall be provided in accord with the needs of the patient.~~

~~7.4.5 All nursing personnel shall be assigned duties consistent with their education and experience.~~

~~7.4.6 All nursing personnel caring for infants, children, and adolescents shall have training appropriate to the care including pediatric pharmacology, normal growth and development, and the special psychological needs of the dying child.~~

~~7.4.7 There shall be documentation of nursing care given which shall include observations which contribute to the continuity of patient care and treatment goals.~~

~~7.4.8 Each nursing visit shall be documented in the clinical record.~~

~~7.4.9 Nursing service shall be ensured 24 hours a day, 7 days a week.~~

~~7.4.10 There shall be periodic meetings of the professional nursing staff to enhance the nursing care provided in the hospice. Written documentation of such meetings must be maintained.~~

~~7.5 Social/counseling services: The hospice shall provide, either directly or by arrangement, social/counseling services to the patient/family before and after the patient's death.~~

~~7.5.1 Social/counseling services shall be available 7 days a week.~~

~~7.5.2 Social/counseling services shall provide support to enable an individual to adjust to experiences associated with death.~~

~~7.5.3 Social/counseling services shall be delivered consistent with the patient care plan.~~

~~7.6 Volunteer Services: The hospice shall utilize trained volunteer services to promote the availability of care, meet the broadest range of patient/family unit needs, and effect financial economy in the operation of the hospice.~~

~~7.6.1 The hospice shall designate a volunteer services director.~~

~~7.6.2 A hospice shall develop, implement and document a program which meets the operational needs of the volunteer program, coordinates orientation and education of volunteers, defines the role and responsibilities of volunteers, recruits volunteers, and coordinates the utilization of volunteers with other program directors.~~

~~7.6.3 The volunteer services director shall be a member of the interdisciplinary team.~~

~~7.6.4 Volunteer service staff shall be aware of a patient's condition and treatment as indicated on the written plan of care.~~

~~7.6.5 Services provided by volunteers shall be in accord with the written plan of care and shall be documented in the clinical record.~~

~~7.7 Bereavement Services: The hospice shall provide services to the family to assist them in coping with the death of the family member. Bereavement services shall be provided under the supervision of an individual who has documented evidence of training and experience in dealing with bereavement.~~

~~7.7.1 Bereavement services shall be available to families/significant others before and after the patient's death.~~

~~7.7.2 Bereavement services shall be available 7 days a week and shall be available to the family for a period not less than 12 months following the death of the patient.~~

~~7.7.3 Bereavement services shall be delivered consistent with the written plan of care with criteria for termination and/or referral.~~

~~7.8 Spiritual Services: The hospice shall provide the services of at least one clergy-person or spiritual advisor.~~

~~7.8.1 There shall be defined policies regarding the delivery of spiritual services.~~

~~7.8.2 The hospice program of spiritual care shall not impose upon the patient/family the dictates of any value or belief system.~~

~~7.8.3 All spiritual services provided shall be documented in the patient/family record.~~

~~7.9 Personal Care and Home-Maker Services~~

~~7.9.1 The hospice shall provide documented supervision according to agency policy of personal care/homemaker services.~~

~~7.9.2 The hospice shall assure that personal care givers shall have received forty (40) hours of training prior to service delivery in:~~

~~1) hospice philosophy and orientation.~~

~~2) basic personal care procedures including grooming.~~

~~3) bowel and bladder care.~~

~~4) food, nutrition, diet planning, etc.~~

~~5) methods of making patients comfortable.~~

~~6) assisting patient mobility including transfer.~~

~~7) basic needs of the frail elderly and/or the physical disabled persons.~~

~~8) first aid and handling emergencies.~~

~~9) health oriented record keeping including time/employment records.~~

~~10) basic techniques in observation of patient's mental and physical health.~~

~~11) basic techniques of identifying and correcting potential safety hazards in the home.~~

~~12) techniques in lifting.~~

~~7.9.3 The hospice shall ensure that homemakers have received eight (8) hours of training in providing the following care:~~

~~1) basic techniques in cleaning including floor care, appliances, supplies inventory, sanitation, vacuuming, etc.~~

~~2) basic household appliance maintenance.~~

~~3) basic nutritional requirements, shopping, food preparation and storage.~~

~~4) basic techniques in observation of patient's mental and physical health.~~

~~5) basic techniques of identifying and correcting potential safety hazards in the home.~~

~~6) techniques in lifting.~~

~~7) first aid and emergency procedures.~~

~~8) basic needs of frail elderly and/or physically disabled persons.~~

~~7.9.4 The hospice shall ensure that the training provided the homemaker/personal care giver is specific to the unique needs of the patient.~~

~~7.9.5 The personal care giver/homemaker shall meet all personnel requirements of Section 10.~~

~~8. DAY CARE~~

~~8.1 Day care services shall include but not be limited to:~~

~~1) daily monitoring to assure that patients are maintaining personal hygiene and participating in appropriate social and recreational activities prescribed; and assisting with activities of daily living (e.g., eating, dressing).~~

~~2) emergency services including written procedures to meet medical crises.~~

~~3) assistance in the development of self-care capabilities, personal hygiene, and social support services.~~

~~4) provision of nourishments appropriate to the hours in which the patient is served.~~

~~5) nursing services provided to monitor patient's health status, supervise medications and carry out the plan of care.~~

~~6) social and recreational services as prescribed to meet the patient's needs.~~

~~8.2 Day care centers shall meet the following standards:~~

~~1) the center shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulations.~~

~~2) the center shall provide a clean environment, free of obstacles that could pose a hazard to client health and safety.~~

~~3) the center shall provide lockers or a safe place for patient's personal items.~~

~~4) the center shall provide recreational areas and activities appropriate to the number and needs of the patients.~~

~~5) drinking facilities shall be located within easy access to patients.~~

~~6) the center shall provide eating and resting areas consistent with the number and needs of the patients being served.~~

~~7) the center shall provide easily accessible toilet facilities, hand-washing facilities and paper towel dispensers.~~

~~8) the center shall be accessible to patients with supportive devices for ambulation or in wheelchairs.~~

~~8.3 The center shall maintain such records and information necessary to document services provided the patient. Records shall include but not be limited to:~~

~~1) medications the patient is taking and whether they are being self-administered.~~

~~2) special dietary needs, if any.~~

~~3) restrictions on outside-of-center activities identified in the plan of care.~~

~~8.4 The day care center shall be staffed with qualified personnel in numbers sufficient to provide:~~

~~1) daily nursing services.~~

~~2) therapies as prescribed in the Plan of Care.~~

~~3) volunteer services.~~

~~4) supervision of patients at all times during operating hours.~~

~~5) immediate response to emergency situations.~~

~~6) prescribed recreational and social activities.~~

~~7) monitoring of the on-going medical needs.~~

~~8) administrative, recreational, and supportive functions of the center.~~

~~8.5 The center shall have written policies and procedures relevant to the operation of the day care center. Such policies and procedures shall include but not be limited to:~~

~~1) admission criteria that qualify patients to be appropriately served in the center.~~

~~2) an assessment procedure conducted for qualified patients and/or family members prior to admission to the center.~~

~~3) meals and nourishments including special diets that will be provided.~~

~~4) hours that the patients will be served in the center and days of the week services will be available.~~

~~5) personal items that the patients may bring with them to the center.~~

~~8.6 A written, signed contract shall be drawn up between the patient or responsible party and the center outlining rules and responsibilities of the facility and of the patient. Each party to the contract shall have a copy.~~

~~9. RESPITE CARE~~

~~9.1 Respite services shall be hospice services provided in a patient's home or in a distinct part of a health care facility licensed as a general hospital, skilled nursing facility, residential hospice facility or inpatient hospice facility.~~

~~9.2 Respite services may vary according to individual patient needs and support systems but shall be provided under the direction of the hospice.~~

~~9.3 Respite providers shall meet all standards contained in these regulations.~~

~~9.4 Normal procedures for admission to in-patient facilities shall be waived except for requiring the plan of care.~~

~~10. PERSONNEL~~

~~10.1 The hospice shall employ, or have available through volunteers, at least the following services:~~

~~1) physician services.~~

~~2) registered professional nursing services.~~

~~3) a social worker or counselor services.~~

~~4) pastoral counseling services.~~

~~5) trained volunteers services.~~

~~10.1.1 The hospice shall provide clerical staff sufficient in quantity to provide administrative services.~~

~~10.1.2 There shall be written personnel policies, approved by the governing body that govern the conditions of employment.~~

~~10.1.3 There shall be a written program of orientation for all personnel that includes but is not limited to:~~

~~1) personnel screening for suitability for hospice service.~~

~~2) history, philosophy and structure of the hospice concept.~~

~~3) current hospice concepts.~~

~~4) the interdisciplinary approach.~~

~~5) communication skills.~~

~~6) hospice services offered.~~

~~7) agency organizational structure.~~

~~8) agency policies and procedures.~~

~~9) personnel policies.~~

~~10) continuing educational requirements.~~

~~11) infection control.~~

~~10.1.4 There shall be a mechanism to ensure an ongoing staff education program for all personnel which offers, at a minimum, 20 hours of education/training annually to enhance hospice related skills.~~

10.1.5 There shall be personnel records on each employee including application, documentation of orientation, documentation of staff education, verification of credentials, and evaluations.

10.1.6 The hospice shall have a written policy regarding on-the-job injuries.

10.1.7 There shall be a mechanism to ensure that the governing body and administrator provide the hospice staff with the means and opportunity for psychological support.

11. PHARMACEUTICAL SERVICES

11.1 The hospice shall develop and maintain written policies and procedures for the administration and provision of pharmaceutical services that are consistent with the drug therapy needs of the patient as determined by the medical director and patient's primary physician.

11.1.1 Medications ordered shall be consistent with the hospice philosophy which focuses on palliation, i.e., controlling pain and other symptoms which are manifested during the dying process and are consistent with professional practice and regulations of the Colorado Board of

Pharmacy.

11.2 Medication Labeling and Disposition of Medications. *[Eff. 07/30/2006]*

11.2.1 Unless the pharmacy provides a unit dose system, all prescription drugs (to include "bubble" or "blister" cards) shall be labeled and shall include:

1) name of pharmacy.

2) name of patient.

3) name of prescribing physician.

4) date prescription filled.

5) prescription number.

6) name of medication.

7) directions and dosage.

8) expiration date.

9) quantity dispensed.

11.2.2 Medications shall be destroyed when:

1) the label is mutilated or indistinct.

2) the medication is beyond the expiration or shelf life date.

~~3) unused portions remain due to discontinuance, death, or discharge, except for medications returned to a pharmacist or transferred to a relief agency pursuant to Chapter II, Subpart 7.200 Donation of Unused Medications, Medical Devices and Medical Supplies.~~

~~11.3 Pharmaceutical Services: Home Program~~

~~11.3.1 All prescription medications shall be ordered in writing by a licensed physician or dentist, dispensed by a licensed pharmacy, received by the patient/family and maintained in the home.~~

~~11.3.2 The hospice shall maintain current documentation of all prescription medications being administered.~~

~~11.3.3 The hospice shall have a written procedure for destruction of drugs according to acceptable standards. The procedure to be used for destruction of controlled substances depends upon the ownership of the drugs. If the controlled substances have been obtained by prescription, they are the property of the patient and either the patient or relatives should be encouraged by the attending physician or nurse to destroy the drugs.~~

~~11.4 Pharmaceutical Services: In-Patient Facilities~~

~~11.4.1 The in-patient facilities shall meet all standards for pharmaceutical services in chapter IV, General Hospitals, or chapter V, Nursing Care Facility, or chapter VI, Intermediate Care Facility, if maintained as a distinct part of such a licensed facility.~~

~~11.4.2 Pharmacy services shall be under the supervision of a registered pharmacist.~~

~~11.4.3 All medications shall be obtained from a licensed pharmacy.~~

~~11.4.4 All medications shall be prescribed by a licensed physician and, unless self-administered, be administered by a licensed nurse.~~

~~11.4.5 A pharmacist and one other responsible individual shall destroy medications (except scheduled drugs). *[Eff. 07/30/2006]*~~

~~11.4.6 Medication destruction shall be accomplished by incineration or by disposal in a sewer system.~~

~~11.4.7 If the controlled substances involved have been furnished to the patient from a physician's "bag stock" or a hospital or pharmacy stock, not pursuant to a prescription, the drugs should be returned to the physician, hospital or pharmacy in compliance with the Colorado Board of Pharmacy regulations on such procedures.~~

~~11.4.8 If the controlled drugs (scheduled 2-5) are being held by the hospice on behalf of a patient and the medications are no longer needed, the hospice is authorized to conduct on-site destruction of the controlled substances. The following procedures must be adhered to in the destruction process of schedule 2-5 drugs:~~

~~1) all destructions must be properly inventoried and a copy of the inventory must be kept on file for a minimum of two (2) years. DBA Form 41 is not required for the inventory.~~

~~2) each destruction must be witnessed by the facility administrator or designee, the supervisory nurse and the consulting pharmacist. Each must actually witness the destruction inventory.~~

~~3) the destruction must be performed in such a manner, as to render the drugs totally un-retrievable.~~

~~11.4.9 Non-prescription medications may be maintained in and administered in the hospice providing the following conditions are met:~~

~~1) the physician has authorized the medication.~~

~~2) the medication is brought to the hospice unopened and in its original carton.~~

~~3) the medication is labeled with tape containing the patient's full name.~~

~~4) the tape is place upon the container in such a manner as not to obscure the original label.~~

~~11.4.10 Medications shall be self-administered only upon written authorization of a physician.~~

~~11.4.11 Medications shall not be left at the bedside unless authorized by a physician. When authorized, provision shall be made for storage of medications in a safe and sanitary manner.~~

~~11.4.12 All medication administration shall be documented in the patient's record.~~

~~11.4.13 Medications not stored at the bedside shall be maintained in locked storage in a centralized location.~~

~~12. RECORDS~~

~~12.1 In accordance with accepted principles of medical record practice, the hospice shall maintain a centralized and complete record on every individual receiving service.~~

~~12.2 All entries shall be permanent and legible and signed with name and title of individual making the entries.~~

~~12.3 The record shall include documentation of all services provided whether furnished directly or by arrangement.~~

~~12.4 Each record shall include but not be limited to:~~

~~1) identification and demographic data.~~

~~2) initial and subsequent assessments.~~

~~3) the plan of care.~~

~~4) medical history.~~

~~5) documentation of all services and events.~~

6) consent and authorization forms.

7) physicians' orders.

8) medication and records.

9) discharge/transfer records.

12.5 The hospice shall ensure the safety of the records against loss, destruction or unauthorized use.

12.6 All records shall be maintained for a period of 5 years after death or discharge. In the case of a minor, the record shall be maintained for a period of 5 years after death or, if a minor attains majority, for a five-year period thereafter.

13. CONTRACTUAL SERVICES

13.1 A hospice may contract as defined by law with other health care providers for the provision of all but core services.

13.1.1 Contracts shall be written and shall clearly delineate the authority and responsibility of each of the contracting parties.

13.1.2 The hospice shall maintain responsibility for coordinating and administering the hospice program.

13.1.3 All contracts shall specify that services provided shall be as specified in the Plan of Care.

13.1.4 All contracts shall specify financial arrangements including arrangements for donated services.

13.2 All contracts shall be dated and signed by an authorized agent of the hospice and the contracting agency.

13.3 All contracts shall be reviewed and/or revised by the hospice on an annual basis.

13.4 Individuals providing contract services shall be credentialed as applicable. The hospice shall maintain documentation of such credentials.

13.5 Contracting for a service shall not absolve the hospice form legal responsibility for the provision of that service.

13.6 The hospice shall ensure that employees of an agency providing a contractual service shall not seek or accept reimbursement in addition to that due the agency for the actual service delivered.

13.7 If contract services are utilized, the contractor shall meet all applicable provisions of hospice regulations.

14. IN-PATIENT AND RESIDENTIAL FACILITIES

~~14.1 The hospice shall ensure that in-patient services are available to meet the needs of the patient as determined by the hospice.~~

~~14.2 The hospice shall maintain administrative control of and responsibility for the provision of all services.~~

~~14.3 There shall be written policies and procedures to meet medical emergencies.~~

~~14.4 The hospice shall provide areas that ensure private patient/family visiting.~~

~~14.5 The hospice shall provide or arrange for accommodations for family members to remain with the patient overnight.~~

~~14.6 The hospice shall provide accommodations for family privacy after a patient's death.~~

~~14.7 The hospice visiting hours shall be flexible and shall not exclude children or pets.~~

~~14.8 The hospice shall provide a Patient Care Control Areas, designed and equipped for record recording, communications and storage of supplies and staff personal effects.~~

~~14.9 A separate handicapped accessible telephone shall be provided for resident use.~~

~~14.10 The facility shall meet all state and local laws and regulations pertaining to health and safety, and where applicable, zoning regulations.~~

~~14.11 There will be a disaster plan to cover evacuation of patients.~~

~~14.12 Sewage shall be discharged into a public sewer system, or if such is not available, it shall be disposed of in a manner approved by the state and local health authorities and the Colorado State Water Pollution Control Commission.~~

~~14.13 Garbage and rubbish not as sewage shall be stored in impervious containers in such a manner as not to become a nuisance or a health hazard. A sufficient number of impervious containers with tight-fitting lids shall be provided and kept clean and in good repair. Refuse shall be removed from the outside storage area at least once a week (preferably twice) to a disposal site approved by the local health department. Open burning on the premises is prohibited.~~

~~14.14 The water supply shall be designed, constructed and protected so as to assure that a safe, potable and adequate water supply is available for domestic purposes in compliance with state and local laws and regulations.~~

~~14.15 All plumbing shall be installed and maintained in accordance with the Colorado Plumbing Code and local plumbing codes. All plumbing shall be maintained in good repair and free of the possibility of backflow and backsiphonage, through the use of vacuum breakers and fixed air gaps, in accordance with state and local codes.~~

~~14.16 Inpatient or residential facilities with 8 or more patients must have a water heater with a capacity of 75 gallons or more.~~

~~14.17 The facility shall be maintained free of infestations of insects and rodents and all openings to the outside shall be adequately screened. A pest control inspection is required annually by an approved pest control company.~~

~~14.18 Furnishings shall be of a home-like variety and include lounge furniture as well as that contained in patient rooms. Accessories such as wallpaper, bedspreads, carpets, lamps, etc. shall be selected to create such an atmosphere. Provision shall be made for each patient to bring items from home to place about his/her room to the extent of space available, and as long as item will not jeopardize patient safety.~~

~~14.19 There may be single and/or double bedrooms to meet the needs of the patients. There shall be no more than two beds per patient room. Each patient room shall be located at or above ground level, have a window, and have direct entry from the corridor.~~

~~14.20 Patient rooms shall be 100-sq feet for one-bed rooms and 80-sq feet per bed in multi-bedrooms, exclusive of closets, lockers.~~

~~14.21 Artificial lighting shall be provided as consistent with a home-like decor and illumination to meet treatment needs.~~

~~14.22 Each patient room shall contain a comfortable, appropriately sized bed, equipped with a mattress protected by waterproof material, mattress pad and comfortable pillow; a comfortable chair and other furniture as appropriate to the decor and patient needs.~~

~~14.23 Infants and small children shall not be placed in a room with an adult patient. All equipment and supplies shall be age appropriate.~~

~~14.24 Housekeeping practices and procedures shall be employed to keep the facility free from offensive odors, accumulation of dirt, rubbish and dust.~~

~~14.25 Each facility shall provide storage for housekeeping equipment.~~

~~14.26 Cleaning shall be performed in a manner to minimize the spread of pathogenic organisms. Floors shall be cleaned regularly. Polishes on floors shall provide a non-slip finish; throw or scatter rugs shall not be used except for non-slip entrance mats.~~

~~14.27 Test reagents, general disinfectants, cleaning agents, etc., shall not be stored in the medication area and shall be maintained in a safe, secure manner.~~

~~14.28 The hospice shall provide a separate area for storage of clean linen.~~

~~14.29 The shared use of linens and other personal care articles is prohibited.~~

~~14.30 The hospice shall ensure supplies of clean bed linen, towels, and washcloths in quantities appropriate to the proper care of patients.~~

~~14.31 Laundry facilities and/or arrangements with commercial laundry shall provide for the necessary washing, drying and ironing equipment to adequately serve the needs of the facility.~~

~~14.32 Separate storage for soiled linen and clothing shall be provided. Such storage may consist of individual plastic bags or hampers or a soiled linen room.~~

~~14.33 The hospice shall provide a ventilated area for medication preparation. The area shall include a refrigerator used primarily for storage of medications. Specimens and food may be stored in the refrigerator, in separately labeled areas. The area shall include counter-space with illumination providing 100 foot-candles at the work surface, a sink with handwashing facilities and, if applicable, cabinets with locking devices to protect drugs stored therein.~~

~~14.34 Patient Care Areas (inpatient facilities)~~

~~14.34.1 Inpatient care may be provided in a distinct part of a health care facility licensed as a general hospital, skilled nursing facility, or inpatient hospice facility.~~

~~14.34.2 There shall be a registered nurse on duty in each patient care unit 24 hours a day.~~

~~14.34.3 Hospice in-patient care units shall have a identifiable and appropriately trained staff.~~

~~14.34.4 Hospice nursing care staff (RN'S, LPN'S, CNA'S, and personal care givers) shall be in ratios no fewer than 1:6 during the 12 hour day and early evening hours and 1:8 during the 12 hour late evening and night hours.~~

~~14.34.5 There shall be a storage room on each patient care unit for storage of patient care equipment. *[Eff. 04/30/2009]*~~

~~14.34.6 The medication preparation area shall be ventilated and the room temperature shall not exceed 72 degrees F. *[Eff. 04/30/2009]*~~

~~14.34.7 Each patient care unit shall have a separate clean holding area equipped with 1) counter, 2) sink with mixing faucet, 3) blade controls, 4) soap, 5) hand-drying equipment, 6) waste container and cupboards for supplies. *[Eff. 04/30/2009]*~~

~~14.34.8 In facilities with more than 8 patients, each patient care unit shall have a separate soiled holding area equipped with 1) counter, 2) double sink with mixing faucet, 3) blade controls, 4) soap and hand-drying equipment, 5) covered waste container, 6) soiled linen hamper with impervious liner, 7) clinical flushing sink and shelf space. *[Eff. 04/30/2009]*~~

~~14.34.9 In facilities with more than 8 patients, each patient care unit shall have a janitor's closet equipped with 1) floor-mounted sink with mixing faucets, 2) hook strips for mop handles, 3) shelves, 4) soap and hand-washing facilities, 5) waste receptacles and floor area adequate to store mop buckets on roller carriages. *[Eff. 04/30/2009]*~~

~~14.34.10 Each patient room shall be furnished with a call system that registers a visual signal from the patient. It shall register in the corridor outside the patient's room and at the Patient Care Control Center. Call stations shall be located at the patient's I bed, the toilet rooms and each tub and shower. Call stations at I toilet rooms and bathing areas shall be emergency calls. *[Eff. 04/30/2009]*~~

~~14.34.11 Each patient room shall have closet space for each patient for clothing and personal belongings. *[Eff. 04/30/2009]*~~

~~14.34.12 Bed linens shall be changed as often as necessary, but no less than twice each week. *[Eff. 04/30/2009]*~~

~~14.34.13 Toilet facilities shall be easily accessible from each patient room. One toilet may service two patient rooms but not more than four beds. Minimum dimensions of any toilet room shall be 18 square feet. The door to the toilet room shall be at least 32 inches wide and swing out. The toilet room shall be furnished with the following: (1) toilet with grab bars; (2) lavatory with wrist blade controls and mixing faucet; (3) mirror; (4) soap and hand drying facilities, waste paper receptacle with a removable impervious liner. *Eff. 04/30/2009]*~~

~~14.34.14 There shall be bathing facilities in the ratio of one tub or shower for each fifteen patients. Approved grab bars shall be installed at each tub or shower and tubs shall have a non-slip surface. There shall be toilet and lavatory facilities in the bathroom with mixing faucet, blade controls, soap and hand-drying accommodations. *[Eff. 04/30/2009]*~~

~~14.35 Patient Care Areas - Residential Facility~~

~~14.35.1 Hospices maintained as residential facilities shall provide documentation of approval from local zoning commissions, fire departments, code enforcement and building departments. *[Eff. 04/30/2009]*~~

~~14.35.2 There shall be an audible and accessible call system furnished in each patient, toilet, or tub room.~~

~~14.35.3 There shall be an area provided for charting, storage of supplies and personal effects of staff.~~

~~14.35.4 Provisions shall be made for the storage of patient care equipment.~~

~~14.35.5 There shall be bathing facilities in the ratio of one tub or shower for each eight residents. Approved grab bars shall be installed at each tub or shower and tubs shall have a non-slip surface.~~

~~14.35.6 There shall be toilet and lavatory facilities in the ration of one for each four residents. These shall be equipped with blade controls, mixing faucet, soap and hand-drying accommodations and waste basket. or locker~~

~~14.35.7 Each resident shall be provided with a closet or locker space and a towel rack in the bedroom.~~

~~14.35.8 Dining space shall be provided in an area capable of comfortably seating all residents at the same time.~~

~~14.35.9 A two compartment sink or domestic dishwashing machine shall be required.~~

~~14.35.10 Bed linens shall be changed as often as necessary, but no less than once each week.~~

~~**15. DIETARY SERVICES FOR INPATIENT AND RESIDENTIAL FACILITIES**~~

~~15.1 The hospice shall develop and maintain written policies and procedures for dietary services.~~

~~15.2 The hospice shall provide a practical freedom-of-choice diet to patients and shall assure that patients' favorite foods are included in their diets whenever possible.~~

~~15.3 The hospice shall appoint a staff member trained or experienced in food management to:~~

~~1) plan menus to meet the nutritional needs of the patients.~~

~~2) supervise meal preparation and service.~~

~~3) provide therapeutic diets as prescribed by the physician.~~

~~15.4 The food service shall be planned and staffed to adequately serve three balanced meals at regular intervals or at a variety of times depending upon the needs of the residents. Between-meal snacks of nourishing quality shall be offered and be available on a 24 hour basis.~~

~~15.5 The hospice shall provide one or more areas for dining, recreation and/or social activities. These areas may not be used for corridor traffic.~~

~~15.6 The food service shall meet acceptable standards relative to food sources, refrigeration, refuse handling, pest control, storage, preparation, procuring, serving and handling.~~

~~16. INFECTION CONTROL~~

~~16.1 The hospice shall develop and implement an infection control program.~~

~~16.2 There shall be written policies and procedures governing the infection control program developed by the hospice administrator and medical director and approved by the governing body.~~

~~16.3 A procedure shall be developed whereby the implementation of the infection control program is monitored on A monthly basis.~~

~~16.4 All employees shall wear clean outer garments and/or protective clothing at all times and shall practice good personal hygiene and cleanliness.~~

~~16.5 The inpatient hospice shall isolate only those patients with diseases with a high risk of transmission.~~

~~16.6 The inpatient hospice shall be responsible for ensuring that residents maintain an acceptable level of personal hygiene at all times.~~

~~17. GENERAL BUILDING AND LIFE SAFETY CODE REQUIREMENTS [Eff. 04/30/2009]~~

~~17.1 COMPLIANCE WITH THE LIFE SAFETY CODE. Facilities with one or more inpatient or residential beds shall be compliant with the National Fire Protection Association (NFPA) 101, Life Safety Code (2000), which is hereby incorporated by reference. Such incorporation by~~

~~reference, as provided for in 6 CCR 1011-1, Chapter II, excludes later amendments to or editions of referenced material.~~

~~17.1.1 Facilities licensed on or before March 11, 2003 shall meet Chapter 19, Existing Health Care Occupancies, NFPA 101 (2000).~~

~~17.1.2 Facilities licensed on or after March 11, 2003 or portions of facilities that undergo remodeling on or after October 1, 2003 shall meet Chapter 18, New Health Care Occupancies, NFPA 101 (2000). In addition, if the remodel represents a modification of more than 50 percent, or more than 4,500 square feet of the smoke compartment, the entire smoke compartment shall be renovated to meet Chapter 18, NFPA 101 (2000).~~

~~17.1.3 Notwithstanding NFPA 101 Life Safety Code provisions to the contrary:~~

~~(1) when differing fire safety standards are imposed by federal, state or local jurisdictions, the most stringent standard shall apply.~~

~~(2) any story containing an exterior door or an exterior window that opens to grade level shall be counted as a story.~~

~~(3) licensed facilities shall be separated from unlicensed contiguous occupancies by an occupancy separation with a fire resistance rating of not less than 2 hours.~~

~~(4) a health care occupancy shall be defined as the operation in such occupancy of one or more inpatient or residential beds.~~

~~17.2 PLAN REVIEW AND PLAN REVIEW FEES. Plan review and plan review fees are required as listed below. If the facility has been approved by the Department to use more than one building for the direct care of patients on its campus, each building is subject to the applicable base fee plus square footage costs. Fees are nonrefundable and shall be submitted prior to the Department initiating a plan review for a facility.~~

~~17.2.1~~ Initial Licensure, Additions, Relocations

~~(1) Plan review is applicable to the following, and includes new facility construction and new occupancy of existing structures:~~

~~(a) applications for an initial license, when such initial license is not a change of ownership and the application is submitted on or after July 1, 2009.~~

~~(b) additions of previously uninspected or unlicensed square footage to an existing occupancy and the building permit for such addition is issued on or after July 1, 2009 or if no permit is required by the local jurisdiction, construction began on or after July 1, 2009.~~

~~(c) relocations of a currently licensed facility in whole or in part to another physical plant, where the occupancy date occurs on or after July 1, 2009.~~

~~(2) Initial licensure, addition, and relocation plan review fees: base fee of $2,500, plus square footage costs as shown in the table below.~~

Square Footage	Cost per Square Foot	Explanatory Note
0-25,000 sq ft	$0.10	This is the cost for the first 25,000 sq ft of any plan submitted.
25,001+ sq ft	$0.01	This cost is applicable to the additional square footage over 25,000 sq ft.

17.2.2 Remodeling

(1) Plan review is applicable to remodeling for which the application for the building permit from the local authority having jurisdiction is dated on or after July 1, 2009, or if no permit is required by the local jurisdiction, construction began on or after July 1, 2009. Remodeling includes, but is not limited to:

(a) alteration, in patient sleeping areas, of a structural element subject to Life Safety Code standards, such as egress door widths and smoke or fire resisting walls.

(b) relocation, removal or installation of walls that results in alteration of 25% or more of the existing habitable square footage or 50% or more of a smoke compartment.

(c) conversion of existing space not previously used for providing patient services, including storage space, to resident sleeping areas.

(d) changes to egress components, specifically the alteration of a structural element, relocation, or addition of an egress component. Examples of egress components include, but are not limited to, corridors, stairwells, exit enclosures, and points of refuge.

(e) installation of any new sprinkler systems or the addition, removal or relocation of 20 or more sprinkler heads.

(f) installation of any new fire alarm system, or addition, removal or relocation of 20 or more fire alarm system appliances including, but not limited to, pull stations, detectors and notification devices.

(g) installation, removal or renovation of any kitchen hood suppression system.

(h) essential electrical system: replacement or addition of a generator or transfer switch.

(2) Remodeling plan review fees: base fee of $2,000, plus square footage costs as shown in the table below.

Square Footage	Cost per Square Foot	Explanatory Note
0-20,000 sq ft	$0.08	This is the cost for the first 20,000 sq ft of any plan submitted.
20,001+ sq ft	$0.01	This cost is applicable to the additional square footage over 20,000 sq ft.

17.3 The "Guidelines of Design and Construction of Health Care Facilities" (2006 Edition), American Institute of Architects (AIA), may be used by the Department in resolving health, building, and life safety issues for construction initiated or systems installed on or after July 1, 2009. AIA Guidelines are hereby incorporated by reference. Such incorporation by reference, as provided for in 6 CCR 1011-1, Chapter II, excludes later amendments to or editions of referenced material.

18. LICENSE FEES

18.1 All license fees are non-refundable and the applicable fee total shall be submitted with the appropriate license application.

18.2 Initial License - $6,370 per hospice.

(A) If there are no licensed hospices within a 60-mile radius of the hospice applying for an initial license, the initial license fee shall be $4,150 per hospice.

18.3 Annual Renewal License

(A) Renewal license fees shall be phased in over two years. For licenses with a renewal date between October 1, 2010 and September 30, 2011, the renewal fee shall be $1950 per hospice, except as set forth in paragraphs (1) through (7) below.

(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be $1,200 per hospice.

(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be $750 per hospice.

(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be $375 per hospice.

(4) A discount of $150 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location,

(5) A discount of $212 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing

~~with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.~~

~~(6) Upon request, the Department may waive the fee for a hospice that demonstrates it is a not-for-profit organization that charges no fees and is staffed entirely by uncompensated volunteers.~~

~~(7) For hospices that have the same ownership and governing body and that provide hospice care in both the home and inpatient or residential hospice settings, the fee shall be as follows and no other discounts shall apply:~~
~~(a) When both service models are contained in the same physical location, the license fee shall be $3,200.~~

~~(b) When the services are not in the same physical location but are within a 10-mile drive of each other, the home care hospice and the inpatient hospice shall each pay a separate license fee of $1,600.~~

~~(B) Effective October 1, 2011, the base renewal fee shall be $3,900 per hospice. The total renewal fee shall reflect all applicable adjustments as set forth below.~~

~~(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be $2,400 per hospice.~~

~~(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be $1,500 per hospice.~~

~~(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be $750 per hospice.~~

~~(4) A discount of $300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location,~~

~~(5) A discount of $425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.~~

~~(6) Upon request, the Department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.~~

~~(7) For hospices that have the same ownership and governing body and that provide hospice care in both the home and inpatient or residential hospice settings, the fee shall be as follows and no other discounts shall apply:~~

~~(a) When both service models are contained in the same physical location, the license fee shall be $6,400.~~

~~(b) When the services are not in the same physical location but are within a 10-mile drive of each other, the home care hospice and the inpatient hospice shall each pay a separate license fee of $3,200.~~

~~18.4 Workstation Fees~~
~~(A) A workstation is an offsite location maintained solely for the convenience of hospice staff to access policies and procedures, obtain forms or use various electronic communication tools. A workstation shall not contain patient records or be used for patient admissions and shall not display any public signage.~~
~~(B) In addition to any other licensure fees, a hospice that operates one or more satellite workstations shall pay an annual fee of $50 per workstation. The fee shall be submitted with the initial and/or renewal license application.~~

~~18.5 Change of Ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, Part 2. The fee shall be $6,370 per hospice.~~

THE FOLLOWING TEXT IS INTENDED TO REPLACE IN ITS ENTIRETY THE CURRENT CHAPTER XXI THAT IS SHOWN IN STRIKE-OUT ABOVE.

CHAPTER XXI – HOSPICES

SECTION 1 STATUTORY AUTHORITY AND APPLICABILITY

1.1 THE STATUTORY AUTHORITY FOR THE PROMULGATION OF THESE RULES IS SET FORTH IN SECTION 25-1.5-103, *ET SEQ.*, C.R.S.

1.2 A PROVIDER OF HOSPICE SERVICES, AS DEFINED HEREIN, SHALL COMPLY WITH ALL APPLICABLE FEDERAL AND STATE STATUTES AND REGULATIONS, INCLUDING BUT NOT LIMITED TO, THE FOLLOWING:

(A) THIS CHAPTER XXI AS IT APPLIES TO THE TYPE OF SERVICES PROVIDED.

(B) 6 CCR 1011-1, CHAPTER II, GENERAL LICENSURE STANDARDS, UNLESS OTHERWISE SPECIFICALLY MODIFIED HEREIN.

SECTION 2 DEFINITIONS

2.1 "BEREAVEMENT COUNSELING" MEANS EMOTIONAL, PSYCHOSOCIAL, AND SPIRITUAL SUPPORT AND SERVICES PROVIDED BEFORE AND AFTER THE DEATH OF THE PATIENT TO ASSIST WITH ISSUES RELATED TO GRIEF, LOSS, AND ADJUSTMENT.

2.2 "COMPREHENSIVE ASSESSMENT" MEANS A THOROUGH EVALUATION OF THE PATIENT'S PHYSICAL, PSYCHOSOCIAL, EMOTIONAL AND SPIRITUAL STATUS RELATED TO THE TERMINAL ILLNESS AND RELATED CONDITIONS. THIS INCLUDES A THOROUGH EVALUATION OF THE CAREGIVER'S AND FAMILY'S WILLINGNESS AND CAPABILITY TO CARE FOR THE PATIENT.

2.3 "CORE SERVICES" MEANS PHYSICIAN, NURSING, COUNSELING AND MEDICAL SOCIAL SERVICES. THESE SERVICES ARE ROUTINELY AND SUBSTANTIALLY PROVIDED BY HOSPICE EMPLOYEES EXCEPT FOR PHYSICIAN SERVICES THAT MAY BE CONTRACTED.

2.4 "DEPARTMENT" MEANS THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT.

2.5 "EMPLOYEE" MEANS PAID STAFF OR VOLUNTEERS PROVIDING HOSPICE SERVICES ON BEHALF OF THE HOSPICE.

2.6 "HOSPICE CARE" MEANS A COMPREHENSIVE SET OF SERVICES IDENTIFIED AND COORDINATED BY AN INTERDISCIPLINARY GROUP TO PROVIDE FOR THE PHYSICAL, PSYCHOSOCIAL, SPIRITUAL, AND EMOTIONAL NEEDS OF A TERMINALLY ILL PATIENT AND FAMILY MEMBERS AS DELINEATED IN A SPECIFIC PATIENT PLAN OF CARE. HOSPICE CARE SERVICES ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK IN THE PATIENT'S PLACE OF RESIDENCE AND/OR LICENSED HEALTH FACILITY.

2.7 "HOSPICE INPATIENT FACILITY" IS A UNIT OR BUILDING OPERATED BY A LICENSED HOSPICE DELIVERING HOSPICE SERVICES 24 HOURS A DAY, 7 DAYS A WEEK, IN A HOMELIKE SETTING.

2.8 "INTERDISCIPLINARY GROUP (IDG)" MEANS A GROUP OF QUALIFIED INDIVIDUALS, CONSISTING OF AT LEAST A PHYSICIAN, REGISTERED NURSE, SOCIAL WORKER, CHAPLAIN OR OTHER COUNSELOR WHO COLLECTIVELY HAVE EXPERTISE IN MEETING THE SPECIAL NEEDS OF THE HOSPICE PATIENT/FAMILY.

2.9 "PALLIATIVE CARE" MEANS SPECIALIZED MEDICAL CARE FOR PEOPLE WITH SERIOUS ILLNESSES. THIS TYPE OF CARE IS FOCUSED ON PROVIDING PATIENTS 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 PATIENT AND THE FAMILY. PALLIATIVE CARE IS PROVIDED BY A TEAM OF PHYSICIANS, NURSES AND OTHER SPECIALISTS WHO WORK WITH A PATIENT'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. HOSPICE PROVIDERS MAY PERFORM PALLIATIVE CARE SERVICES THAT ARE SEPARATE AND DISTINCT FROM HOSPICE CARE SERVICES.

2.10 "PATIENT/FAMILY" MEANS THE PATIENT AND THOSE INDIVIDUALS WHO ARE CLOSELY LINKED WITH THE PATIENT INCLUDING THE IMMEDIATE FAMILY, THE PRIMARY CAREGIVER AND/OR OTHER INDIVIDUALS WITH SIGNIFICANT PERSONAL TIES.

2.11 "TERMINALLY ILL" MEANS THAT THE INDIVIDUAL HAS A MEDICAL PROGNOSIS THAT INCLUDES A LIMITED LIFE EXPECTANCY OF DAYS, WEEKS OR MONTHS IF THE ILLNESS RUNS ITS ANTICIPATED COURSE. PALLIATIVE CARE PATIENTS MAY FALL OUTSIDE OF A PAYER'S COVERAGE GUIDELINES FOR THE HOSPICE BENEFIT.

SECTION 3 GOVERNING BODY

3.1 THE GOVERNING BODY IS THE PERSON OR GROUP OF PERSONS WHO EXERCISES ALL CORPORATE OR OTHER POWER AND MANAGES THE BUSINESS AND AFFAIRS OF THE ENTITY

WHICH IS LICENSED TO OPERATE A HOSPICE PURSUANT TO THESE REGULATIONS. THE GOVERNING BODY ASSUMES FULL LEGAL AUTHORITY AND RESPONSIBILITY FOR THE MANAGEMENT OF THE HOSPICE, THE PROVISION OF ALL HOSPICE SERVICES, ITS FISCAL OPERATIONS, AND CONTINUOUS QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT.

3.2 THE GOVERNING BODY OF A HOSPICE SHALL BE RESPONSIBLE FOR ASSURING THAT THE HOSPICE COMPLIES WITH ALL APPLICABLE REGULATIONS AND STANDARDS FOR THE OPERATION AND MAINTENANCE OF A HOSPICE LICENSE.

3.3 THE GOVERNING BODY SHALL APPOINT AND EMPLOY AN ADMINISTRATOR WHO SHALL POSSESS EDUCATION AND EXPERIENCE SUFFICIENT TO QUALIFY THE PERSON TO BE A HOSPICE ADMINISTRATOR. THE GOVERNING BODY MAY DELEGATE TO SUCH ADMINISTRATOR THE RESPONSIBILITY FOR THE MANAGEMENT OF THE HOSPICE ON A DAY-TO-DAY BASIS.

3.4 THE GOVERNING BODY SHALL PROVIDE OR ARRANGE FOR THE FACILITIES, QUALIFIED PERSONNEL AND SERVICES WHICH ARE SUFFICIENT AND NECESSARY TO PROVIDE EFFECTIVE HOSPICE CARE, INCLUDING PHYSICAL, EMOTIONAL, PSYCHOSOCIAL AND SPIRITUAL CARE FOR TERMINALLY ILL PATIENTS AND THEIR FAMILIES AND, IF IT CHOOSES, PALLIATIVE CARE AS A SEPARATE AND DISTINCT SERVICE FROM HOSPICE CARE SERVICES.

SECTION 4 ADMINISTRATION

4.1 THE HOSPICE SHALL ORGANIZE, MANAGE, AND ADMINISTER ITS RESOURCES TO PROVIDE HOSPICE CARE AND SERVICES TO PATIENTS, CAREGIVERS AND FAMILIES NECESSARY FOR THE PALLIATION AND MANAGEMENT OF THE TERMINAL ILLNESS.

4.2 THE HOSPICE SHALL HAVE AN ADMINISTRATOR WHO HAS TRAINING AND EXPERIENCE IN BUSINESS OR HEALTH SERVICE ADMINISTRATION AND AT LEAST TWO YEARS OF SUPERVISORY OR ADMINISTRATIVE EXPERIENCE IN HOSPICE CARE OR CLOSELY RELATED HEALTH CARE SERVICES.

4.3 THE ADMINISTRATOR SHALL BE RESPONSIBLE FOR THE MANAGEMENT OF THE HOSPICE STAFF AND OPERATIONS AND SHALL BE ACCOUNTABLE FOR AND REPORT TO THE GOVERNING BODY REGARDING THE DISCHARGE OF ALL DELEGATED DUTIES AND FUNCTIONS. IF THE ADMINISTRATOR DELEGATES SPECIFIC DUTIES, THE PERSON RESPONSIBLE SHALL BE CLEARLY IDENTIFIED.

4.4 THE DUTIES OF THE ADMINISTRATOR SHALL INCLUDE BUT NOT BE LIMITED TO:

(A) DIRECTING THE HOSPICE AND ENSURING IMPLEMENTATION OF POLICIES AND PROCEDURES REGARDING ALL ACTIVITIES AND PATIENT/FAMILY CARE SERVICES PROVIDED IN THE HOSPICE, WHETHER PROVIDED THROUGH STAFF EMPLOYED DIRECTLY BY THE HOSPICE, BY VOLUNTEERS OR THROUGH CONTRACT ARRANGEMENT;

(B) DESIGNATING AN ALTERNATE TO ACT IN HIS OR HER ABSENCE;

(C) IMPLEMENTING ADMINISTRATIVE POLICIES AND PROCEDURES. AND

(D) IMPLEMENTING FINANCIAL POLICIES AND PROCEDURES, APPROVED BY THE GOVERNING BODY, ACCORDING TO SOUND BUSINESS PRACTICE.

4.5 THE HOSPICE SHALL DEVELOP, IMPLEMENT, AND MAINTAIN AN EFFECTIVE, ONGOING, HOSPICE-WIDE DATA-DRIVEN QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM THAT COMPLIES WITH 6 CCR 1011-1, CHAPTER II, PART 3. IN ADDITION, THE HOSPICE'S GOVERNING BODY SHALL ENSURE THAT THE PROGRAM:

(A) REFLECTS THE COMPLEXITY OF ITS ORGANIZATION AND SERVICES;

(B) INVOLVES ALL HOSPICE SERVICES (INCLUDING THOSE SERVICES FURNISHED UNDER CONTRACT OR ARRANGEMENT);

(C) FOCUSES ON INDICATORS RELATED TO IMPROVED PALLIATIVE OUTCOMES, AND

(D) TAKES ACTIONS TO DEMONSTRATE IMPROVEMENT IN HOSPICE PERFORMANCE.

4.6 THE HOSPICE SHALL MAINTAIN DOCUMENTED EVIDENCE THAT ITS QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM HAS BEEN IMPLEMENTED AND IS FUNCTIONING EFFECTIVELY.

SECTION 5 PATIENT RIGHTS AND RESPONSIBILITIES

5.1 UPON ADMISSION, EACH HOSPICE PATIENT/FAMILY SHALL RECEIVE A COPY OF THE HOSPICE PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES.

5.2 THERE SHALL BE WRITTEN DOCUMENTATION OF RECEIPT OF THE COPY OF THE PATIENT RIGHTS AND RESPONSIBILITIES.

5.3 BY WRITTEN DECLARATION THE HOSPICE SHALL AFFIRM THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES:

(A) THE RIGHT TO BE INFORMED OF THE HOSPICE CONCEPT, ADMISSION CRITERIA, SERVICES TO BE PROVIDED, OPTIONS AVAILABLE, AND ANY CHARGES WHICH MAY BE INCURRED.

(B) THE RIGHT TO PARTICIPATE IN DEVELOPING THE PATIENT PLAN OF CARE.

(C) THE RIGHT TO EXPECT THAT ALL RECORDS BE CONFIDENTIAL.

(D) THE RIGHT TO REFUSE SERVICE OR WITHDRAW FROM THE PROGRAM AT ANY TIME.

(E) THE RESPONSIBILITY TO PROVIDE ACCURATE INFORMATION WHICH MAY BE USEFUL TO THE HOSPICE IN DELIVERING APPROPRIATE CARE.

(F) THE RIGHT TO EXPRESS A GRIEVANCE WITHOUT FEAR OF REPRISAL.

5.4 HOSPICE RESPONSIBILITIES SHALL INCLUDE BUT NOT BE LIMITED TO:

(A) PROVIDING QUALITY CARE TO INDIVIDUALS REGARDLESS OF RACE, RELIGION, SEX, AGE, AND/OR PHYSICAL OR MENTAL DISABILITIES OR ABILITY TO PAY;

(B) TRAINING ALL EMPLOYEES AND VOLUNTEERS ADEQUATELY FOR THE TYPE OF SERVICE THEY PROVIDE;

(C) PROVIDING CARE THAT IS ETHICAL, IS IN THE BEST INTEREST OF THE PATIENT, AND IS RESPECTFUL OF THE PATIENT/FAMILY LIFE VALUES, RELIGIOUS PREFERENCE, DIGNITY, INDIVIDUALITY, PRIVACY IN TREATMENT AND PERSONAL NEEDS, AND

(D) ASSURING SPECIAL ATTENTION TO PATIENTS WHO ARE INFANTS, SMALL CHILDREN AND ADOLESCENTS IN REGARD TO THEIR RIGHT TO PRIVACY, CHOICE AND DIGNITY.

SECTION 6 PATIENT CARE SERVICES

6.1 INTERDISCIPLINARY GROUP: THE HOSPICE SHALL ESTABLISH AN INTERDISCIPLINARY GROUP WHOSE RESPONSIBILITY SHALL INCLUDE BUT NOT BE LIMITED TO:

(A) ESTABLISHMENT OF A PLAN OF CARE WHICH INCLUDES DATA ELEMENTS THAT ALLOW FOR MEASUREMENT OF OUTCOMES;

(B) PROVISION AND/OR SUPERVISION OF HOSPICE CARE AND SERVICES;

(C) THE REVIEW AND/OR REVISION OF THE PLAN OF CARE FOR EACH PATIENT/FAMILY RECEIVING HOSPICE CARE, AND

(D) INVOLVEMENT OF THE PATIENT/FAMILY IN HOSPICE CARE.

6.2 ADMISSION CRITERIA:

(A) UPON ADMISSION TO THE HOSPICE THERE SHALL BE AN EVALUATION OF THE PATIENT'S IMMEDIATE NEEDS RELATED TO THEIR TERMINAL CONDITION. AN INITIAL PLAN OF CARE SHALL BE DEVELOPED BASED UPON THE RESULTS OF THE IMMEDIATE NEEDS EVALUATION.

(B) AN INITIAL ASSESSMENT OF THE PATIENT'S PHYSICAL, PSYCHOSOCIAL, SPIRITUAL AND EMOTIONAL STATUS RELATED TO THE PATIENT'S TERMINAL ILLNESS AND RELATED CONDITIONS SHALL BE COMPLETED BY A REGISTERED NURSE WITHIN FORTY-EIGHT (48) HOURS.

6.3 WITHIN FIVE (5) CALENDAR DAYS FOLLOWING ADMISSION, DEPENDING UPON THE PATIENT'S IMMEDIATE NEEDS, A COMPREHENSIVE ASSESSMENT SHALL BE COMPLETED BY THE INTERDISCIPLINARY GROUP. THE COMPREHENSIVE ASSESSMENT SHALL IDENTIFY THE PATIENT'S PHYSICAL, PSYCHOSOCIAL, EMOTIONAL AND SPIRITUAL NEEDS RELATED TO THE TERMINAL ILLNESS AND RELATED CONDITIONS THAT SHALL BE ADDRESSED IN ORDER TO PROMOTE THE PATIENT'S WELL-BEING, COMFORT AND DIGNITY THROUGHOUT THE DYING PROCESS. THIS INCLUDES A THOROUGH EVALUATION OF THE CAREGIVER'S AND FAMILY'S WILLINGNESS AND CAPABILITY TO CARE FOR THE PATIENT. THE COMPREHENSIVE

ASSESSMENT SHALL BE UPDATED AS FREQUENTLY AS THE PATIENT'S CONDITION REQUIRES BUT NO LESS THAN EVERY FIFTEEN (15) DAYS.

6.4 AN INDIVIDUALIZED WRITTEN PLAN OF CARE SHALL BE DEVELOPED TO REFLECT PATIENT AND FAMILY GOALS AND INTERVENTIONS BASED ON THE PROBLEMS IDENTIFIED IN THE INITIAL, COMPREHENSIVE AND UPDATED COMPREHENSIVE ASSESSMENTS. THE PLAN OF CARE SHALL INCLUDE ALL SERVICES NECESSARY FOR THE PALLIATION AND MANAGEMENT OF THE TERMINAL ILLNESS AND INCLUDE BUT NOT BE LIMITED TO:

(A) INTERVENTIONS TO MANAGE PAIN AND SYMPTOMS;

(B) A DETAILED STATEMENT OF THE SCOPE AND FREQUENCY OF SERVICES NECESSARY TO MEET THE SPECIFIC PATIENT AND FAMILY NEEDS;

(C) MEASURABLE OUTCOMES ANTICIPATED FROM IMPLEMENTING AND COORDINATING THE PLAN OF CARE;

(D) DRUGS AND INTERVENTIONS NECESSARY TO MEET THE NEEDS OF THE PATIENT;

(E) MEDICAL SUPPLIES AND APPLIANCES NECESSARY TO MEET THE NEEDS OF THE PATIENT;

(F) COORDINATION OF CARE;

(G) PATIENT/FAMILY UNDERSTANDING AND AGREEMENT WITH THE PLAN OF CARE, AND

(H) WHEN APPLICABLE, PLANS TO MEET THE SPECIAL NEEDS OF PATIENTS WHO ARE INFANTS, CHILDREN AND ADOLESCENTS.

6.5 A DESIGNATED REGISTERED NURSE SHALL COORDINATE THE OVERALL PLAN OF CARE FOR EACH PATIENT.

6.6 THE INTERDISCIPLINARY GROUP (IN COLLABORATION WITH THE INDIVIDUAL'S ATTENDING PHYSICIAN OR NURSE PRACTITIONER) SHALL REVIEW, REVISE AND DOCUMENT THE INDIVIDUALIZED PLAN AS FREQUENTLY AS THE PATIENT'S CONDITION REQUIRES, BUT NO LESS FREQUENTLY THAN EVERY 15 CALENDAR DAYS. A REVISED PLAN OF CARE SHALL INCLUDE INFORMATION FROM THE PATIENT'S UPDATED COMPREHENSIVE ASSESSMENT AND SHALL NOTE THE PATIENT'S PROGRESS TOWARD OUTCOMES AND GOALS SPECIFIED IN THE PLAN OF CARE.

6.7 A SYSTEM OF EFFECTIVE COMMUNICATION SHALL BE DEVELOPED AND MAINTAINED TO ASSURE THAT ALL SERVICES ARE COORDINATED AND PROVIDED IN ACCORDANCE WITH THE PLAN OF CARE, INCLUDING FAMILY, ATTENDING PHYSICIAN OR NURSE PRACTITIONER AND OTHERS PROVIDING CARE.

(A) TO FACILITATE CONTINUITY OF CARE WHEN TRANSFERRING WITHIN THE HOSPICE, TO ANOTHER HOSPICE OR TO ANOTHER PROVIDER, PERTINENT DOCUMENTATION SHALL BE IMMEDIATELY FORWARDED TO THE RECEIVING CARE PROVIDER.

(B) AT THE TIME OF DISCHARGE, THE HOSPICE SHALL PROVIDE PERTINENT CLINICAL RECORDS AND ANY OTHER DOCUMENTATION THAT MAY BE REQUESTED TO ASSIST IN POST-DISCHARGE CONTINUITY OF CARE.

6.8 MEDICAL DIRECTOR: THE HOSPICE SHALL DESIGNATE A PHYSICIAN WHO SHALL ACT AS MEDICAL DIRECTOR. THE PHYSICIAN SHALL BE A DOCTOR OF MEDICINE OR OSTEOPATHY WHO IS AN EMPLOYEE, OR IS UNDER CONTRACT WITH THE HOSPICE, AND HAS A CURRENT UNRESTRICTED LICENSE TO PRACTICE IN THE STATE OF COLORADO.

6.9 THE MEDICAL DIRECTOR OR PHYSICIAN DESIGNEE SHALL BE A MEMBER OF THE INTERDISCIPLINARY GROUP AND BE RESPONSIBLE FOR THE MEDICAL COMPONENT OF THE HOSPICE'S PATIENT CARE PROGRAM INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING:

(A) REVIEWING APPROPRIATE CLINICAL MATERIAL FROM THE REFERRING PHYSICIAN TO VALIDATE THE PROGNOSIS AS ANTICIPATED BY THE PATIENT'S ATTENDING PHYSICIAN OR NURSE PRACTITIONER;

(B) ASSISTING IN DEVELOPING AND MEDICALLY VALIDATING THE INTERDISCIPLINARY PLAN OF CARE FOR EACH PATIENT/FAMILY WITH THE COORDINATION OF THE PATIENT'S ATTENDING PHYSICIAN OR NURSE PRACTITIONER;

(C) RENDERING, AS NECESSARY, OR SUPERVISING ACTIVE MEDICAL CARE OF THE PATIENT AND MAINTAINING A RECORD OF SUCH CARE;

(D) MAINTAINING A REGULAR SCHEDULE OF PARTICIPATION IN PERTINENT COMPONENTS OF THE HOSPICE PATIENT CARE PROGRAM;

(E) BEING READILY AVAILABLE TO THE HOSPICE PROGRAM PERSONALLY OR NAMING A QUALIFIED PHYSICIAN DESIGNEE;

(F) ACTING AS A CONSULTANT TO AND MAINTAINING LIAISON WITH THE ATTENDING PHYSICIAN OR NURSE PRACTITIONER AND OTHER MEMBERS OF THE INTERDISCIPLINARY GROUP;

(G) HELPING TO DEVELOP AND REVIEW PATIENT/FAMILY CARE POLICIES AND PROCEDURES;

(H) SERVING ON APPROPRIATE COMMITTEES

(I) REPORTING ISSUES REGARDING THE DELIVERY OF MEDICAL CARE; AND

(J) APPROVING WRITTEN PROTOCOLS FOR SYMPTOM CONTROL SUCH AS PAIN OR NAUSEA.

6.10 PHYSICIAN SERVICES: THE HOSPICE SHALL ENSURE THAT EACH PATIENT HAS AN ATTENDING PHYSICIAN OR NURSE PRACTITIONER. IF A PATIENT HAS NO ATTENDING PHYSICIAN OR NURSE PRACTITIONER, THERE SHALL BE A MECHANISM FOR ASSURING THE AVAILABILITY OF ONE. THE ATTENDING PHYSICIAN OR NURSE PRACTITIONER SHALL:

(A) APPROVE AND SIGN THE PLAN OF CARE FOR THE PATIENT/FAMILY;

(B) BE AVAILABLE TO THE INTERDISCIPLINARY GROUP AS NECESSARY;

(C) PROVIDE INFORMATION TO THE INTERDISCIPLINARY GROUP IN DEVELOPING THE PLAN OF CARE; AND

(D) REVIEW THE PLAN OF CARE AT LEAST EVERY 90 DAYS.

6.11 NURSING SERVICES: THE HOSPICE SHALL PROVIDE NURSING CARE AND SERVICES BY OR UNDER THE DIRECTION AND SUPERVISION OF A REGISTERED NURSE WITH TRAINING AND EXPERIENCE TO DIRECT HOSPICE NURSING CARE WHO SHALL BE AN EMPLOYEE OF THE HOSPICE. NURSING SERVICES SHALL ENSURE THAT THE PATIENT'S NEEDS ARE MET AS IDENTIFIED IN THE PATIENT'S INITIAL ASSESSMENT, COMPREHENSIVE ASSESSMENT AND UPDATED ASSESSMENTS.

6.12 HIGHLY SPECIALIZED NURSING SERVICES THAT ARE PROVIDED SO INFREQUENTLY THAT THE PROVISION OF SUCH SERVICES BY DIRECT HOSPICE EMPLOYEES WOULD BE IMPRACTICABLE AND PROHIBITIVELY EXPENSIVE, MAY BE PROVIDED UNDER CONTRACT.

6.13 MEDICAL SOCIAL SERVICES: THE HOSPICE SHALL PROVIDE MEDICAL SOCIAL SERVICES PROVIDED BY A QUALIFIED MEDICAL SOCIAL WORKER BASED ON THE INITIAL AND COMPREHENSIVE ASSESSMENTS, THE PATIENT/FAMILY'S NEEDS AND ACCEPTANCE OF SERVICES.

6.14 VOLUNTEER SERVICES: THE HOSPICE SHALL UTILIZE VOLUNTEERS IN ROLES AS DEFINED BY THE HOSPICE THAT SUPPORT PATIENT CARE AND ADMINISTRATIVE SERVICES.

6.15 THE HOSPICE SHALL MAINTAIN A VOLUNTEER PROGRAM WHICH MEETS THE OPERATIONAL NEEDS OF THE HOSPICE AND DEMONSTRATES OVERALL COORDINATION OF VOLUNTEER SERVICES. THE PROGRAM SHALL INCLUDE RECRUITMENT, ORIENTATION, TRAINING, SUPERVISION, MONITORING AND EVALUATION.

6.16 PATIENT SERVICES PROVIDED BY VOLUNTEERS SHALL BE IN ACCORDANCE WITH THE PLAN OF CARE AND SHALL BE DOCUMENTED IN THE CLINICAL RECORD.

6.17 BEREAVEMENT COUNSELING: BEFORE AND FOR ONE YEAR FOLLOWING THE PATIENT'S DEATH, THE HOSPICE SHALL PROVIDE BEREAVEMENT SERVICES TO FAMILIES AND OTHERS INCLUDING INDIVIDUALS IN RESIDENTIAL FACILITIES WHERE THE PATIENT RESIDED. THESE SERVICES SHALL BE PROVIDED IN ACCORDANCE WITH THE NEEDS OF THE INDIVIDUAL AND FURNISHED UNDER THE SUPERVISION OF A QUALIFIED PROFESSIONAL WITH EXPERIENCE OR EDUCATION IN GRIEF OR LOSS COUNSELING.

6.18 SPIRITUAL COUNSELING: THE HOSPICE SHALL PROVIDE SPIRITUAL COUNSELING SERVICES BASED ON THE INITIAL AND COMPREHENSIVE ASSESSMENT OF THE SPIRITUAL NEEDS AND ACCEPTANCE OF THIS SERVICE BY THE PATIENT, FAMILY AND SIGNIFICANT OTHERS.

6.19 HOSPICE AIDE SERVICES: THE HOSPICE SHALL ENSURE THAT HOSPICE AIDES HAVE SUCCESSFULLY COMPLETED A STATE APPROVED CERTIFIED NURSE AIDE (CNA) TRAINING

PROGRAM AND ARE CURRENTLY CERTIFIED BY THE COLORADO DEPARTMENT OF REGULATORY AGENCIES (DORA).

6.20 HOSPICE AIDE SERVICES: HOSPICE AIDES SHALL BE SUPERVISED BY A REGISTERED NURSE EVERY 14 DAYS TO ASSESS THE QUALITY OF CARE AND SERVICES PROVIDED BY THE AIDE. THE HOSPICE AIDE DOES NOT NEED TO BE PRESENT DURING THIS VISIT. ON-SITE SUPERVISION AND EVALUATION OF THE HOSPICE AIDE WILL BE COMPLETED BY A REGISTERED NURSE ANNUALLY AND WHEN AN AREA OF CONCERN IS NOTED.

6.21 NURSING SERVICES, PHYSICIAN SERVICES, DRUGS AND BIOLOGICALS SHALL BE AVAILABLE 24 HOURS A DAY, SEVEN DAYS A WEEK. OTHER HOSPICE SERVICES SHALL BE AVAILABLE 24 HOURS A DAY WHEN MEDICALLY NECESSARY TO MEET THE NEEDS OF THE PATIENT AND FAMILY.

6.22 TERMINATION OF CARE: THE HOSPICE SHALL ESTABLISH SPECIFIC CRITERIA FOR TERMINATION OF CARE, INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING:

(A) THERE SHALL BE POLICIES AND PROCEDURES RELATED TO TERMINATION OF CARE AND/OR REFERRAL; AND

(B) THE CLINICAL RECORD SHALL CONTAIN DOCUMENTATION OF THE REASON CARE HAS BEEN TERMINATED.

SECTION 7 PERSONNEL

7.1 THE HOSPICE SHALL PROVIDE PHYSICIAN SERVICES, NURSING SERVICES, MEDICAL SOCIAL WORK OR COUNSELING SERVICES, SPIRITUAL COUNSELING, AND TRAINED VOLUNTEERS. THESE SERVICES SHALL BE CONSISTENT WITH ACCEPTABLE STANDARDS OF PRACTICE.

7.2 THE HOSPICE SHALL ROUTINELY PROVIDE SUBSTANTIALLY ALL CORE SERVICES DIRECTLY BY HOSPICE EMPLOYEES.

7.3 THERE SHALL BE WRITTEN POLICIES THAT GOVERN EMPLOYMENT AND PERSONNEL PRACTICES.

7.4 THE HOSPICE SHALL REQUIRE ANY PROSPECTIVE EMPLOYEE TO SUBMIT TO A CRIMINAL HISTORY RECORD CHECK THAT SHALL BE CONDUCTED NOT MORE THAN 90 DAYS PRIOR TO EMPLOYMENT OF THE INDIVIDUAL. THE HOSPICE SHALL DEVELOP AND IMPLEMENT POLICIES AND PROCEDURES REGARDING THE EMPLOYMENT OF ANY INDIVIDUAL WHO IS CONVICTED OF A FELONY OR MISDEMEANOR TO ENSURE THAT THE INDIVIDUAL DOES NOT POSE A RISK TO THE HEALTH, SAFETY AND WELFARE OF THE PATIENT.

7.5 BEFORE EMPLOYING ANY INDIVIDUAL TO PROVIDE DIRECT PATIENT CARE OR SERVICES, THE HOSPICE SHALL VERIFY WITH THE COLORADO DEPARTMENT OF REGULATORY AGENCIES (DORA) WHETHER A LICENSE, REGISTRATION OR CERTIFICATION EXISTS AND IS IN GOOD STANDING. A COPY OF THE VERIFICATION SHALL BE PLACED IN THE INDIVIDUAL'S PERSONNEL FILE.

7.6 THERE SHALL BE AN INITIAL ORIENTATION FOR EACH EMPLOYEE THAT INCLUDES:

(A) HISTORY, PHILOSOPHY AND STRUCTURE OF THE HOSPICE CONCEPT;

(B) THE INTERDISCIPLINARY APPROACH;

(C) COMMUNICATION SKILLS;

(D) HOSPICE SERVICES OFFERED;

(E) AGENCY ORGANIZATIONAL STRUCTURE;

(F) ACCESS TO AGENCY POLICIES AND PROCEDURES;

(G) PERSONNEL POLICIES;

(H) CONTINUING EDUCATIONAL REQUIREMENTS; AND

(I) INFECTION CONTROL.

7.7 THE HOSPICE SHALL ASSESS AND DOCUMENT THE COMPETENCE AND SKILLS OF EACH EMPLOYEE PRIOR TO PROVIDING DIRECT PATIENT CARE. THE HOSPICE SHALL HAVE WRITTEN POLICIES AND PROCEDURES DESCRIBING ITS METHODS OF ASSESSMENT OF COMPETENCY.

7.8 THE HOSPICE SHALL ENSURE THAT EACH HOSPICE AIDE IS COMPETENT TO CARRY OUT ALL ASSIGNED TASKS IN THE PATIENT'S PLACE OF RESIDENCE.

(A) PRIOR TO INITIAL ASSIGNMENT, A REGISTERED NURSE SHALL CONDUCT A COMPETENCY EVALUATION INCLUDING, BUT NOT LIMITED TO, THE TASKS LISTED IN THIS SUBSECTION:

(1) BATHING,

(2) SKIN CARE,

(3) HAIR CARE,

(4) NAIL CARE,

(5) MOUTH CARE,

(6) SHAVING,

(7) DRESSING,

(8) FEEDING,

(9) ASSISTANCE WITH AMBULATION,

(10) EXERCISE AND TRANSFERS,

(11) POSITIONING,

(12) BLADDER AND BOWEL CARE,

(13) MEDICATION REMINDING, AND

(14) THE USE OF ADAPTIVE EQUIPMENT.

7.9 THE HOSPICE SHALL HAVE A PROGRAM FOR EDUCATION AND TRAINING THAT OFFERS A MINIMUM OF 20 HOURS OF EDUCATION ANNUALLY TO ENHANCE HOSPICE RELATED SKILLS FOR ALL EMPLOYEES WHO PROVIDE DIRECT PATIENT CARE. THE HOSPICE SHALL MAINTAIN DOCUMENTATION OF THE ANNUAL EDUCATION AND TRAINING OFFERED.

7.10 THERE SHALL BE DOCUMENTATION OF EACH EMPLOYEE'S APPLICATION, VERIFICATION OF CREDENTIALS, COMPETENCY EVALUATIONS, STAFF EDUCATION/TRAINING AND PERFORMANCE APPRAISALS.

SECTION 8 PHARMACEUTICAL SERVICES

8.1 THE HOSPICE SHALL DEVELOP AND MAINTAIN WRITTEN POLICIES AND PROCEDURES FOR THE ADMINISTRATION AND PROVISION OF PHARMACEUTICAL SERVICES THAT ARE CONSISTENT WITH THE NEEDS OF THE PATIENT AS DETERMINED BY THE HOSPICE'S MEDICAL DIRECTOR, PATIENT'S ATTENDING PHYSICIAN OR NURSE PRACTITIONER.

8.2 MEDICATIONS ORDERED SHALL BE CONSISTENT WITH THE HOSPICE PHILOSOPHY WHICH FOCUSES ON PALLIATION AND ARE CONSISTENT WITH PROFESSIONAL PRACTICE AND REGULATIONS OF THE COLORADO BOARD OF PHARMACY.

8.3 MANAGING MEDICATIONS AND BIOLOGICALS.

(A) THE HOSPICE SHALL ENSURE THAT THE INTERDISCIPLINARY GROUP CONFERS WITH AN INDIVIDUAL WITH EDUCATION AND TRAINING IN MEDICATION MANAGEMENT AS DEFINED IN HOSPICE POLICIES AND PROCEDURES AND STATE LAW, WHO IS AN EMPLOYEE OF OR UNDER CONTRACT WITH THE HOSPICE TO ENSURE THAT MEDICATIONS AND BIOLOGICALS MEET EACH PATIENT'S NEEDS.

(B) A HOSPICE INPATIENT FACILITY SHALL PROVIDE PHARMACY SERVICES UNDER THE DIRECTION OF A QUALIFIED LICENSED PHARMACIST WHO IS AN EMPLOYEE OF OR UNDER CONTRACT WITH THE HOSPICE. THE PHARMACIST SERVICES SHALL INCLUDE EVALUATION OF A PATIENT'S RESPONSE TO MEDICATION THERAPY, IDENTIFICATION OF POTENTIAL ADVERSE MEDICATION REACTIONS, AND RECOMMENDED APPROPRIATE CORRECTIVE ACTION.

8.4 ORDERING OF MEDICATIONS.

(A) ONLY A LICENSED HEALTH CARE PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY MAY ORDER MEDICATIONS FOR THE PATIENT.

(B) IF THE PRESCRIPTION MEDICATION ORDER IS VERBAL OR GIVEN BY OR THROUGH ELECTRONIC TRANSMISSION:

(1) THE ORDER SHALL BE GIVEN ONLY TO A LICENSED NURSE, NURSE PRACTITIONER, PHARMACIST, OR PHYSICIAN; AND

(2) THE INDIVIDUAL RECEIVING THE ORDER SHALL RECORD AND SIGN IT IMMEDIATELY AND HAVE THE PRESCRIBING PERSON SIGN IT IN ACCORDANCE WITH STATE AND FEDERAL LAW.

8.5 ADMINISTRATION OF MEDICATION AND BIOLOGICALS.

(A) THE INTERDISCIPLINARY GROUP, AS PART OF THE REVIEW OF THE PLAN OF CARE, SHALL DETERMINE THE ABILITY OF THE PATIENT AND/OR FAMILY TO SAFELY SELF-ADMINISTER MEDICATIONS AND BIOLOGICALS TO THE PATIENT IN HIS OR HER HOME.

8.6 DISPENSING AND STORAGE OF MEDICATIONS AND BIOLOGICALS.

(A) THE HOSPICE SHALL OBTAIN MEDICATIONS AND BIOLOGICALS IN COMPLIANCE WITH STATE AND FEDERAL LAW INCLUDING COLORADO BOARD OF PHARMACY RULES.

(B) MEDICATIONS AND BIOLOGICALS SHALL BE LABELED IN ACCORDANCE WITH CURRENTLY ACCEPTED PROFESSIONAL PRACTICE AND SHALL INCLUDE APPROPRIATE USAGE, CAUTIONARY INSTRUCTIONS, AND AN EXPIRATION DATE (IF APPLICABLE).

(C) THE HOSPICE SHALL HAVE WRITTEN POLICIES AND PROCEDURES SPECIFIC TO THE PATIENT'S CARE SETTING FOR THE MANAGEMENT AND DISPOSAL OF THE PATIENT'S MEDICATIONS. AT THE TIME MEDICATIONS ARE FIRST ORDERED THE HOSPICE SHALL:

(1) PROVIDE A COPY OF THE HOSPICE WRITTEN POLICIES AND PROCEDURES ON THE MANAGEMENT AND DISPOSAL OF MEDICATIONS TO THE PATIENT OR PATIENT REPRESENTATIVE AND FAMILY;

(2) DISCUSS THE HOSPICE POLICIES AND PROCEDURES FOR MANAGING THE SAFE USE AND DISPOSAL OF MEDICATIONS WITH THE PATIENT OR REPRESENTATIVE AND THE FAMILY IN A LANGUAGE AND MANNER THAT THEY UNDERSTAND TO ENSURE THAT THESE PARTIES ARE EDUCATED REGARDING THE SAFE USE AND DISPOSAL OF MEDICATIONS;

(3) DOCUMENT IN THE PATIENT'S CLINICAL RECORD THAT THE WRITTEN POLICIES AND PROCEDURES FOR MANAGING MEDICATIONS WAS PROVIDED AND DISCUSSED; AND

(4) ADVISE THAT IF MEDICATIONS (INCLUDING CONTROLLED SUBSTANCES) HAVE BEEN OBTAINED BY PRESCRIPTION FOR THE PATIENT, THEY ARE THE PROPERTY OF THE PATIENT.

(D) THE HOSPICE SHALL HAVE A WRITTEN POLICY REGARDING THE MANAGEMENT AND USE OF EMERGENCY KITS FOR AS NEEDED MEDICATIONS ORDERED FOR AN INDIVIDUAL PATIENT. THE USE OF AN EMERGENCY KIT THAT IS NOT PRESCRIBED FOR AN INDIVIDUAL PATIENT SHALL BE CONSISTENT WITH THE COLORADO BOARD OF PHARMACY REGULATIONS.

SECTION 9 CLINICAL RECORDS

9.1 THE HOSPICE SHALL MAINTAIN A CENTRALIZED AND COMPLETE RECORD ON EVERY INDIVIDUAL RECEIVING SERVICE IN ACCORDANCE WITH ACCEPTED PRINCIPLES OF MEDICAL RECORD PRACTICE.

9.2 THE RECORD SHALL INCLUDE DOCUMENTATION OF ALL SERVICES PROVIDED WHETHER FURNISHED DIRECTLY OR BY CONTRACT.

9.3 EACH RECORD SHALL INCLUDE BUT NOT BE LIMITED TO:

(A) IDENTIFICATION AND DEMOGRAPHIC DATA;

(B) THE INITIAL PLAN OF CARE, UPDATED PLANS OF CARE, INITIAL ASSESSMENT, COMPREHENSIVE ASSESSMENT, UPDATED COMPREHENSIVE ASSESSMENTS, AND CLINICAL NOTES;

(C) HISTORY OF TERMINAL ILLNESS AND OTHER RELATED CONDITIONS;

(D) DOCUMENTATION OF ALL SERVICES AND RESPONSES TO TREATMENTS AND INTERVENTIONS INCLUDING LISTS OF CURRENT MEDICATIONS AND MEDICATION ADMINISTRATION RECORDS (IF APPLICABLE);

(E) SIGNED CONSENTS, AUTHORIZATIONS, AND ADVANCE DIRECTIVES;

(F) ORDERS FROM LICENSED PROVIDERS WITH PRESCRIPTIVE AUTHORITY AND/OR OTHER LICENSED OR QUALIFIED HEALTH CARE PROFESSIONALS, AND

(G) DISCHARGE/TRANSFER RECORDS.

9.4 ALL ENTRIES SHALL BE COMPLETED IN A MANNER THAT IS LEGIBLE AND PERMANENT; DATED AND AUTHENTICATED IN ACCORDANCE WITH HOSPICE POLICY AND CURRENTLY ACCEPTED STANDARDS OF PRACTICE.

9.5 HOSPICE SHALL ENSURE THE PRIVACY, SECURITY AND SAFETY OF THE RECORDS AGAINST LOSS, DESTRUCTION OR UNAUTHORIZED USE, INCLUDING COMPLIANCE WITH PROTECTED HEALTH INFORMATION IN COMPLIANCE WITH FEDERAL AND STATE LAW.

9.6 ALL RECORDS SHALL BE MAINTAINED FOR A PERIOD OF SIX (6) YEARS AFTER DEATH OR DISCHARGE. IN THE CASE OF A MINOR, THE RECORD SHALL BE MAINTAINED FOR A PERIOD OF SIX (6) YEARS AFTER DEATH OR FOR SIX YEARS AFTER THE MINOR ATTAINS MAJORITY (18 YEARS OLD).

9.7 IF THE HOSPICE DISCONTINUES OPERATION, HOSPICE POLICIES SHALL PROVIDE FOR RETENTION AND STORAGE OF CLINICAL RECORDS ACCORDING TO STATE AND FEDERAL LAW. THE HOSPICE SHALL INFORM THE STATE LICENSING AGENCY WHERE SUCH CLINICAL RECORDS WILL BE STORED AND HOW THEY MAY BE ACCESSED.

9.8 THE CLINICAL RECORD, WHETHER HARD COPY OR IN ELECTRONIC FORM, SHALL BE MADE READILY AVAILABLE ON REQUEST BY AN APPROPRIATE AUTHORITY.

SECTION 10 CONTRACTUAL SERVICES

10.1 THE HOSPICE MAY CONTRACT AS DEFINED BY LAW WITH OTHER HEALTH CARE PROVIDERS FOR THE PROVISION OF ALL BUT CORE SERVICES EXCEPT THE EXCLUSIONS AS OUTLINED IN SECTION 10.5.

10.2 A HOSPICE THAT HAS A WRITTEN AGREEMENT WITH ANOTHER AGENCY, INDIVIDUAL, OR ORGANIZATION TO FURNISH ANY SERVICES UNDER CONTRACT SHALL RETAIN ADMINISTRATIVE AND FINANCIAL MANAGEMENT, LEGAL RESPONSIBILITY AND OVERSIGHT OF STAFF AND SERVICES FOR ALL CONTRACTED SERVICES, TO ENSURE THE PROVISION OF QUALITY CARE.

10.3 CONTRACTED SERVICES SHALL BE SUPPORTED BY WRITTEN AGREEMENTS THAT REQUIRE ALL SERVICES BE:

(A) AUTHORIZED BY THE HOSPICE;

(B) FURNISHED IN A SAFE AND EFFECTIVE MANNER BY QUALIFIED PERSONNEL;

(C) DELIVERED IN ACCORDANCE WITH THE PATIENT'S PLAN OF CARE, AND

(D) EVALUATED AS PART OF THE QUALITY MANAGEMENT PROGRAM.

10.4 IF CONTRACT SERVICES ARE UTILIZED, THE CONTRACTOR SHALL MEET ALL APPLICABLE PROVISIONS OF HOSPICE REGULATIONS.

10.5 THE HOSPICE MAY USE CONTRACTED STAFF TO SUPPLEMENT HOSPICE EMPLOYEES IN ORDER TO MEET THE NEEDS OF PATIENTS UNDER EXTRAORDINARY OR OTHER NON-ROUTINE CIRCUMSTANCES. CIRCUMSTANCES UNDER WHICH A HOSPICE MAY ENTER INTO A WRITTEN ARRANGEMENT FOR THE PROVISION OF CORE SERVICES INCLUDE: UNANTICIPATED PERIODS OF HIGH PATIENT LOADS, STAFFING SHORTAGES DUE TO ILLNESS OR OTHER SHORT-TERM TEMPORARY SITUATIONS THAT INTERRUPT PATIENT CARE; AND TEMPORARY TRAVEL OF A PATIENT OUTSIDE OF THE HOSPICE'S SERVICE AREA.

10.6 HOSPICE SERVICES PROVIDED TO RESIDENTS OF NON-HOSPICE LICENSED FACILITIES:

(A) WHEN HOSPICE SERVICES ARE PROVIDED IN A LONG TERM CARE FACILITY, ASSISTED LIVING RESIDENCE OR INTERMEDIATE CARE FACILITY FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, THERE SHALL BE A WRITTEN AGREEMENT THAT SPECIFIES THE PROVISION OF HOSPICE SERVICES IN THE FACILITY. THE WRITTEN AGREEMENT SHALL BE SIGNED BY AUTHORIZED REPRESENTATIVES OF THE HOSPICE

AND THE NON-HOSPICE LICENSED FACILITY PRIOR TO THE PROVISION OF HOSPICE SERVICES.

(B) THE WRITTEN AGREEMENT SHALL INCLUDE AT LEAST THE FOLLOWING:

(1) THE MANNER IN WHICH THE FACILITY AND THE HOSPICE ARE TO COMMUNICATE WITH EACH OTHER AND DOCUMENT SUCH COMMUNICATION TO ENSURE THAT THE NEEDS OF THE PATIENT ARE ADDRESSED AND MET 24 HOURS A DAY;

(2) A PROVISION THAT THE FACILITY SHALL IMMEDIATELY NOTIFY THE HOSPICE IF:

(A) THERE IS A SIGNIFICANT CHANGE IN THE PATIENT'S PHYSICAL, MENTAL, SOCIAL, OR EMOTIONAL STATUS THAT MAY NECESSITATE A CHANGE TO THE PLAN OF CARE;

(B) THERE IS A NEED TO TRANSFER THE PATIENT FROM THE FACILITY, IN SUCH CASE, THE HOSPICE SHALL COORDINATE ANY NECESSARY CARE RELATED TO THE TERMINAL ILLNESS AND RELATED CONDITIONS, OR

(C) THE PATIENT DIES.

(3) A PROVISION STATING THAT THE HOSPICE ASSUMES RESPONSIBILITY FOR DETERMINING THE APPROPRIATE COURSE OF HOSPICE CARE, INCLUDING THE DETERMINATION TO CHANGE THE LEVEL OF SERVICES PROVIDED, AND

(4) A PROVISION STATING THAT IT IS THE FACILITY'S RESPONSIBILITY TO PROVIDE 24-HOUR ROOM AND BOARD CARE AND TO PROVIDE SERVICES AS DEFINED BY THE FACILITY'S LICENSE.

10.7 SHORT-TERM INPATIENT CARE: THE HOSPICE SHALL ENSURE THAT SHORT-TERM INPATIENT CARE IS AVAILABLE TO MEET THE ACUTE AND RESPITE NEEDS OF THE PATIENT AS DETERMINED BY THE HOSPICE. THIS SHORT-TERM INPATIENT CARE MAY BE PROVIDED IN A HOSPITAL, LONG TERM CARE FACILITY, OR HOSPICE INPATIENT FACILITY.

(A) IF THE HOSPICE HAS AN ARRANGEMENT WITH A FACILITY TO PROVIDE FOR SHORT-TERM INPATIENT CARE, THE ARRANGEMENT IS DESCRIBED IN A WRITTEN AGREEMENT, COORDINATED BY THE HOSPICE, AND AT A MINIMUM SPECIFIES THAT:

(1) THE HOSPICE SUPPLIES THE INPATIENT PROVIDER A COPY OF THE PATIENT'S PLAN OF CARE AND SPECIFIES THE INPATIENT SERVICES TO BE FURNISHED;

(2) THE INPATIENT PROVIDER HAS ESTABLISHED PATIENT CARE POLICIES CONSISTENT WITH THOSE OF THE HOSPICE AND AGREES TO ABIDE BY THE HOSPICE PLAN OF CARE;

(3) THE HOSPICE PATIENT'S INPATIENT CLINICAL RECORD INCLUDES ALL ASPECTS OF THE PATIENT'S CARE, CONDITION AND SERVICES FURNISHED DURING THE PATIENT'S INPATIENT STAY. A COPY OF THE INPATIENT FACILITY'S DISCHARGE SUMMARY SHALL BE PROVIDED TO THE HOSPICE AT THE TIME OF THE INPATIENT FACILITY'S DISCHARGE. A COPY OF THE INPATIENT FACILITY'S COMPLETE CLINICAL RECORD SHALL BE AVAILABLE TO THE HOSPICE, AND

(4) THE INPATIENT FACILITY HAS IDENTIFIED AN INDIVIDUAL WITHIN THE FACILITY WHO IS RESPONSIBLE FOR THE IMPLEMENTATION OF THE PROVISIONS OF THE WRITTEN AGREEMENT.

SECTION 11 HOSPICE INPATIENT FACILITY

11.1 STAFFING

(A) THE FACILITY SHALL PROVIDE 24 HOURS A DAY NURSING SERVICES THAT MEET THE NURSING NEEDS OF ALL PATIENTS AND ARE FURNISHED IN ACCORDANCE WITH EACH PATIENT'S PLAN OF CARE. EACH PATIENT SHALL RECEIVE ALL NURSING SERVICES AS PRESCRIBED AND SHALL BE KEPT COMFORTABLE, CLEAN, WELL GROOMED, AND PROTECTED FROM ACCIDENT, INJURY, AND INFECTION.

(B) IF AT LEAST ONE PATIENT IN THE FACILITY IS RECEIVING ACUTE SHORT-TERM INPATIENT CARE, THEN EACH SHIFT SHALL INCLUDE A REGISTERED NURSE WHO PROVIDES DIRECT PATIENT CARE.

(C) THE FACILITY SHALL ALSO PROVIDE, AS NECESSARY, FOR THE AVAILABILITY AND PROMPT RESPONSE OF ALL OTHER CORE SERVICES.

11.2. ENVIRONMENT

THE FACILITY SHALL MEET ALL STATE AND LOCAL LAWS AND REGULATIONS PERTAINING TO HEALTH, SAFETY, ACCESSIBILITY AND ZONING REGULATIONS.

(A) SAFETY MANAGEMENT

(1) THE FACILITY SHALL INVESTIGATE AND CORRECT REAL OR POTENTIAL THREATS TO THE HEALTH AND SAFETY OF THE PATIENTS, OTHERS, AND PROPERTY.

(2) THE FACILITY SHALL HAVE A WRITTEN DISASTER PREPAREDNESS PLAN IN EFFECT FOR MANAGING THE CONSEQUENCES OF POWER FAILURES, NATURAL DISASTERS, AND OTHER EMERGENCIES THAT WOULD AFFECT THE HOSPICE'S ABILITY TO PROVIDE CARE. THE PLAN SHALL BE PERIODICALLY REVIEWED AND REHEARSED WITH STAFF (INCLUDING NON-EMPLOYEE STAFF) WITH SPECIAL EMPHASIS PLACED ON CARRYING OUT THE PROCEDURES NECESSARY TO PROTECT PATIENTS AND OTHERS.

(B) PHYSICAL PLANT AND EQUIPMENT

THE FACILITY SHALL ENSURE:

(1) ADEQUATE LIGHT, COMFORTABLE TEMPERATURE, AND APPROPRIATE VENTILATION/AIR EXCHANGES THROUGHOUT THE FACILITY;

(2) EMERGENCY GAS, ELECTRICAL AND WATER SUPPLY;

(3) AVAILABILITY OF HOT WATER AT ALL TIMES WITH PLUMBING FIXTURES THAT REGULATE THE WATER TEMPERATURE;

(4) SCHEDULED AND EMERGENCY MAINTENANCE AND REPAIR OF ALL EQUIPMENT;

(5) A SEPARATE CLEAN HOLDING AREA EQUIPPED WITH:

(A) COUNTER;

(B) SINK WITH MIXING FAUCET;

(C) SINK WITH BLADE CONTROLS;

(D) SOAP AND HAND-WASHING AND DRYING EQUIPMENT;

(E) WASTE CONTAINER, AND

(F) SHELF SPACE FOR SUPPLIES.

(6) A SEPARATE SOILED HOLDING AREA EQUIPPED WITH:

(A) COUNTER;

(B) SINK WITH MIXING FAUCET;

(C) SINK WITH BLADE CONTROLS;

(D) SOAP AND HAND-WASHING AND DRYING EQUIPMENT;

(E) COVERED BIO-HAZARD WASTE CONTAINER;

(F) COVERED WASTE CONTAINER;

(G) SOILED LINEN HAMPER WITH IMPERVIOUS LINER, AND

(H) SHELF SPACE FOR SUPPLIES.

(7) A CUSTODIAL CLOSET EQUIPPED WITH:

(A) CLEANING EQUIPMENT AND SUPPLIES;

(B) FLOOR-MOUNTED SINK WITH MIXING FAUCETS;

(C) SHELF SPACE AND APPROPRIATE STORAGE, AND

(D) WASTE RECEPTACLES.

(C) SANITATION

THE FACILITY SHALL PROVIDE:

(1) A SANITARY ENVIRONMENT ADHERING TO CURRENT STANDARDS OF PRACTICE, INCLUDING NATIONALLY RECOGNIZED INFECTION CONTROL PRECAUTIONS;

(2) ROUTINE STORAGE AND PROMPT DISPOSAL OF TRASH AND MEDICAL WASTE;

(3) CLEAN LINEN IN SUFFICIENT AMOUNTS FOR ALL PATIENT USES THAT IS HANDLED IN SUCH A MANNER AS TO PREVENT THE SPREAD OF CONTAMINANTS;

(4) BED LINEN THAT IS CHANGED AS OFTEN AS NECESSARY BUT NO LESS THAN TWO TIMES PER WEEK;

(5) PATIENT MEDICAL SUPPLIES AND EQUIPMENT THAT ARE STORED SEPARATELY AND HANDLED IN SUCH A MANNER AS TO PREVENT THE SPREAD OF CONTAMINANTS, AND

(6) A PROGRAM TO EFFECTIVELY CONTROL INSECT, RODENT AND PEST INFESTATIONS.

11.3 PATIENT AREAS

THE FACILITY SHALL PROVIDE:

(A) PRIVATE SPACE FOR PATIENT/FAMILY VISITING;

(B) ADEQUATE DINING SPACE;

(C) ACCOMMODATIONS FOR FAMILY MEMBERS TO REMAIN WITH THE PATIENT OVERNIGHT;

(D) PRIVATE SPACE FOR FAMILY FOLLOWING A PATIENT'S DEATH; AND

(E) FLEXIBLE VISITING HOURS THAT DO NOT EXCLUDE CHILDREN OR PETS.

11.4 PATIENT ROOMS

THE FACILITY SHALL PROVIDE:

(A) PATIENT ROOMS DESIGNED AND EQUIPPED TO PROVIDE CLINICAL CARE, COMFORT AND PRIVACY OF PATIENTS;

(B) AGE AND GENDER APPROPRIATE ROOM ASSIGNMENTS;

(C) ACCOMMODATION FOR A SINGLE ROOM WHEN POSSIBLE UPON PATIENT OR FAMILY REQUEST;

(D) PATIENT ROOMS THAT:

(1) ARE AT OR ABOVE GRADE LEVEL;

(2) PROVIDE AT LEAST 80 SQUARE FEET FOR EACH PATIENT IN A DOUBLE ROOM AND AT LEAST 100 SQUARE FEET FOR EACH PATIENT IN A SINGLE ROOM;

(3) ACCOMMODATE NO MORE THAN TWO PATIENTS;

(4) CONTAIN A SUITABLE BED AND OTHER APPROPRIATE FURNITURE FOR EACH PATIENT;

(5) HAVE PRIVATE CLOSET SPACE FOR CLOTHING AND PERSONAL BELONGINGS;

(6) ARE EQUIPPED WITH AN EASILY-ACTIVATED DEVICE ACCESSIBLE TO EACH PATIENT TO CALL FOR ASSISTANCE, AND

(7) HAVE TOILET AND BATHING FACILITIES THAT ARE EASILY ACCESSIBLE FROM EACH PATIENT ROOM AND EQUIPPED WITH GRAB BARS AND AN EASILY ACCESSIBLE DEVICE TO CALL FOR ASSISTANCE.

(A) FOR EXISTING FACILITIES, ONE TOILET MAY SERVICE TWO PATIENT ROOMS ONLY IF EACH PATIENT ROOM ALSO HAS A SINK.

(B) FOR NEW CONSTRUCTION AFTER MARCH 1, 2012, THERE SHALL BE A MINIMUM OF ONE TOILET FOR EVERY TWO BEDS.

11.5 STAFF AREAS

THE FACILITY SHALL PROVIDE STAFF AREAS DESIGNED AND EQUIPPED FOR DOCUMENTATION, MEDICAL RECORDS, COMMUNICATIONS, OFFICE SUPPLIES AND EQUIPMENT, AND STAFF PERSONAL EFFECTS.

11.6 DIETARY

THE FACILITY SHALL PROVIDE MEALS AND/OR FOOD CHOICES AT REGULAR INTERVALS OR AT A VARIETY OF TIMES DEPENDING UPON THE NEEDS OF THE PATIENTS. FOOD SHALL BE AVAILABLE ON A 24-HOUR, SEVEN-DAY A WEEK BASIS AND BE:

(A) CONSISTENT WITH THE PATIENT'S CHOICE, PLAN OF CARE, NUTRITIONAL NEEDS, AND THERAPEUTIC DIET;

(B) PALATABLE AND ATTRACTIVE;

(C) SERVED AT THE PROPER TEMPERATURE, AND

(D) OBTAINED, STORED, PREPARED, DISTRIBUTED, AND SERVED IN COMPLIANCE WITH LOCAL SANITARY REGULATIONS.

OTHER FORMS OF NOURISHMENT SHALL BE PROVIDED ACCORDING TO THE PATIENT'S PLAN OF CARE.

11.7 PHARMACEUTICAL SERVICES

(A) THE FACILITY SHALL OBTAIN DRUGS AND BIOLOGICALS IN COMPLIANCE WITH FEDERAL AND STATE LAW INCLUDING COLORADO BOARD OF PHARMACY REGULATIONS.

(B) THE FACILITY SHALL:

(1) HAVE A WRITTEN POLICY AND PROCEDURE FOR ACCURATE DISPENSING OF PHARMACEUTICALS, AND

(2) MAINTAIN CURRENT AND ACCURATE RECORDS OF THE RECEIPT AND DISPOSITION OF ALL CONTROLLED SUBSTANCES.

(C) THE FACILITY SHALL LIMIT THE ADMINISTRATION OF PATIENT MEDICATIONS TO THE FOLLOWING INDIVIDUALS:

(1) A LICENSED NURSE, PHYSICIAN, OR OTHER HEALTH CARE PROFESSIONAL IN ACCORDANCE WITH THEIR SCOPE OF PRACTICE AND STATE LAW; OR

(2) THE PATIENT, UPON APPROVAL BY THE INTERDISCIPLINARY GROUP.

(D) THE FACILITY SHALL DISPOSE OF MEDICATIONS IN COMPLIANCE WITH THE HOSPICE POLICY AND IN ACCORDANCE WITH STATE AND FEDERAL REQUIREMENTS. THE FACILITY SHALL MAINTAIN CURRENT AND ACCURATE RECORDS OF THE RECEIPT AND DISPOSITION OF ALL CONTROLLED SUBSTANCES.

(E) THE FACILITY SHALL COMPLY WITH THE FOLLOWING ADDITIONAL REQUIREMENTS:

(1) ALL MEDICATIONS AND BIOLOGICALS SHALL BE STORED IN SECURE AREAS. ALL CONTROLLED SUBSTANCES LISTED IN SCHEDULES II, III, IV, AND V OF THE COMPREHENSIVE DRUG ABUSE PREVENTION AND CONTROL ACT OF 1976 SHALL BE STORED IN LOCKED COMPARTMENTS WITHIN SECURE STORAGE AREAS. ONLY PERSONNEL AUTHORIZED TO ADMINISTER CONTROLLED SUBSTANCES AS NOTED IN SECTION 11.7(C) OF THIS CHAPTER SHALL HAVE ACCESS TO THE LOCKED COMPARTMENTS; AND

(2) DISCREPANCIES IN THE ACQUISITION, STORAGE, DISPENSING, ADMINISTRATION, DISPOSAL, OR RETURN OF CONTROLLED SUBSTANCES SHALL BE INVESTIGATED IMMEDIATELY BY THE HOSPICE ADMINISTRATOR OR DESIGNEE AND/OR THE PHARMACIST AND WHERE REQUIRED REPORTED TO THE APPROPRIATE STATE AUTHORITY. A WRITTEN ACCOUNT OF THE INVESTIGATION SHALL BE MADE AVAILABLE TO STATE AND FEDERAL OFFICIALS IF REQUIRED BY LAW OR REGULATION.

SECTION 12 INFECTION CONTROL

12.1 THE HOSPICE SHALL MAINTAIN AND DOCUMENT AN EFFECTIVE INFECTION CONTROL PROGRAM THAT PROTECTS PATIENTS, FAMILIES, VISITORS, AND HOSPICE PERSONNEL BY PREVENTING AND CONTROLLING INFECTIONS AND COMMUNICABLE DISEASES.

12.2 THE HOSPICE SHALL EVALUATE THE ADEQUACY AND EFFECTIVENESS OF ITS INFECTION CONTROL PROGRAM AT LEAST ANNUALLY AND IMPLEMENT NECESSARY CHANGES.

12.3 THE HOSPICE SHALL FOLLOW ACCEPTED STANDARDS OF PRACTICE TO PREVENT THE TRANSMISSION OF INFECTIONS AND COMMUNICABLE DISEASES, INCLUDING THE USE OF STANDARD PRECAUTIONS.

12.4 THE HOSPICE SHALL PROVIDE INFECTION CONTROL EDUCATION TO STAFF, PATIENTS, AND FAMILY MEMBERS OR OTHER CAREGIVERS.

SECTION 13 GENERAL BUILDING AND LIFE SAFETY CODE REQUIREMENTS

13.1 COMPLIANCE WITH THE LIFE SAFETY CODE. FACILITIES WITH ONE OR MORE INPATIENT BEDS SHALL BE COMPLIANT WITH THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101, LIFE SAFETY CODE (2000), WHICH IS HEREBY INCORPORATED BY REFERENCE. SUCH INCORPORATION BY REFERENCE, AS PROVIDED FOR IN 6 CCR 1011-1, CHAPTER II, EXCLUDES LATER AMENDMENTS TO OR EDITIONS OF REFERENCED MATERIAL.

(A) FACILITIES LICENSED ON OR BEFORE MARCH 11, 2003 SHALL MEET CHAPTER 19, EXISTING HEALTH CARE OCCUPANCIES, NFPA 101 (2000).

(B) FACILITIES LICENSED ON OR AFTER MARCH 11, 2003 OR PORTIONS OF FACILITIES THAT UNDERGO REMODELING ON OR AFTER OCTOBER 1, 2003 SHALL MEET CHAPTER 18, NEW HEALTH CARE OCCUPANCIES, NFPA 101 (2000). IN ADDITION, IF THE REMODEL REPRESENTS A MODIFICATION OF MORE THAN 50 PERCENT, OR MORE THAN 4,500 SQUARE FEET OF THE SMOKE COMPARTMENT, THE ENTIRE SMOKE COMPARTMENT SHALL BE RENOVATED TO MEET CHAPTER 18, NFPA 101 (2000).

(C) NOTWITHSTANDING NFPA 101 LIFE SAFETY CODE PROVISIONS TO THE CONTRARY:

(1) WHEN DIFFERING FIRE SAFETY STANDARDS ARE IMPOSED BY FEDERAL, STATE OR LOCAL JURISDICTIONS, THE MOST STRINGENT STANDARD SHALL APPLY.

(2) ANY STORY CONTAINING AN EXTERIOR DOOR OR AN EXTERIOR WINDOW THAT OPENS TO GRADE LEVEL SHALL BE COUNTED AS A STORY.

(3) LICENSED FACILITIES SHALL BE SEPARATED FROM UNLICENSED CONTIGUOUS OCCUPANCIES BY AN OCCUPANCY SEPARATION WITH A FIRE RESISTANCE RATING OF NOT LESS THAN 2 HOURS.

(4) A HEALTH CARE OCCUPANCY SHALL BE DEFINED AS THE OPERATION IN SUCH OCCUPANCY OF ONE OR MORE INPATIENT BEDS.

13.2 PLAN REVIEW AND PLAN REVIEW FEES. PLAN REVIEW AND PLAN REVIEW FEES ARE REQUIRED AS LISTED BELOW. IF THE FACILITY HAS BEEN APPROVED BY THE DEPARTMENT TO USE MORE THAN ONE BUILDING FOR THE DIRECT CARE OF PATIENTS ON ITS CAMPUS, EACH BUILDING IS SUBJECT TO THE APPLICABLE BASE FEE PLUS SQUARE FOOTAGE COSTS. FEES ARE NONREFUNDABLE AND SHALL BE SUBMITTED PRIOR TO THE DEPARTMENT INITIATING A PLAN REVIEW FOR A FACILITY.

(A) INITIAL LICENSURE, ADDITIONS, RELOCATIONS

(1) PLAN REVIEW IS APPLICABLE TO THE FOLLOWING, AND INCLUDES NEW FACILITY CONSTRUCTION AND NEW OCCUPANCY OF EXISTING STRUCTURES:

(A) APPLICATIONS FOR AN INITIAL LICENSE, WHEN SUCH INITIAL LICENSE IS NOT A CHANGE OF OWNERSHIP AND THE APPLICATION IS SUBMITTED ON OR AFTER JULY 1, 2009.

(B) ADDITIONS OF PREVIOUSLY UNINSPECTED OR UNLICENSED SQUARE FOOTAGE TO AN EXISTING OCCUPANCY AND THE BUILDING PERMIT FOR SUCH ADDITION IS ISSUED ON OR AFTER JULY 1, 2009 OR IF NO PERMIT IS REQUIRED BY THE LOCAL JURISDICTION, CONSTRUCTION BEGAN ON OR AFTER JULY 1, 2009.

(C) RELOCATIONS OF A CURRENTLY LICENSED FACILITY IN WHOLE OR IN PART TO ANOTHER PHYSICAL PLANT, WHERE THE OCCUPANCY DATE OCCURS ON OR AFTER JULY 1, 2009.

(2) INITIAL LICENSURE, ADDITION, AND RELOCATION PLAN REVIEW FEES: BASE FEE OF $2,500, PLUS SQUARE FOOTAGE COSTS AS SHOWN IN THE TABLE BELOW.

SQUARE FOOTAGE	COST PER SQUARE FOOT	EXPLANATORY NOTE
0-25,000 SQ FT	$0.10	THIS IS THE COST FOR THE FIRST 25,000 SQ FT OF ANY PLAN SUBMITTED.

25,001+ SQ FT	$0.01	THIS COST IS APPLICABLE TO THE ADDITIONAL SQUARE FOOTAGE OVER 25,000 SQ FT.

(B) REMODELING

(1) PLAN REVIEW IS APPLICABLE TO REMODELING FOR WHICH THE APPLICATION FOR THE BUILDING PERMIT FROM THE LOCAL AUTHORITY HAVING JURISDICTION IS DATED ON OR AFTER JULY 1, 2009, OR IF NO PERMIT IS REQUIRED BY THE LOCAL JURISDICTION, CONSTRUCTION BEGAN ON OR AFTER JULY 1, 2009. REMODELING INCLUDES, BUT IS NOT LIMITED TO:

(A) ALTERATION, IN PATIENT SLEEPING AREAS, OF A STRUCTURAL ELEMENT SUBJECT TO LIFE SAFETY CODE STANDARDS, SUCH AS EGRESS DOOR WIDTHS AND SMOKE OR FIRE RESISTING WALLS.

(B) RELOCATION, REMOVAL OR INSTALLATION OF WALLS THAT RESULTS IN ALTERATION OF 25% OR MORE OF THE EXISTING HABITABLE SQUARE FOOTAGE OR 50% OR MORE OF A SMOKE COMPARTMENT.

(C) CONVERSION OF EXISTING SPACE NOT PREVIOUSLY USED FOR PROVIDING PATIENT SERVICES, INCLUDING STORAGE SPACE, TO RESIDENT SLEEPING AREAS.

(D) CHANGES TO EGRESS COMPONENTS, SPECIFICALLY THE ALTERATION OF A STRUCTURAL ELEMENT, RELOCATION, OR ADDITION OF AN EGRESS COMPONENT. EXAMPLES OF EGRESS COMPONENTS INCLUDE, BUT ARE NOT LIMITED TO, CORRIDORS, STAIRWELLS, EXIT ENCLOSURES, AND POINTS OF REFUGE.

(E) INSTALLATION OF ANY NEW SPRINKLER SYSTEMS OR THE ADDITION, REMOVAL OR RELOCATION OF 20 OR MORE SPRINKLER HEADS.

(F) INSTALLATION OF ANY NEW FIRE ALARM SYSTEM, OR ADDITION, REMOVAL OR RELOCATION OF 20 OR MORE FIRE ALARM SYSTEM APPLIANCES INCLUDING, BUT NOT LIMITED TO, PULL STATIONS, DETECTORS AND NOTIFICATION DEVICES.

(G) INSTALLATION, REMOVAL OR RENOVATION OF ANY KITCHEN HOOD SUPPRESSION SYSTEM.

(H) ESSENTIAL ELECTRICAL SYSTEM: REPLACEMENT OR ADDITION OF A GENERATOR OR TRANSFER SWITCH.

(2) REMODELING PLAN REVIEW FEES: BASE FEE OF $2,000, PLUS SQUARE FOOTAGE COSTS AS SHOWN IN THE TABLE BELOW.

SQUARE FOOTAGE	COST PER SQUARE FOOT	EXPLANATORY NOTE
0-20,000 SQ FT	$0.08	THIS IS THE COST FOR THE FIRST 20,000 SQ FT OF ANY PLAN SUBMITTED.
20,001+ SQ FT	$0.01	THIS COST IS APPLICABLE TO THE ADDITIONAL SQUARE FOOTAGE OVER 20,000 SQ FT.

13.3 THE "GUIDELINES OF DESIGN AND CONSTRUCTION OF HEALTH CARE FACILITIES" (2006 EDITION), AMERICAN INSTITUTE OF ARCHITECTS (AIA), MAY BE USED BY THE DEPARTMENT IN RESOLVING HEALTH, BUILDING, AND LIFE SAFETY ISSUES FOR CONSTRUCTION INITIATED OR SYSTEMS INSTALLED ON OR AFTER JULY 1, 2009. AIA GUIDELINES ARE HEREBY INCORPORATED BY REFERENCE. SUCH INCORPORATION BY REFERENCE, AS PROVIDED FOR IN 6 CCR 1011-1, CHAPTER II, EXCLUDES LATER AMENDMENTS TO OR EDITIONS OF REFERENCED MATERIAL.

SECTION 14 LICENSE FEES

14.1 ALL LICENSE FEES ARE NON-REFUNDABLE AND THE APPLICABLE FEE TOTAL SHALL BE SUBMITTED WITH THE APPROPRIATE LICENSE APPLICATION.

14.2 INITIAL LICENSE - $6,370 PER HOSPICE.

(A) IF THERE ARE NO LICENSED HOSPICES WITHIN A 60-MILE RADIUS OF THE HOSPICE APPLYING FOR AN INITIAL LICENSE, THE INITIAL LICENSE FEE SHALL BE $4,150 PER HOSPICE.

14.3 ANNUAL RENEWAL LICENSE

(A) RENEWAL LICENSE FEES SHALL BE PHASED IN OVER TWO YEARS. FOR LICENSES WITH A RENEWAL DATE BETWEEN OCTOBER 1, 2010 AND SEPTEMBER 30, 2011, THE RENEWAL FEE SHALL BE $1950 PER HOSPICE, EXCEPT AS SET FORTH IN PARAGRAPHS (1) THROUGH (7) BELOW.

(1) FOR A HOSPICE THAT IS PHYSICALLY LOCATED IN A COUNTY OTHER THAN ADAMS, ARAPAHOE, BOULDER, BROOMFIELD, DENVER, DOUGLAS, EL PASO, JEFFERSON, LARIMER, PUEBLO OR WELD; AND THAT PROVIDES AT LEAST 75 PERCENT OF ITS SERVICES IN COUNTIES OTHER THAN THOSE NAMED IN THIS PARAGRAPH, THE FEE SHALL BE $1,200 PER HOSPICE.

(2) FOR HOSPICES WITH LESS THAN 2000 ANNUAL PATIENT DAYS, AS REPORTED ON THE MOST RECENT MEDICARE COST REPORT, THE FEE SHALL BE $750 PER HOSPICE.

(3) FOR HOSPICES WITH LESS THAN 1000 ANNUAL PATIENT DAYS, AS REPORTED ON THE MOST RECENT MEDICARE COST REPORT, THE FEE SHALL BE $375 PER HOSPICE.

(4) A DISCOUNT OF $150 PER HOSPICE SHALL APPLY IF THE SAME BUSINESS ENTITY OWNS SEPARATELY LICENSED HOSPICES AT MORE THAN ONE COLORADO LOCATION,

(5) A DISCOUNT OF $212 SHALL APPLY IF THE HOSPICE IS DEEMED BY AN ACCREDITING ORGANIZATION RECOGNIZED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND REMAINS IN GOOD STANDING WITH THAT ORGANIZATION. TO BE CONSIDERED FOR THIS DISCOUNT, THE HOSPICE SHALL AUTHORIZE ITS ACCREDITING ORGANIZATION TO SUBMIT DIRECTLY TO THE DEPARTMENT COPIES OF ALL THE HOSPICE'S SURVEYS AND PLAN(S) OF CORRECTION FOR THE PREVIOUS LICENSE YEAR, ALONG WITH THE MOST RECENT LETTER OF ACCREDITATION SHOWING THE HOSPICE HAS FULL ACCREDITATION STATUS.

(6) UPON REQUEST, THE DEPARTMENT MAY WAIVE THE FEE FOR A HOSPICE THAT DEMONSTRATES IT IS A NOT-FOR-PROFIT ORGANIZATION THAT CHARGES NO FEES AND IS STAFFED ENTIRELY BY UNCOMPENSATED VOLUNTEERS.

(7) FOR HOSPICES THAT HAVE THE SAME OWNERSHIP AND GOVERNING BODY AND THAT PROVIDE HOSPICE CARE IN BOTH THE HOME AND INPATIENT OR RESIDENTIAL HOSPICE SETTINGS, THE FEE SHALL BE AS FOLLOWS AND NO OTHER DISCOUNTS SHALL APPLY:

(A) WHEN BOTH SERVICE MODELS ARE CONTAINED IN THE SAME PHYSICAL LOCATION, THE LICENSE FEE SHALL BE $3,200.

(B) WHEN THE SERVICES ARE NOT IN THE SAME PHYSICAL LOCATION BUT ARE WITHIN A 10-MILE DRIVE OF EACH OTHER, THE HOME CARE HOSPICE AND THE INPATIENT HOSPICE SHALL EACH PAY A SEPARATE LICENSE FEE OF $1,600.

(A) EFFECTIVE OCTOBER 1, 2011, THE BASE RENEWAL FEE SHALL BE $3,900 PER HOSPICE. THE TOTAL RENEWAL FEE SHALL REFLECT ALL APPLICABLE ADJUSTMENTS AS SET FORTH BELOW.

(1) FOR A HOSPICE THAT IS PHYSICALLY LOCATED IN A COUNTY OTHER THAN ADAMS, ARAPAHOE, BOULDER, BROOMFIELD, DENVER, DOUGLAS, EL PASO, JEFFERSON, LARIMER, PUEBLO OR WELD; AND THAT PROVIDES AT LEAST 75 PERCENT OF ITS SERVICES IN COUNTIES OTHER THAN THOSE NAMED IN THIS PARAGRAPH, THE FEE SHALL BE $2,400 PER HOSPICE.

(2) FOR HOSPICES WITH LESS THAN 2000 ANNUAL PATIENT DAYS, AS REPORTED ON THE MOST RECENT MEDICARE COST REPORT, THE FEE SHALL BE $1,500 PER HOSPICE.

(3) FOR HOSPICES WITH LESS THAN 1000 ANNUAL PATIENT DAYS, AS REPORTED ON THE MOST RECENT MEDICARE COST REPORT, THE FEE SHALL BE $750 PER HOSPICE.

(4) A DISCOUNT OF $300 PER HOSPICE SHALL APPLY IF THE SAME BUSINESS ENTITY OWNS SEPARATELY LICENSED HOSPICES AT MORE THAN ONE COLORADO LOCATION,

(5) A DISCOUNT OF $425 SHALL APPLY IF THE HOSPICE IS DEEMED BY AN ACCREDITING ORGANIZATION RECOGNIZED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND REMAINS IN GOOD STANDING WITH THAT ORGANIZATION. TO BE CONSIDERED FOR THIS DISCOUNT, THE HOSPICE SHALL AUTHORIZE ITS ACCREDITING ORGANIZATION TO SUBMIT DIRECTLY TO THE DEPARTMENT COPIES OF ALL THE HOSPICE'S SURVEYS AND PLAN(S) OF CORRECTION FOR THE PREVIOUS LICENSE YEAR, ALONG WITH THE MOST RECENT LETTER OF ACCREDITATION SHOWING THE HOSPICE HAS FULL ACCREDITATION STATUS.

(6) UPON REQUEST, THE DEPARTMENT MAY WAIVE THE FEE FOR A HOSPICE THAT DEMONSTRATES IT IS A NOT FOR PROFIT ORGANIZATION THAT CHARGES NO FEES AND IS STAFFED ENTIRELY BY UNCOMPENSATED VOLUNTEERS.

(7) FOR HOSPICES THAT HAVE THE SAME OWNERSHIP AND GOVERNING BODY AND THAT PROVIDE HOSPICE CARE IN BOTH THE HOME AND INPATIENT HOSPICE SETTINGS, THE FEE SHALL BE AS FOLLOWS AND NO OTHER DISCOUNTS SHALL APPLY:

(A) WHEN BOTH SERVICE MODELS ARE CONTAINED IN THE SAME PHYSICAL LOCATION, THE LICENSE FEE SHALL BE $6,400.

(B) WHEN THE SERVICES ARE NOT IN THE SAME PHYSICAL LOCATION BUT ARE WITHIN A 10-MILE DRIVE OF EACH OTHER, THE HOME CARE HOSPICE AND THE INPATIENT HOSPICE SHALL EACH PAY A SEPARATE LICENSE FEE OF $3,200.

14.4 WORKSTATION FEES

(A) A WORKSTATION IS AN OFFSITE LOCATION MAINTAINED SOLELY FOR THE CONVENIENCE OF HOSPICE STAFF TO ACCESS POLICIES AND PROCEDURES, OBTAIN FORMS OR USE VARIOUS ELECTRONIC COMMUNICATION TOOLS. A WORKSTATION SHALL NOT CONTAIN PATIENT RECORDS OR BE USED FOR PATIENT ADMISSIONS AND SHALL NOT DISPLAY ANY PUBLIC SIGNAGE.

(B) IN ADDITION TO ANY OTHER LICENSURE FEES, A HOSPICE THAT OPERATES ONE OR MORE SATELLITE WORKSTATIONS SHALL PAY AN ANNUAL FEE OF $50 PER WORKSTATION. THE FEE SHALL BE SUBMITTED WITH THE INITIAL AND/OR RENEWAL LICENSE APPLICATION.

14.5 CHANGE OF OWNERSHIP - CHANGE OF OWNERSHIP SHALL BE DETERMINED IN ACCORDANCE WITH THE CRITERIA SET FORTH IN CHAPTER II, PART 2. THE FEE SHALL BE $6,370 PER HOSPICE.