COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Steve Cox, Home and Community Services Branch Chief, and Jo Tansey, Acute Care and Nursing Facilities Branch Chief, Health Facilities and Emergency Medical Services Division

Through: Elaine McManis, Division Director *E.M.*

Date: April 19, 2023

Subject: Request for a Rulemaking Hearing concerning 6 CCR 1011-1, Standards for Hospitals and Health Care Facilities, Chapter 5 – Nursing Care Facilities and Chapter 7 – Assisted Living Residences

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The Department is requesting consideration of several sets of rules in the attached package. These rules are responsive to two laws passed in 2022:

Senate Bill 22-079 which requires dementia training for direct-care staff and
Senate Bill 22-053 which provides a visitation right for residents.

Because the two bills apply to both nursing care facilities and assisted living residences, the Department is presenting a packet that includes changes to both 6 CCR 1011-1, Chapter 5 – Nursing Care Facilities and 6 CCR 1011-1, Chapter 7 – Assisted Living Residences. The additions addressing dementia training and visitation rights are substantially the same in each chapter, although the placement of language is unique to the structure of existing rules within the chapter.

The proposed dementia training mandates, as located in SB 22-079, require that all current direct care staff complete at least four hours of initial dementia training. The effective date of the requirement is October 1, 2023, and all staff must be trained no later than 120 days after that date. An additional two hours of continuing education is required for the same staff every two years after the initial training. Facilities must provide the training at no cost to employees, and facilities bear the responsibility for tracking the completion of training as well as ensuring that the trainer providing the education meets the minimum qualifications. Such documentation will be provided to the employee for ease of movement to another job. Facilities will develop policies and procedures for the implementation of this requirement.

Senate Bill 22-053 grants visitation rights to residents of nursing homes and assisted living residences but provides for some limitations during "a period when the risk of transmission of a communicable disease is heightened." The proposed rules provide definitions for several new terms and focus on the development of policies and procedures to ensure that visitation is available to residents even during a communicable disease outbreak.

In addition, a non-substantive change is being proposed for Chapter 5. Staff have added an index to promote easier usage of the rules.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 CCR 1011-1, Standards for Hospitals and Health Care Facilities, Chapter 5 – Nursing Care Facilities and Chapter 7 – Assisted Living Residences

Basis and Purpose.
The Department is proposing rules to address mandates created in two laws passed during the 2022 legislative session:

- Senate Bill 22-079, "Concerning required dementia training for direct-care staff of specified facilities that provide services to clients living with dementia," and
- Senate Bill 22-053, "Concerning visitation rights at health-care facilities…"

Both laws direct the Board of Health to adopt rules regarding these subjects, and both address the same facility types - assisted living residences and nursing care facilities. The requirements for the two facility types are identical, thus the Department has undertaken a single public process including constituents from both facility types and subject matter experts on both topics to address the requirements in these laws.

The proposed rules regarding SB 22-079, the dementia training requirements, include:

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

Senate Bill 22-0-79 requires the Board of Health to adopt rules regarding training requirements no later than January 1, 2024.

The proposed rules regarding SB 22-053, the requirement for visitation rights, include:

- New definitions of advance medical directive, caregiver, communicable disease, compassionate care visit, essential caregiver, and patient or resident with a disability.
- A resident right to visitation.
- Requirements for visitation policies and procedures at every facility.
- Limitations to the visitation right allowed by law during heightened risk of a communicable disease.

In addition, an index of chapter topics has been added to Chapter 5 Nursing Care Facilities. Similar indices have been added to other chapters, but this user-oriented tool was missing from Chapter 5.

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

Specific Statutory Authority.
Statutes that require or authorize rulemaking:
Section 25-1-12, C.R.S.
Section 25-1.5-118, C.R.S.
Section 25-3-125, C.R.S.
Section 25-1.5-103, C.R.S.
Section 25-27-104, C.R.S.

Is this rulemaking due to a change in state statute?

____XX__ Yes, the bill number is SB22-079 and SB22-053. Rules are ___ authorized
_XX__ required.
______ No

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

______ Yes ___ URL
__XX__ No

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

______ Yes
__XX__ No

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

_XX__ No.

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

REGULATORY ANALYSIS
for Amendments to
6 CCR 1011-1, Standards for Hospitals and Health Care Facilities, Chapter 5 – Nursing Care Facilities and Chapter 7 – Assisted Living Residences

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

Group of persons/entities Affected by the Proposed Rule	Size of the Group	Relationship to the Proposed Rule Select category: C/S/B
Licensed Nursing Care Facilities	223	C
Licensed Assisted Living Residences	689	C
Residents of Nursing Care Facilities (20,300 licensed beds)	Number unknown	B
Residents of Assisted Living Residences (25,296 licensed beds)	Number unknown	B
Friends, family members, guardians, etc. of residents.	Number unknown	S, B

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

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

More than one category may be appropriate for some stakeholders.

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

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

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

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

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

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

   there will not be a need for additional training for some individuals, particularly those working in a secure environment. The exception will also apply to anyone who has taken equivalent training as defined in the rule, within the 24 months prior to the effective date of the dementia training requirement in this rule or the start date of the employment.

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

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

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

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

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

requirements.

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

S: N/A

B: The residents of ALRs and NCFs may bear the burden of slight cost increases to meet the new requirements for additional staff training. It is not anticipated that this would be significant compared to the cost of other services offered by facility.

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

C:
SB22-079 – Dementia Training
When the new dementia training requirements become effective (proposed for October 1, 2023), facilities will have 120 days to ensure that all direct-care staff members receive the initial four-hour training or qualify for an exception if staff has received an equivalent training prior to October 1, 2023. Facility administrators will need to research training opportunities and ensure that all employees are compliant no later than January 29, 2024 (a 120 days after October 1). However, any training that is equivalent to the proposed rules and is taken prior to October 1, 2023, will also be allowable, so the cost and time away from work for all can be spread over the coming months. Also, this will require some small amount of additional time in the hiring process as the administrator or designee will need to check credentials for new employees who are claiming an exception, as well as the ongoing need to track initial training and continuing education for all employees. The additional time and effort should result in a better-trained staff caring for residents.

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

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

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

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

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

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

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

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

      Explain whether it is a net neutral, supported by an internal shift in resources, absorbable or if funding was provided to support the rule change via the long bill, new legislation, etc. If the funding ties to new legislation, consider using a table comparable to the fiscal note. Example:

Type of Expenditure	Year 1	Appropriation	Year 2
SB22-053 0.6 FTE	$54,390	$45,409 (general fund)	$54,390
SB22-079 0.7 FTE	$90,868	$0	
SB22-079 0.4 FTE			$48,218
Total			

Costs for SB 22-053 (visitation): The Department anticipates an ongoing need of 0.6 FTE for personal services (surveyor positions) to investigate any complaints received by facilities. This is estimated to be $54,390 per year.

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

Anticipated CDPHE Revenues:
N/A

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

Anticipated Revenues for another state agency:

N/A

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

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

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

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

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

policy, practice and environmental changes. ___ Increases physical activity by promoting local and state policies to improve active transportation and access to recreation. ___ Increases the reach of the National Diabetes Prevention Program and Diabetes Self-Management Education and Support by collaborating with the Department of Health Care Policy and Financing.
4. Decrease the number of Colorado children (age 2-4 years) who participate in the WIC Program and have obesity from 2120 to 2115 by June 30, 2020 and to 2100 by June 30, 2023. ___ Ensures access to breastfeeding-friendly environments.
5. Reverse the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023. ___ Reverses the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023. ___ Performs targeted programming to increase immunization rates. ___ Supports legislation and policies that promote complete immunization and exemption data in the Colorado Immunization Information System (CIIS).
6. Colorado will reduce the suicide death rate by 5% by June 30, 2020 and 15% by June 30, 2023. ___ Creates a roadmap to address suicide in Colorado. ___ Improves youth connections to school, positive peers and caring adults, and promotes healthy behaviors and positive school climate. ___ Decreases stigma associated with mental health and suicide, and increases help-seeking behaviors among working-age males, particularly within high-risk industries. ___ Saves health care costs by reducing reliance on emergency departments and connects to responsive community-based resources.
7. The Office of Emergency Preparedness and Response (OEPR) will identify 100% of jurisdictional gaps to inform the required work of the Operational Readiness Review by June 30, 2020. ___ Conducts a gap assessment. ___ Updates existing plans to address identified gaps. ___ Develops and conducts various exercises to close gaps.
8. For each identified threat, increase the competency rating from 0% to 54% for outbreak/incident investigation steps by June 30, 2020 and increase to 92% competency rating by June 30, 2023. ___ Uses an assessment tool to measure competency for CDPHE’s response to an outbreak or environmental incident. ___ Works cross-departmentally to update and draft plans to address identified gaps

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

___ Advance CDPHE Division-level strategic priorities.

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

N/A – these rules are responsive to statutory change, and thus action is required.

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

Rulemaking is required for the dementia training standards; thus there would be no other method allowable for this topic. Further, for both topics, the rules have taken language from the law where possible and added to that language only where directed to by statute, e.g., the law directed the creation of a definition or process. The language proposed in this rulemaking was developed in conjunction with many stakeholders. The benefits, risks, and costs of the proposed language was compared to the costs and benefits of other options. The proposed revisions provide the most benefit for the least amount of cost, are the minimum necessary, and are the most feasible manner to achieve compliance with statute.

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

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

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

Criteria for an "exception to initial training requirement" and definition of "equivalent" training: The law dictates that these topics be addressed in the rule, and they generated considerable discussion. The Department and stakeholders came to agreement that the exception should apply to people who have taken an equivalent training (one that meets the requirements of the initial training) and, if necessary, the continuing education required every two years. These requirements should allow for staff to move between facilities without being required to retake training, unless the facility wishes to require it. Again, facilities are given autonomy in making the decision to require more than the minimums set in law and rule.

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

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

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

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

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

STAKEHOLDER ENGAGEMENT
for Amendments to
6 CCR 1011-1, Standards for Hospitals and Health Care Facilities, Chapter 5 – Nursing Care Facilities and Chapter 7 – Assisted Living Residences

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

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

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

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

	Apeck	
	Beth Williams	
	Brian	
	Bridget Garcia	
	Christin M Palmer	
	Gia Verras	
	Glenice Wade	
	Heather	
	Hilary Samuel	
	J Ackerman	
	Jameson Hendler	
	Janel Tolchin	
	Jenn	
	Jo Johnson	
	Julie	
	Karen	
	Kmagana	
	Krystal	
	Mallory Montoya	
	Mark Jorgensen	
	Melissa Lantham	
	Melissa Wood	
	PMC Platform	
	Raj Rai	
	Sing Palat	
	Steve Feldman	
	T Samuel	
	Tara	
	Tony	
	Traci Bradley	
Provider Messaging System from the Department to all ALRs (689) and NCFs (223) regarding each meeting and the opportunity to participate.		
Stakeholder engagement list – notice regarding each meeting and the opportunity to participate. 171 participants on list as of March 2023.		

Stakeholder meetings were held monthly from September 2022 through February 2023. Participation was open to the public and available via a Zoom online platform. Seven to fourteen days before stakeholder meetings were held, 808 Assisted Living Residence contacts (from 689 ALRs) and 995 Nursing Homes contacts (from 223 NCFs) were notified of the meeting through the provider messaging system. In addition to these provider messages being sent out to facilities, direct notice was given via email to 171 interested parties. A public link to the Google meeting folder, which contained the signed law, a stakeholder information letter, meeting agendas, draft rules, and all material being shared at the meetings, was available. Once the meetings concluded, a recording of the zoom meeting was posted along with the zoom chat records.

Stakeholder Group Notification

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

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

____ Yes.

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

> The Department worked closely to reach consensus on all the issues that were discussed during the stakeholder meetings. Where consensus was not reached, the Department worked to refine language to achieve as close to consensus as possible while still prioritizing resident safety and rights.

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

> All patients with dementia and many other residents of nursing care facilities and assisted living residences meet the statutory definition of "patient or resident with a disability."

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

Select all that apply.

X	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.	X	Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.
	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.		Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.
	Improves access to food and healthy food options.		Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.

	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.		Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.
	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.		Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.	X	Ensures a competent public and environmental health workforce or health care workforce.
	Other:____		Other:____

An Act

SENATE BILL 22-053

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) END-OF-LIFE SITUATIONS;

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

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

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

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

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

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

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

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

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

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

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

(III) BLINDNESS;

(IV) AUTISM SPECTRUM DISORDER; OR

(V) DEMENTIA.

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

SECTION 4. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.

Steve Fenberg
PRESIDENT OF
THE SENATE

Alec Garnett
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

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

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

An Act

SENATE BILL 22-079

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) DEMENTIA DISEASES AND RELATED DISABILITIES;

(II) PERSON-CENTERED CARE;

(III) CARE PLANNING;

(IV) ACTIVITIES OF DAILY LIVING; AND

(V) DEMENTIA-RELATED BEHAVIORS AND COMMUNICATION;

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

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

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

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

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

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

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

(B) PROVIDED PROOF OF SATISFACTORY COMPLETION OF THE

TRAINING PROGRAM;

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

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

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

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

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

(3) AS USED IN THIS SECTION:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) DEMENTIA DISEASES AND RELATED DISABILITIES;

(II) PERSON-CENTERED CARE;

(III) CARE PLANNING;

(IV) ACTIVITIES OF DAILY LIVING; AND

(V) DEMENTIA-RELATED BEHAVIORS AND COMMUNICATION;

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

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

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

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

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

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

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

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

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

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

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

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

IMPLEMENT THIS SECTION.

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

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

Steve Fenberg
PRESIDENT OF
THE SENATE

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

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
Health Facilities and Emergency Medical Services Division
STANDARDS FOR HOSPITALS AND HEALTH FACILITIES CHAPTER 5 - NURSING CARE FACILITIES
6 CCR 1011-1 Chapter 5

Index

SECTION 1 - STATUTORY AUTHORITY AND APPLICABILITY

1.1 The statutory authority for the promulgation of these rules is set forth in Sections 25-1-107.5(2), 25-1-120, 25-1.5-103(1)(a), 25-1.5-118, ~~and~~ 25-3-100.5, et seq., and 25-3-125, C.R.S.

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SECTION 2 – DEFINITIONS

"Advance Medical Directive" means a written instruction, as defined in Section 15-18.7-102 (2), C.R.S., concerning medical treatment decisions to be made on behalf of the resident who provided the instruction in the event that the individual becomes incapacitated.

"At-Risk Elder" means a person age 70 and older.

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

"COMMUNICABLE DISEASE" HAS THE SAME MEANING AS SET FORTH IN SECTION 25-1.5-102 (1)(A)(IV), C.R.S.

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

A) END-OF-LIFE SITUATIONS;

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

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

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

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

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

“Department” means the Colorado Department of Public Health and Environment.

“DEMENTIA DISEASES AND RELATED DISABILITIES” MEANS A CONDITION WHERE MENTAL ABILITY DECLINES AND IS SEVERE ENOUGH TO INTERFERE WITH AN INDIVIDUAL’S ABILITY TO PERFORM EVERYDAY TASKS. DEMENTIA DISEASES AND RELATED DISABILITIES INCLUDES ALZHEIMER’S DISEASE, MIXED DEMENTIA, LEWY BODY DEMENTIA, VASCULAR DEMENTIA, FRONTOTEMPORAL DEMENTIA, AND OTHER TYPES OF DEMENTIA, AS SET FORTH IN SECTION 25-1-502 (2.5), C.R.S.

“Designated Facility” means an agency that has applied and been approved by the Department of Human Services to provide mental health services.

“Enforcement Activity” means the imposition of remedies such as civil money penalties; appointment of a receiver or temporary manager; conditional licensure; suspension or revocation of a license; a directed plan of correction; intermediate restrictions or conditions, including retaining a consultant, department monitoring or providing additional training to employees, owners or operators; or any other remedy provided by state or federal law or as authorized by federal survey, certification, and enforcement regulations and agreements for violations of federal or state law.

“ESSENTIAL CAREGIVER” – ESSENTIAL CAREGIVERS ARE NOT GENERAL VISITORS. THESE INDIVIDUALS MEET AN ESSENTIAL NEED FOR THE RESIDENT BY ASSISTING WITH ACTIVITIES OF DAILY LIVING OR POSITIVELY INFLUENCING THE BEHAVIOR OF THE RESIDENT. THE GOAL OF SUCH A DESIGNATION IS TO HELP ENSURE RESIDENTS CONTINUE TO RECEIVE INDIVIDUALIZED, PERSON-CENTERED CARE. THE PLAN OF CARE SHOULD INCLUDE SERVICES PROVIDED BY THE ESSENTIAL CAREGIVER.

“Governing Body” means the individual, group of individuals or corporate entity that has ultimate authority and legal responsibility for the operation of the facility.

“Medical Director” means a physician who oversees the medical care and other designated care and services in the facility.

"Non-Physician Practitioner" means a physician assistant or advance practice nurse (i.e., nurse practitioner or clinical nurse specialist).

"Nursing Care Facility" means a licensed health care entity that is planned, organized, operated and maintained to provide supportive, restorative and preventative services to persons who, due to physical and/or mental disability, require continuous or regular inpatient nursing care.

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

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

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

C) BLINDNESS;

D) AUTISM SPECTRUM DISORDER; OR

E) DEMENTIA.

"Placement Facility" means a public or private nursing care facility that has a written agreement with a designated facility to provide care and treatment to any individual undergoing mental health evaluation or treatment by the designated facility.

"Practitioner" means physician and non-physician practitioner.

"Resident Representative" means either an individual of the resident's choice who has access to the resident's personal health information and participates in discussions regarding the resident's health care or a personal representative with legal standing including, but not limited to, power of attorney; medical power of attorney; legal guardian or health care surrogate appointed or designated in accordance with state law.

"Skilled Nursing Care Facility" means a nursing care facility that is federally certified by the Centers for Medicare and Medicaid Services.

"Telehealth" means a mode of delivery of health care services through telecommunication systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education and care management of a resident's health care when the resident and practitioner are located at different sites. Telehealth includes "telemedicine" as defined in Section 12-36-102.5(8), C.R.S.

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SECTION 4 - FACILITY ADMINISTRATION

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4.4 POLICIES AND PROCEDURES REGARDING VISITATION RIGHTS

A) EACH SKILLED NURSING FACILITY SHALL HAVE WRITTEN POLICIES AND PROCEDURES REGARDING THE VISITATION RIGHTS DETAILED IN SECTION 25-3-125 (3)(A), C.R.S. SUCH POLICIES AND PROCEDURES SHALL:

1) SET FORTH THE VISITATION RIGHTS OF THE RESIDENT, CONSISTENT WITH 42 CFR 482.13(H);

42 U.S.C. 1396R(C)(3)(C); 42 U.S.C. 1395I(C)(3)(C); 42 CFR483.10(A), (B), AND (F); AND SECTION 25-27-104, C.R.S., AS APPLICABLE TO THE FACILITY TYPE;

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

3) BE AVAILABLE FOR INSPECTION AT THE REQUEST OF THE DEPARTMENT; AND

4) BE PROVIDED TO RESIDENTS AND/OR FAMILY MEMBERS UPON REQUEST.

4.~~4~~5 FACILITY STAFFING PLAN

The facility shall have a master staffing plan for providing staffing in compliance with these regulations; distribution of personnel; replacement of personnel and forecasting future personnel needs.

4.~~5~~6 POSTING DEFICIENCIES

The facility shall post conspicuously in public view either the statement of deficiencies following its most recent survey or a notice stating the location and times at which the statement can be reviewed.

4.~~6~~7 WAIVERS

A facility may request waivers to these regulations pursuant to 6 CCR 1011-1, Chapter 2, General Licensure Standards, Part 5, Waiver of Regulations for Facilities and Agencies.

4.~~7~~8 MANDATORY REPORTING

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SECTION 6 – PERSONNEL

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6.3 STAFF DEVELOPMENT

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F) DEMENTIA TRAINING REQUIREMENTS

1) AS OF OCTOBER 1, 2023, EACH NURSING CARE FACILITY SHALL ENSURE THAT ITS DIRECT-CARE STAFF MEMBERS MEET THE DEMENTIA TRAINING REQUIREMENTS IN THIS SUB-SECTION 6.3 (F).

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

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

B) "EQUIVALENT TRAINING" IN THIS SUB-SECTION SHALL MEAN ANY INITIAL TRAINING PROVIDED BY A COVERED FACILITY MEETING THE REQUIREMENTS OF SUB-SECTION 6.3(F)(3). IF THE EQUIVALENT TRAINING WAS PROVIDED MORE THAN 24 MONTHS PRIOR TO THE DATE OF HIRE AS ALLOWED IN THE EXCEPTION FOUND IN PART 6.3(F)(4)(B), THE INDIVIDUAL MUST DOCUMENT PARTICIPATION

IN BOTH THE INITIAL TRAINING AND ALL REQUIRED CONTINUING EDUCATION SUBSEQUENT TO THE INITIAL TRAINING.

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

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

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

I) DEMENTIA DISEASES AND RELATED DISABILITIES;

II) PERSON-CENTERED CARE OF RESIDENTS WITH DEMENTIA;

III) CARE PLANNING FOR RESIDENTS WITH DEMENTIA;

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

V) DEMENTIA-RELATED BEHAVIORS AND COMMUNICATION.

C) FOR DIRECT-CARE STAFF MEMBERS ALREADY EMPLOYED PRIOR TO OCTOBER 1, 2023, THE INITIAL TRAINING MUST BE COMPLETED AS SOON AS PRACTICAL, BUT NO LATER THAN 120 DAYS AFTER OCTOBER 1, 2023, UNLESS AN EXCEPTION, AS DESCRIBED IN SUB-SECTION 6.3(F)(4)(A), APPLIES.

D) FOR DIRECT-CARE STAFF MEMBERS HIRED OR PROVIDING CARE ON OR AFTER OCTOBER 1, 2023, THE INITIAL TRAINING MUST BE COMPLETED AS SOON AS PRACTICAL, BUT NO LATER THAN 120 DAYS AFTER THE START OF EMPLOYMENT OR THE PROVISION OF DIRECT-CARE SERVICES, UNLESS AN EXCEPTION, AS DESCRIBED IN SUB-SECTION 6.3 (F)(4)(B), APPLIES.

4) EXCEPTION TO INITIAL DEMENTIA TRAINING REQUIREMENT

A) ANY DIRECT-CARE STAFF MEMBER WHO IS EMPLOYED BY OR PROVIDING DIRECT-CARE SERVICES PRIOR TO THE OCTOBER 1, 2023, MAY BE EXEMPTED FROM THE FACILITY'S INITIAL TRAINING REQUIREMENT IF BOTH OF THE FOLLOWING CONDITIONS ARE MET:

I) THE DIRECT-CARE STAFF MEMBER HAS COMPLETED AN EQUIVALENT INITIAL DEMENTIA TRAINING PROGRAM, AS DEFINED IN THESE RULES, WITHIN THE 24 MONTHS IMMEDIATELY PRECEDING OCTOBER 1, 2023; AND

II) THE DIRECT-CARE STAFF MEMBER CAN PROVIDE DOCUMENTATION OF THE SATISFACTORY COMPLETION OF THE INITIAL TRAINING PROGRAM.

B) ANY DIRECT-CARE STAFF MEMBER WHO IS HIRED BY OR BEGINS PROVIDING DIRECT-CARE SERVICES ON OR AFTER OCTOBER 1, 2023, MAY BE EXEMPTED FROM THE FACILITY'S INITIAL TRAINING REQUIREMENT IF ALL OF THE FOLLOWING CONDITIONS ARE MET. THE DIRECT-CARE STAFF MEMBER:

I) HAS COMPLETED AN EQUIVALENT INITIAL DEMENTIA TRAINING PROGRAM, AS DEFINED IN THESE RULES, EITHER:

(A) WITHIN THE 24 MONTHS IMMEDIATELY PRECEDING OCTOBER 1, 2023; OR

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

II) CAN PROVIDE DOCUMENTATION OF THE SATISFACTORY COMPLETION OF THE INITIAL TRAINING PROGRAM; AND

III) CAN PROVIDE DOCUMENTATION OF ALL REQUIRED CONTINUING EDUCATION SUBSEQUENT TO THE INITIAL TRAINING.

C) SUCH EXCEPTIONS SHALL NOT NEGATE THE REQUIREMENT FOR DEMENTIA TRAINING CONTINUING EDUCATION AS DESCRIBED IN SUB-PART 6.3(F)(5).

5) DEMENTIA TRAINING: CONTINUING EDUCATION

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

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

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

6) MINIMUM REQUIREMENTS FOR INDIVIDUALS CONDUCTING DEMENTIA TRAINING

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

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

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

6.4 RECORDS

A) The facility shall maintain personnel records on each employee, including an employment application that includes training and past experience, verification of credentials, references of past work experience, orientation and evidence that health status is appropriate to perform duties in the employee's job description.

B) DOCUMENTATION OF INITIAL DEMENTIA TRAINING AND CONTINUING EDUCATION

1) THE FACILITY SHALL MAINTAIN DOCUMENTATION OF THE COMPLETION OF INITIAL DEMENTIA TRAINING AND CONTINUING EDUCATION. SUCH RECORDS SHALL BE AVAILABLE FOR INSPECTION BY REPRESENTATIVES OF THE DEPARTMENT.

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

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

4) DOCUMENTATION OF THE SATISFACTORY COMPLETION OF AN EQUIVALENT INITIAL TRAINING PROGRAM AS DEFINED IN SUB-SECTION 6.3(F)(2)(B) AND AS REQUIRED IN THE CRITERIA FOR AN EXCEPTION DISCUSSED IN SUB-SECTION 6.3(F)(4), SHALL INCLUDE THE INFORMATION REQUIRED IN THIS SUB-SECTION 6.4(B)(2) AND (3).

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

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SECTION 15 RESIDENT RIGHTS

15.1 STATEMENT OF RIGHTS

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P) VISITATION RIGHTS AND LIMITATIONS ON VISITATION RIGHTS

1) EACH RESIDENT OF A SKILLED NURSING FACILITY MAY HAVE AT LEAST ONE VISITOR OF THE RESIDENT'S CHOOSING DURING THEIR STAY AT THE FACILITY, UNLESS RESTRICTIONS OR LIMITATIONS UNDER FEDERAL LAW OR REGULATION, OTHER STATE STATUTE, OR STATE OR LOCAL PUBLIC HEALTH ORDER APPLY. THIS VISITATION RIGHT SHALL BE EXERCISED IN ACCORDANCE WITH THE FOLLOWING:

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

B) FOR A RESIDENT WITH A DISABILITY:

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

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

PURSUANT TO SECTION 15-18.7-102 (2) C.R.S., "(2) 'ADVANCE MEDICAL DIRECTIVE' MEANS A WRITTEN INSTRUCTION CONCERNING MEDICAL TREATMENT DECISIONS TO BE MADE ON BEHALF OF THE ADULT WHO PROVIDED THE INSTRUCTION IN THE EVENT THAT HE OR SHE BECOMES INCAPACITATED. AN ADVANCE MEDICAL DIRECTIVE

INCLUDES, BUT NEED NOT BE LIMITED TO: (A) A MEDICAL DURABLE POWER OF ATTORNEY EXECUTED PURSUANT TO SECTION 15-14-506; (B) A DECLARATION EXECUTED PURSUANT TO THE "COLORADO MEDICAL TREATMENT DECISION ACT", ARTICLE 18 OF THIS TITLE; (C) A POWER OF ATTORNEY GRANTING MEDICAL TREATMENT AUTHORITY EXECUTED PRIOR TO JULY 1, 1992, PURSUANT TO SECTION 15-14-501, AS IT EXISTED PRIOR TO THAT DATE; OR (D) A CPR DIRECTIVE OR DECLARATION EXECUTED PURSUANT TO ARTICLE 18.6 OF THIS TITLE."

C) FOR A RESIDENT WHO IS UNDER EIGHTEEN YEARS OF AGE, THE PARENT, LEGAL GUARDIAN, OR PERSON STANDING IN LOCO PARENTIS TO THE RESIDENT IS ALLOWED TO EXERCISE THESE VISITATION RIGHTS PURSUANT TO ANY LIMITATIONS DESCRIBED IN SECTION 15.1(P)(2), (3), AND (4) LIMITATIONS ON VISITATION RIGHTS.

2) LIMITATIONS ON VISITATION RIGHTS: DURING A PERIOD WHEN THE RISK OF TRANSMISSION OF A COMMUNICABLE DISEASE IS HEIGHTENED, A SKILLED NURSING FACILITY MAY:

A) REQUIRE VISITORS TO ENTER THE FACILITY THROUGH A SINGLE, DESIGNATED ENTRANCE;

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

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

D) REQUIRE VISITORS TO SIGN A DOCUMENT ACKNOWLEDGING:

I) THE RISKS OF ENTERING THE FACILITY WHILE THE RISK OF TRANSMISSION OF A COMMUNICABLE DISEASE IS HEIGHTENED; AND

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

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

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

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

H) IF A SKILLED NURSING FACILITY REQUIRES THAT A VISITOR USE A MEDICAL MASK, FACE COVERING, OR OTHER PERSONAL PROTECTIVE EQUIPMENT OR TO TAKE A TEST FOR A COMMUNICABLE DISEASE IN ORDER TO VISIT A RESIDENT AT THE HEALTH-CARE FACILITY, NOTHING IN THESE REGULATIONS:

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

II) REQUIRES THE FACILITY TO SUPPLY THE REQUIRED EQUIPMENT OR TEST TO THE VISITOR, OR BEAR THE COST OF THE EQUIPMENT FOR THE VISITOR; OR

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

3) ADDITIONAL LIMITATIONS FOR THE VISITORS OF A RESIDENT WITH A COMMUNICABLE DISEASE WHO IS ISOLATED: THE FACILITY MAY IMPOSE ADDITIONAL RESTRICTIONS INCLUDING:

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

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

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

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

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

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
Health Facilities and Emergency Medical Services Division
STANDARDS FOR HOSPITALS AND HEALTH FACILITIES
CHAPTER 7 - ASSISTED LIVING RESIDENCES
6 CCR 1011-1 Chapter 7

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PART 1 – STATUTORY AUTHORITY AND APPLICABILITY

1.1 Authority to establish minimum standards through regulation and to administer and enforce such regulations is provided by Sections 25-1.5-103, 25-1.5-118, 25-3-125, 25-27-101, and 25-27-104, C.R.S.

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PART 2 – DEFINITIONS

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2.4 “Advance Medical Directive” means a written instruction, as defined in Section 15-18.7-102 (2) C.R.S., concerning medical treatment decisions to be made on behalf of the resident who provided the instruction in the event that the individual becomes incapacitated.

2.~~4~~5 “Alternative care facility” means an assisted living residence certified by the Colorado Department of Health Care Policy and Financing to receive Medicaid reimbursement for the services provided pursuant to 10 CCR 2505-10, Section 8.495.

2.~~5~~6 “Appropriately skilled professional” means an individual that has the necessary qualifications and/or training to perform the medical procedures prescribed by a practitioner. This includes, but is not limited to, registered nurse, licensed practical nurse, physical therapist, occupational therapist, respiratory therapist, and dietitian.

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

(A) A residential facility that makes available to three or more adults not related to the owner of such facility, either directly or indirectly through a resident agreement with the resident, room and board and at least the following services: personal services; protective oversight; social care due to impaired capacity to live independently; and regular supervision that shall be available on a twenty-four-hour basis, but not to the extent that regular twenty-four hour medical or nursing care is required, or

(B) A Supportive Living Program residence that, in addition to the criteria specified in the above paragraph, is certified by the Colorado Department of Health Care Policy and Financing to also provide health maintenance activities, behavioral management and education, independent living skills training and other related services as set forth in the supportive living program regulations at 10 CCR 2505-10, Section 8.515.

(C) Unless otherwise indicated, the term “assisted living residence” is synonymous with the terms “health care entity,” “health facility,” or “facility” as used elsewhere in 6 CCR 1011-1, Standards for Hospitals and Health Facilities.

2.~~7~~8 “At-risk person” means any person who is 70 years of age or older, or any person who is 18 years of age or older and meets one or more of the following criteria:

(A) Is impaired by the loss (or permanent loss of use) of a hand or foot, blindness or permanent impairment of vision sufficient to constitute virtual blindness;

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

(C) Is unable to breathe without mechanical assistance;

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

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

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

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

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

2.~~8~~9 “Auxiliary aid” means any device used by persons to overcome a physical disability and includes but is not limited to a wheelchair, walker or orthopedic appliance.

2.~~9~~10 “Care plan” means a written description, in lay terminology, of the functional capabilities of an individual, the individual’s need for personal assistance, service received from external providers, and the services to be provided by the facility in order to meet the individual’s needs. In order to deliver person-centered care, the care plan shall take into account the resident’s preferences and desired outcomes. “Care plan” may also mean a service plan for those facilities which are licensed to provide services specifically for the mentally ill.

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

2.1~~0~~2 “Caretaker neglect” means neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision or any other service necessary for the health or safety of an at-risk person is not secured for that person or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise, or a caretaker knowingly uses harassment, undue influence or intimidation to create a hostile or fearful environment for an at-risk person.

2.1~~1~~3 “Certified nurse medication aide (CNA-Med)” means a certified nurse aide who meets the qualifications specified in 3 CCR 716-1, Rule 1.19, and who is currently certified as a nurse aide with medication aide authority by the State Board of Nursing.

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

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

(A) END-OF-LIFE SITUATIONS;

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

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

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

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

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

2.1~~2~~6 “Controlled substance” means any medication that is regulated and classified by the Controlled Substances Act at 21 U.S.C., §812 as being schedule II through V.

2.1~~3~~7 “Deficiency” means a failure to fully comply with any statutory and/or regulatory requirements applicable to a licensed assisted living residence.

2.1~~4~~8 “Deficiency list” means a listing of deficiency citations which contains a statement of the statute or regulation violated, and a statement of the findings, with evidence to support the deficiency.

2.19 “DEMENTIA DISEASES AND RELATED DISABILITIES” MEANS A CONDITION WHERE MENTAL ABILITY DECLINES AND IS SEVERE ENOUGH TO INTERFERE WITH AN INDIVIDUAL’S ABILITY TO PERFORM EVERYDAY TASKS. DEMENTIA DISEASES AND RELATED DISABILITIES INCLUDES ALZHEIMER’S DISEASE, MIXED DEMENTIA, LEWY BODY DEMENTIA, VASCULAR DEMENTIA, FRONTOTEMPORAL DEMENTIA, AND OTHER TYPES OF DEMENTIA.

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

2.~~16~~21 “Disproportionate share facilities” means facilities that serve a disproportionate share of low income residents as evidenced by having qualified for federal or state low income housing assistance; planning to serve low income residents with incomes at or below 80 percent of the area median income; and submitting evidence of such qualification, as required by the Department.

2.~~17~~22 “Discharge” means termination of the resident agreement and the resident’s permanent departure from the facility.

2.~~18~~23 “Egress alert device” means a device that is affixed to a structure or worn by a resident that triggers a visual or auditory alarm when a resident leaves the building or grounds. Such devices shall only be used to assist staff in redirecting residents back into the facility when staff are alerted to a resident’s departure from the facility as opposed to restricting the free movement of residents.

2.~~19~~24 “Emergency contact” means one of the individuals identified on the face sheet of the resident record to be contacted in the case of an emergency.

2.25 “ESSENTIAL CAREGIVER” – ESSENTIAL CAREGIVERS ARE NOT GENERAL VISITORS. THESE INDIVIDUALS MEET AN ESSENTIAL NEED FOR THE RESIDENT BY ASSISTING WITH ACTIVITIES OF DAILY LIVING OR POSITIVELY INFLUENCING THE BEHAVIOR OF THE RESIDENT. THE GOAL OF SUCH A DESIGNATION IS TO HELP ENSURE RESIDENTS CONTINUE TO RECEIVE INDIVIDUALIZED, PERSON-CENTERED CARE. THE PLAN OF CARE SHOULD INCLUDE SERVICES PROVIDED BY THE ESSENTIAL CAREGIVER.

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

(A) Uses deception, harassment, intimidation or undue influence to permanently or temporarily deprive an at-risk person of the use, benefit or possession of anything of value;

(B) Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the at-risk person;

(C) Forces, compels, coerces or entices an at-risk person to perform services for the profit or advantage of the person or another person against the will of the at-risk person; or

(D) Misuses the property of an at-risk person in a manner that adversely affects the at-risk person's ability to receive health care, health care benefits, or to pay bills for basic needs or obligations.

2.2~~1~~7 "External services" means personal services and protective oversight services provided to a resident by family members or healthcare professionals who are not employees, contractors, or volunteers of the facility. External service providers include, but are not limited to, home health, hospice, private pay caregivers and family members.

2.2~~2~~8 "High Medicaid utilization facility" means a facility that has no less than 35 percent of its licensed beds occupied by Medicaid enrollees as indicated by complete and accurate fiscal year claims data; and served Medicaid clients and submitted claims data for a minimum of nine (9) months of the relevant fiscal year.

2.2~~3~~9 "Hospice care" means a comprehensive set of services identified and coordinated by an external service provider in collaboration with the resident, family and assisted living residence to provide for the physical, psychosocial, spiritual and emotional needs of a terminally ill resident as delineated in a care plan. Hospice care services shall be available 24 hours a day, seven days a week pursuant to the requirements for hospice providers set forth in 6 CCR 1011-1, Chapter 21, Hospices.

2.~~24~~30 "Licensee" means the person or entity to whom a license is issued by the Department pursuant to Section 25-1.5-103 (1) (a), C.R.S., to operate an assisted living residence within the definition herein provided. For the purposes of this Chapter 7, the term "licensee" is synonymous with the term "owner."

2.~~25~~31 "Medical waste" means waste that may contain disease causing organisms or chemicals that present potential health hazards such as discarded surgical gloves, sharps, blood, human tissue, prescription or over-the-counter pharmaceutical waste, and laboratory waste.

2.~~26~~32 "Medication administration" means assisting a person in the ingestion, application, inhalation, or, using universal precautions, rectal or vaginal insertion of medication, including prescription drugs, according to the legibly written or printed directions of the attending physician or other authorized practitioner, or as written on the prescription label, and making a written record thereof with regard to each medication administered, including the time and the amount taken.

(A) Medication administration does not include:

(1) Medication monitoring; or

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

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

2.~~27~~33 "Medication monitoring" means:

(A) Reminding the resident to take medication(s) at the time ordered by the authorized practitioner;

(B) Handing to a resident a container or package of medication that was lawfully labeled previously by an authorized practitioner for the individual resident;

(C) Visual observation of the resident to ensure compliance;

(D) Making a written record of the resident's compliance with regard to each medication, including the time taken; and

(E) Notifying the authorized practitioner if the resident refuses or is unable to comply with the practitioner's instructions regarding the medication.

2.~~28~~34 "Mistreatment" means abuse, caretaker neglect, or exploitation.

2.~~29~~35 "Nurse" means an individual who holds a current unrestricted license to practice pursuant to Article 255 of Title 12, C.R.S., and is acting within the scope of such authority.

2.3~~0~~6 "Nursing services" means support for activities of daily living, the administration of medications, and the provision of treatment by a nurse in accordance with orders from the resident's practitioner.

2.3~~1~~7 "Owner" means the person or business entity that applies for assisted living residence licensure and/or in whose name the license is issued.

2.3~~2~~8 "Palliative care" means specialized medical care for people with serious illnesses. This type of care is focused on providing residents with relief from the symptoms, pain and stress of serious illness, whatever the diagnosis. The goal is to improve quality of life for both the resident and the family. Palliative care is provided by a team of physicians, nurses and other specialists who work with a resident's other health care providers to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided together with curative treatment. Unless otherwise indicated, the term "palliative care" is synonymous with the terms "comfort care," "supportive care," and similar designations.

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

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

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

(C) BLINDNESS;

(D) AUTISM SPECTRUM DISORDER; OR

(E) DEMENTIA.

2.~~33~~40 "Personal care worker" means an individual who:

(A) Provides personal services for any resident; and

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

2.~~3~~41 "Personal services" means those services that an assisted living residence and its staff provide for each resident including, but not limited to:

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

(B) Individualized social supervision,

(C) Assistance with transportation, and

(D) Assistance with activities of daily living.

2.~~35~~42 "Plan of correction" means a written plan to be submitted by an assisted living residence to the Department for approval, detailing the measures that shall be taken to correct all cited deficiencies.

2.~~36~~43 "Practitioner" means a physician, physician assistant or advance practice nurse (i.e., nurse practitioner or clinical nurse specialist) who has a current, unrestricted license to practice and is acting within the scope of such authority.

2.~~37~~44 "Pressure sore" (also called pressure ulcer, decubitus ulcer, bed-sore or skin breakdown) means an area of the skin or underlying tissue (muscle, bone) that is damaged due to loss of blood flow to the area. Symptoms and medical treatment of pressure sores are based upon the level of severity or "stage" of the pressure sore.

(A) Stage 1 affects only the upper layer of skin. Symptoms include pain, burning, or itching and the affected area may look or feel different from the surrounding skin.

(B) Stage 2 goes below the upper surface of the skin. Symptoms include pain, broken skin, or open wound that is swollen, warm, and/or red, and may be oozing fluid or pus.

(C) Stage 3 involves a sore that looks like a crater and may have a bad odor. It may show signs of infection such as red edges, pus, odor, heat, and/or drainage.

(D) Stage 4 is a deep, large sore. The skin may have turned black and show signs of infection such as red edges, pus, odor, heat and/or drainage. Tendons, muscles, and bone may be visible.

2.~~38~~45 "Protective oversight" means guidance of a resident as required by the needs of the resident or as reasonably requested by the resident, including the following:

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

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

2.~~39~~46 "Qualified medication administration person" or "QMAP" means an individual who passed a competency evaluation administered by the Department before July 1, 2017, or passed a competency evaluation administered by an approved training entity on or after July 1, 2017, and whose name appears on the Department's list of persons who have passed the requisite competency evaluation.

2.4~~0~~7 "Renovation" means the moving of walls and reconfiguring of existing floor plans. It includes the rebuilding or upgrading of major systems, including but not limited to: heating, ventilation, and electrical systems. It also means the changing of the functional operation of the space.

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

2.4~~1~~8 “Resident’s legal representative” means one of the following:

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

(B) An individual named as the agent in a power of attorney (POA) that authorizes the individual to act on the resident’s behalf, as enumerated in the POA;

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

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

2.4~~2~~9 “Restraint” means any method or device used to involuntarily limit freedom of movement including, but not limited to, bodily physical force, mechanical devices, chemicals, or confinement.

2.~~43~~50 “Secure environment” means any grounds, building or part thereof, method, or device that prohibits free egress of residents. An environment is secure when the right of any resident thereof to move outside the environment during any hours is limited.

2.~~44~~51 “Self-administration” means the ability of a resident to take medication independently without any assistance from another person.

2.~~45~~52 “Staff” means employees and contracted individuals intended to substitute for or supplement employees who provide personal services. “Staff” does not include individuals providing external services, as defined herein.

2.~~46~~53 “Therapeutic diet” means a diet ordered by a practitioner or registered dietician as part of a treatment of disease or clinical condition, or to eliminate, decrease, or increase specific nutrients in the diet. Examples include, but are not limited to, a calorie counted diet; a specific sodium gram diet; and a cardiac diet.

2.~~47~~54 “Transfer” means being able to move from one body position to another. This includes, but is not limited to, moving from a bed to a chair or standing up from a chair to grasp an auxiliary aid.

2.~~48~~55 “Volunteer” means an unpaid individual providing personal services on behalf of and/or under the control of the assisted living residence. “Volunteer” does not include individuals visiting the assisted living residence for the purposes of resident engagement.

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PART 7 – PERSONNEL

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<u>Staff and Volunteer Orientation and Training</u>

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

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

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

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

(3) Hand Hygiene and infection control;

(4) Emergency response policies and procedures, including:

(a) Recognizing emergencies,

(b) Relevant emergency contact numbers,

(c) Fire response, including facility evacuation procedures

(d) Basic first aid,

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

(f) Practitioner assessment, and

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

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

(6) Resident rights;

(7) House rules;

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

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

(B) DEMENTIA TRAINING REQUIREMENTS

(1) AS OF OCTOBER 1, 2023, EACH ASSISTED LIVING RESIDENCE SHALL ENSURE THAT ITS DIRECT-CARE STAFF MEMBERS MEET THE DEMENTIA TRAINING REQUIREMENTS IN THIS PART 7.8(B).

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

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

(B) "EQUIVALENT TRAINING" IN THIS SUB-PART SHALL MEAN ANY INITIAL TRAINING PROVIDED BY A COVERED FACILITY MEETING THE REQUIREMENTS OF THIS SUB-PART 7.8(B)(3). IF THE EQUIVALENT TRAINING WAS PROVIDED MORE THAN 24 MONTHS PRIOR TO THE DATE OF HIRE AS ALLOWED IN THE EXCEPTION FOUND IN PART 7.8(B)(4), THE INDIVIDUAL MUST DOCUMENT PARTICIPATION IN BOTH THE EQUIVALENT TRAINING AND ALL REQUIRED CONTINUING EDUCATION SUBSEQUENT TO THE INITIAL TRAINING.

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

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

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

(I) DEMENTIA DISEASES AND RELATED DISABILITIES;

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

(III) CARE PLANNING FOR RESIDENTS WITH DEMENTIA;

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

(V) DEMENTIA-RELATED BEHAVIORS AND COMMUNICATION.

(C) FOR DIRECT-CARE STAFF MEMBERS ALREADY EMPLOYED PRIOR TO OCTOBER 1, 2023, THE INITIAL TRAINING MUST BE COMPLETED AS SOON AS PRACTICAL, BUT NO LATER THAN 120 DAYS AFTER OCTOBER 1, 2023, UNLESS AN EXCEPTION, AS DESCRIBED IN SUB-PART 7.8(B)(4)(A), APPLIES.

(D) FOR DIRECT-CARE STAFF MEMBERS HIRED OR PROVIDING CARE ON OR AFTER OCTOBER 1, 2023, THE INITIAL TRAINING MUST BE COMPLETED AS SOON AS PRACTICAL, BUT NO LATER THAN 120 DAYS AFTER THE START OF EMPLOYMENT OR THE PROVISION OF DIRECT-CARE SERVICES, UNLESS AN EXCEPTION, AS DESCRIBED IN SUB-PART 7.8(B)(4)(B), APPLIES.

(4) EXCEPTION TO INITIAL DEMENTIA TRAINING REQUIREMENT

(A) ANY DIRECT-CARE STAFF MEMBER WHO IS EMPLOYED BY OR PROVIDING DIRECT-CARE SERVICES PRIOR TO THE OCTOBER 1, 2023, MAY BE EXEMPTED FROM THE RESIDENCE'S INITIAL TRAINING REQUIREMENT IF ALL OF THE FOLLOWING CONDITIONS ARE MET:

(I) THE DIRECT-CARE STAFF MEMBER HAS COMPLETED AN EQUIVALENT INITIAL DEMENTIA TRAINING PROGRAM, AS DEFINED IN THESE RULES, WITHIN THE 24 MONTHS IMMEDIATELY PRECEDING OCTOBER 1, 2023; AND

(II) THE DIRECT-CARE STAFF MEMBER CAN PROVIDE DOCUMENTATION OF THE SATISFACTORY COMPLETION OF THE INITIAL TRAINING PROGRAM.

(B) ANY DIRECT-CARE STAFF MEMBER WHO IS HIRED BY OR BEGINS PROVIDING DIRECT-CARE SERVICES ON OR AFTER OCTOBER 1, 2023, MAY BE EXEMPTED FROM THE RESIDENCE'S INITIAL TRAINING REQUIREMENT IF ALL OF THE FOLLOWING CONDITIONS ARE MET. THE DIRECT-CARE STAFF MEMBER:

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

(A) WITHIN THE 24 MONTHS IMMEDIATELY PRECEDING OCTOBER 1, 2023; OR

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

(II) CAN PROVIDE DOCUMENTATION OF THE SATISFACTORY COMPLETION OF THE INITIAL TRAINING PROGRAM; AND

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

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

(5) DEMENTIA TRAINING: CONTINUING EDUCATION

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

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

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

(6) MINIMUM REQUIREMENTS FOR INDIVIDUALS CONDUCTING DEMENTIA TRAINING

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

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

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

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

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Personnel Files

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

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

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

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

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

(C) Orientation and training, including first aid and CPR certification, if applicable;

(D) Verification from the Department of Regulatory Agencies, or other state agency, of an active license or certification, if applicable;

(E) Results of background checks and follow up, as applicable; and

(F) Tuberculin test results, if applicable.

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

(1) THE RESIDENCE SHALL MAINTAIN DOCUMENTATION OF THE COMPLETION OF INITIAL DEMENTIA TRAINING AND CONTINUING EDUCATION. SUCH RECORDS SHALL BE AVAILABLE FOR INSPECTION BY REPRESENTATIVES OF THE DEPARTMENT.

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

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

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

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

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PART 9 – POLICIES AND PROCEDURES

9.1 The assisted living residence shall develop and at least annually review, all policies and procedures. At a minimum, the assisted living residence shall have policies and procedures that address the following items:

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

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

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

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

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

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

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

(B) FOR A RESIDENT WITH A DISABILITY:

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

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

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

(C) FOR A RESIDENT WHO IS UNDER EIGHTEEN YEARS OF AGE, THE PARENT, LEGAL GUARDIAN, OR PERSON STANDING IN LOCO PARENTIS TO THE RESIDENT IS ALLOWED TO EXERCISE THESE VISITATION RIGHTS PURSUANT TO ANY LIMITATIONS DESCRIBED IN SUB-PART 9.1(U)(6) AND (7).

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

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

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

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

(D) REQUIRE VISITORS TO SIGN A DOCUMENT ACKNOWLEDGING:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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PART 13 – RESIDENT RIGHTS

13.1 The assisted living residence shall adopt, and place in a publically visible location, a statement regarding the rights and responsibilities of its residents. The assisted living residence and staff shall observe these rights in the care, treatment, and oversight of the residents. The statement of rights shall include, at a minimum, the following items:

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(E) RIGHT TO VISITATION IN COMPLIANCE WITH FACILITY POLICY AS SET FORTH IN SECTION 9.1 (U).

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