Colorado Health Care Association
and Center for Assisted Living

Presented By:
Kaile Hilliard, L.S.W.
Genesis Healthcare

Maritza Martinez,
Vivage Senior Living

March 18, 2016
CHCA/CCAL Training Center, Denver, CO
9:00 a.m. to 4:00 p.m.

Sponsored By:
Kaile Hilliard, L.S.W., is currently a Regulatory Compliance Manager for Genesis Healthcare’s Western Division, supporting regulatory compliance for nursing homes and assisted living facilities in 9 states. Kaile has spent the last 5 years conducting pre-surveys, writing plans of correction, IDRs and consulting to ensure and assist with best practice and quality. She has worked as a geriatric case manager and as a case manager trainer before working as a long term care state surveyor in Colorado.

Kaile’s areas of expertise include, survey preparedness, management, correction, IDR, State and Federal regulatory compliance, and problem solving. Kaile is a certified Eden Associate, and has been a CPI trainer in the past. Her experience is an asset to conveying information to training recipients and her background as a state surveyor brings a knowledge and understanding of the regulations to help facilities ensure compliance.

Maritza Martinez, C.T.R.S., graduated from Kent State University with degrees in therapeutic recreation and psychology. She did her internship at the King Adult Day Enrichment Center (KADEP) and worked in a nursing home setting for three years prior to becoming a long-term care surveyor for the State of Colorado. After the state health department, Maritza began a career at Vivage as well as Pathways for Quality Consulting. She is currently a Quality Improvement Specialist at Vivage and the Vice President of Clinical Services for Pathways for Quality. In her current position she completes pre-surveys, consults, and educates on the federal regulations.
SURVEY MANAGEMENT BOOT CAMP

OBJECTIVES FOR SURVEY MANAGEMENT

• Identify types and frequency of surveys
• Define the purpose of surveys
• Describe potential survey outcomes
• Explain the survey process
• Discuss survey readiness processes
• Illustrate survey management during the survey
• Formulate an acceptable plan of correction
• Identify what are reportable occurrence to Colorado Department of Public Health and Environment

SURVEY TYPES - COLORADO

• Annual Health Inspection /Recertification Survey
• QIS (Quality Indicator Survey)
  • Complaints
  • Revisits
  • Self-Reports
  • Focused Survey
    • MDS Focused Survey
• Federal
  • FOQIS – Federal Overview Quality Indicator Survey
• Comparative Survey/Look Back Survey
• Life Safety Code
FUTURE SURVEY TYPES

• FOCUSED DEMENTIA CARE SURVEY (PILOTED IN 2014, STATES VOLUNTEERS TO PARTICIPATE IN 2015)
• FIRST ONE IN COLORADO WAS AT WINDSOR HEALTHCARE COMMUNITY
• FOCUSED STAFFING SURVEYS
• INFECTION CONTROL SURVEY
• THE COMMUNITY FOR MEDICARE & MEDICAID SERVICES (CMS) HAS BEGUN A THREE YEAR PILOT PROJECT TO IMPROVE THE ASSESSMENT OF INFECTION CONTROL AND PREVENTION REGULATIONS IN NURSING HOMES, HOSPITALS, AND DURING TRANSITIONS OF CARE. ALL SURVEYS DURING THE PILOT WILL BE EDUCATIONAL, NO CITATIONS WILL BE ISSUED AND WILL BE CONDUCTED BY A NATIONAL CONTRACTOR. NEW SURVEYOR TOOLS AND PROCESSES WILL BE DEVELOPED AND TESTED. FOCUSING ON EXISTING REGULATIONS AS WELL AS RECOMMENDED PRACTICES SUCH AS THOSE FOR ANTIBIOTIC STewardSHIP AND TRANSITIONS OF CARE. TEN PILOT SURVEYS TO BE CONDUCTED IN FISCAL YEAR (FY) 2016 WILL OCCUR IN NURSING HOMES. SURVEYS IN FY2017 AND FY2018 WILL BE CONDUCTED IN NURSING HOMES AND HOSPITALS.
• ADVERSE DRUG EVENTS
• KITCHEN SURVEYS

WHAT IS THE PURPOSE OF SURVEY...

Besides to Drive Us Crazy?
PURPOSE OF SURVEYS

- Enforcement of licensing standards
- Regulatory compliance review
- Incident investigation
  - From occurrence team
- Complaint investigation
  - Substantiate or unsubstantiate complaints
- Re-visits
  - Follow up to cited deficiencies to validate substantial compliance

SURVEY OUTCOMES

- No deficiencies
- Minimum standards of compliance met
- Deficiencies
- Current deficient practice
- Past non-compliance
- Complaint
  - Substantiated – complaint or self report that is confirmed
  - May or may not result in deficiencies
- Unsubstantiated – complaint or self report was not confirmed, not validated

DEFICIENCY NAMES

- Federal deficiencies – “F” tags
- State deficiencies – Colorado – “S” tags
  - Deficiencies – numbered 150 – 522
**SCOPE AND SEVERITY**

- WHEN A REGULATION IS VIOLATED, A DEFICIENCY IS WRITTEN
- REGULATIONS ARE INTERPRETIVE
- TAGS MAY CHANGE UNDER THE QA REVIEW AT THE DEPT
- EACH DEFICIENCY WILL HAVE A SCOPE AND SEVERITY
- SCOPE - THE NUMBER OF RESIDENTS INVOLVED
- SEVERITY - WAS/WERE THE RESIDENTS HARMED/POTENTIAL FOR HARM

**SCOPE AND SEVERITY GRID**

Survey Deficiency Score: Weights for Different Types of Deficiencies

<table>
<thead>
<tr>
<th>Severity</th>
<th>Scope</th>
<th>Isolated</th>
<th>Pattern</th>
<th>Widespread</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate jeopardy to resident health or safety</td>
<td></td>
<td>20 points (75 points)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual harm that is not immediate jeopardy</td>
<td></td>
<td>20 points</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No actual harm with potential for more than min. harm that is not IJ</td>
<td></td>
<td>4 points</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No actual harm with potential for min. harm that is not IJ</td>
<td></td>
<td>0 point</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Tags in the Big Three Cited, at a Scope and Severity in the Red Area would lead to a Substandard Survey

**ACCRUING POINTS**

- A SCORE IS CALCULATED BASED ON POINTS ASSIGNED TO DEFICIENCIES DURING:
  - CURRENT/MOST RECENT SURVEY
  - TWO PRIOR SURVEYS
  - LAST THREE YEARS OF COMPLAINT SURVEYS
  - THIS INCLUDES FOCUSED SURVEYS
  - REVISITS

<table>
<thead>
<tr>
<th>Revisit Number</th>
<th>Noncompliance Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Revisit</td>
<td>0</td>
</tr>
<tr>
<td>2nd Revisit</td>
<td>50% of health inspection score</td>
</tr>
<tr>
<td>3rd Revisit</td>
<td>70% of health inspection score</td>
</tr>
<tr>
<td>4th Revisit</td>
<td>90% of health inspection score</td>
</tr>
</tbody>
</table>
HOW ARE POINTS ACCRUED?

• SURVEY RESULTS - ALL
• REVISIT FAILURES
• SPECIAL FOCUS FACILITY
• 5 STAR RATING
• PUBLIC PERCEPTION
• INSURANCE
• OWNERSHIP

SUBSTANDARD QUALITY OF CARE

• ANY SINGLE DEFICIENCY RELATED TO THE FOLLOWING SECTIONS WHICH REPRESENTS EITHER WIDE SPREAD CONCERNS, ACTUAL HARM, OR IMMEDIATE JEOPARDY FOR THE RESIDENTS.
  • RESIDENT BEHAVIOR AND FACILITY PRACTICES [ABUSE TAGS] (F221 – F226)
  • QUALITY OF LIFE (F240 – F258)
  • QUALITY OF CARE (F309 – F334)
• GETTING A SUBSTANDARD OF CARE DEFICIENCY WILL INVOLVE AN “EXTENDED SURVEY”

IMMEDIATE JEOPARDY

• DEFINITION
  • A SITUATION IN WHICH THE FACILITY’S FAILURE TO MEET ONE OR MORE REQUIREMENTS OF PARTICIPATION HAS CAUSED, OR IS LIKELY TO CAUSE, SERIOUS INJURY, HARM, IMPAIRMENT OR DEATH TO A RESIDENT
• SURVEYOR PROCESS FOR CALLING IJ
• APPENDIX G
• EXAMPLES OF POTENTIAL IJ
  • HEATED PACKS
  • WANDERGUARD SYSTEM
  • COMMUNITY ACQUIRED PRESSURE ULCERS
  • ABUSE
IMMEDIATE JEOPARDY
• ABATEMENT
  • SURVEYORS EVALUATE CORRECTIVE MEASURES OF THE PLAN OF REMOVAL.
  • PLANS CAN BE REJECTED AND A BACK AND FORTH CAN ENSUE UNTIL THE REGIONAL OFFICE ACCEPTS THE ABATEMENT PLAN.
  • SURVEYORS LIFT/REMOVE/ABATE THE IJ.
• OUTCOMES
  • 5 STAR RATING
  • CIVIL MONETARY PENALTIES (CMP)
  • PAY FOR PERFORMANCE

THE QUALITY INDICATOR SURVEY (QIS)
• THE QUALITY INDICATOR SURVEY (QIS) IS A STANDARDIZED PROCESS THAT USES COMPUTER SOFTWARE TO AID IN CONDUCTING THE SURVEY
• THE SOFTWARE GUIDES SURVEYORS THROUGH A TWO-STAGED SYSTEMATIC REVIEW OF REGULATORY REQUIREMENTS USING OBSERVATION, INTERVIEW, AND RECORD REVIEW

THE QIS
• STRUCTURED APPROACH TO PROMOTE MORE ACCURATE AND CONSISTENT RESULTS
• LARGER AND MORE DIVERSE RANDOMLY SELECTED SAMPLES TO OBTAIN A MORE ACCURATE PICTURE OF THE RESIDENTS
• AUTOMATION TO SYSTEMATICALLY REVIEW REGULATORY AREAS, SYNTHESIZE SURVEYOR FINDINGS, ENHANCE INVESTIGATIVE PROTOCOLS, AND ORGANIZE SURVEYOR DOCUMENTATION
• COMPUTER DOES NOT TELL A SURVEYOR AN AREA IS DEFICIENT; SURVEYOR IS STILL RESPONSIBLE FOR PROPER INVESTIGATION AND COMPLIANCE DETERMINATION

THE QUALITY INDICATOR SURVEY (QIS)
SURVEY PROCESS

Offsite Survey Preparation

- Review past deficiencies – OSCAR3
- Review any complaints to be investigated
- Review Ombudsman information
- Review occurrences since last survey

Stage I Sample
- Random selection of residents from MDS data loaded in the software

QIS SURVEY PROCESS

Trust the process

- Care Area Management Review
- Stage I Team Meeting
- Randomized Sample
- Stage I Preliminary Investigation
- Initial Team Meeting

Mandatory Facility Tasks (Non-staged)

Transition from Stage I to Stage II/Sample

Stage II Investigation

- Mandatory Facility Tasks
- Continue mandatory tasks

Stage II Analysis and Decision Making
- Integration of information
- Decisions to cite or not to cite

Conduct the exit conference

OFFSITE SURVEYOR PREP

- Surveyors download survey onto Aspen
- Review past deficiencies – OSCAR3
- Review any complaints to be investigated
- Review Ombudsman information
- Review occurrences since last survey

Stage I Sample
- Random selection of residents from MDS data loaded in the software
**ENTRANCE LIST**

- PROVIDE TO THE SURVEYORS WITHIN 1 HOUR (STANDARD) AND IMMEDIATELY (QIS)
- QIS AND STANDARD HAVE DIFFERENT LISTS
- COLORADO ONLY COMPLETES QIS SURVEYS
- ENTRANCE PAPERWORK CAN BE FOUND HERE:

- *PLEASE NOTE A LIST OF ALL THE RESIDENTS WHO SMOKE HAS BEEN ADDED TO THE CHECKLIST AS OF JULY, 2015*
- THERE SHOULD ONLY BE ONE ALPHABETICAL CENSUS LIST - IF YOUR COMMUNITY HAS SEVERAL NEIGHBORHOODS, ALL NAMES SHOULD BE COMBINED INTO ONE LIST
- IN LIEU OF THE COMPLETED NEW ADMISSION FORM, YOU CAN PROVIDE A LIST OF NEW ADMISSIONS IN THE LAST 30 DAYS WHO ARE STILL RESIDING IN THE FACILITY THAT INCLUDES: ADMISSION DATE, DATE OF BIRTH, AND ROOM NUMBER/UNIT FOR EACH RESIDENT.
- ONLY PROVIDE STAFFING SCHEDULES FROM DAY OF ENTRANCE TO THE END DATE LISTED ON THE YELLOW SURVEY POSTINGS.

**ENTRANCE LIST**

- PAGE 3 OF THE ENTRANCE CONFERENCE WORKSHEET REQUESTS A LIST OF RESIDENTS WHO RECEIVE PASRR LEVEL II SERVICES, VENTILATOR, DIALYSIS (WHETHER IN OR OUT OF THE FACILITY), AND END OF LIFE SERVICES (INCLUDING RESIDENTS RECEIVING COMFORT CARE) OR CERTIFIED MEDICARE HOSPICE. THE SURVEYORS WILL PICK ONE RESIDENT FROM EACH OF THESE CATEGORIES TO REVIEW.
  - FOR RESIDENTS RECEIVING PASRR LEVEL II SERVICES, PROVIDE THE LOCATION OF PASRR INFORMATION.
  - FOR RESIDENTS RECEIVING DIALYSIS, BE PREPARED TO PROVIDE ACCESS TO THE WRITTEN CONTRACT, POLICIES/PROCEDURES, AND PLAN OF CARE, SPECIFYING HOW DIALYSIS CARE IS COORDINATED TO ASSIST WITH THE EVALUATION OF CARE.
- PAGE 4 SHOULD ONLY BE COMPLETED IF DIALYSIS IS PROVIDED IN THE FACILITY
**ENTRANCE ARRANGEMENTS**

- Post notice of survey at entrance of community
- Offer to arrange for interview with resident council president only (QIS)
- Provide access to EHR (electronic health record)
- Offer refreshments

---

**STAGE I ADMISSION SAMPLE**

- Admission sample
  - Review of up to 30 recently admitted residents, either current or discharged
  - Focused record review only
  - Emphasizes issues such as rehospitalization, death, pressure sores, weight loss, or functional loss.
  - You will receive a list of closed records requested. Review will focus on the most recent admission only
  - Surveyors will need quick access to weight records and skin assessments (may be helpful to flag these for them to help expedite the process)

---

**STAGE I CENSUS SAMPLE RECONCILIATION**

- The survey team uses the alphabetical list of residents provided by the facility and new admission form from the entrance conference to reconcile and get a census sample
  - Number in sample depends on current census:
    - Above 100 = 40, 61-100 = 35, 33-60 = 30, 1-32 = 90% of the total
    - Residents are removed that are no longer in the facility
- Includes:
  - Record review, staff interviews, resident/family interviews, and observations
  - Focused record review emphasizes:
    - Weight loss
    - Pressure ulcers
    - Nutritional supplement use
    - Unnecessary medications (antipsychotic, antianxiety, antidepressant, hypnotic, mood stabilizer, anticoagulant, antibiotic, diuretic, or insulin)
INITIAL TOUR

- Surveyors observe residents, staff, physical environment, Med rooms/carts and kitchen
- Initial tour may occur while team leader is reconciling new admission list
- QIS will begin to interview residents as soon as they have their sample list reconciled
- Med pass observations/Med storage review may be conducted while waiting for reconciliation to be finished

TRANSITION FROM STAGE I TO STAGE II

- Usually takes 1.5 days to transition
- Computer selects the Stage II sample to include all triggered care areas
- Surveyors meet as a team and have a transition meeting where all potential triggers are discussed to ensure accuracy
- Surveyors review list of dialysis, hospice, ventilator, and PASRR residents (one resident from each is selected for review in Stage II)
STAGE II

• Minimum of 3 residents from each triggered care area are selected
• Priority is for residents currently residing in the facility
• Also includes closed record reviews and MDS triggers
• For abuse—All triggered residents will be reviewed—Only one negative interview needed to trigger abuse pathway
• In-depth investigation to determine whether deficient practice exists, document deficiencies, and determine severity and scope
• Surveyors begin to ask questions and make copies
• Surveyors can initiate an investigation of care issues for any resident or of facility tasks because of the large QIS samples. Surveyor-initiated investigations are a small part of the process.

QIS MANDATORY TASKS

• Dining Observation (the first meal after entrance, another meal will be observed if problems are found)
• Medication Pass Observations (25 opportunities)
• Infection Control and Immunizations Review
• Kitchen/Food Service Observation
• Liability Notice and Beneficiary Appeal Rights Review
• nominal, SNF AIN, and conveyance of funds after death
• Medication Storage Observation
• Quality Assessment and Assurance Review
• Resident Council President Interview

QIS TRIGGERED TASKS

The following are only conducted when Stage I information indicates:

• Abuse Prohibition Review
• Aggressions, Fills
• Admission, Transfer, and Discharge Review
• Environmental Observations
• Personal Needs Funds Review
• Sufficient Nursing Staff Review
ANALYSIS

- Surveyor Daily Team Meetings
  - Discuss observed problems, areas of concern throughout survey in order to address whether they have identified immediate jeopardy or substandard quality of care, also to gage where they are at in the survey process
- Information Analysis for Deficiency Determination
  - Happens at end of survey. Team has meeting to make determination whether deficient or not has the facility met regulatory requirement
  - Touch base with the home office on what is being cited and receive feedback

ANALYSIS

- Deficiency determinations are made through surveyor team reviews by regulatory groupings
  - Citations in the big three under widespread, potential for more than minimal harm, or immediate jeopardy would lead to a substandard survey
  - Extended survey

Deficiencies must include at least 2 out of 3 items (observation, record review and/or interview) has the facility failed to meet a regulatory requirement

Exit Meeting with Team of Community to Exit

- Ombudsman will be invited
- A surveyor will ask to meet with the resident council representative and/or other residents
- Both exits are usually done simultaneously
- Review preliminary negative findings
  - Do not discuss scope and severity
  - This is not necessarily a time to dispute deficiencies. The surveyors do not really allow it
  - Do provide communities with a 24 hour grace period to submit pertinent information
SURVEY READINESS

• Survey Readiness should happen every day
• Survey Readiness Binder
• Current 802 and 672
• Survey Management Assignments
• Internal Audits
• Review past deficiencies and POCS
• Quality review (Mock Survey)
• Survey Drills
• Review Casper Reports/QMS
  • (Quality Measures)

HOW TO ACCESS CASPER QUALITY MEASURES
• How often should they be accessed
• Who should access the reports
• Review/analyze the data
• Action plans based on the analysis
• Review plan and make adjustments
• Continue to evaluate

CASPER REPORTS & QMS

• How to access Casper Quality Measures
• How often should they be accessed
• Who should access the reports
• Review/analyze the data
• Action plans based on the analysis
• Review plan and make adjustments
• Continue to evaluate
INTERNAL AUDITS

- USE AUDIT TOOLS FOR 24/7 / 365 PREP AND AS NEEDED DURING SURVEY
- TRAIN STAFF:
  - HOW TO CONDUCT AUDITS/ROUNDS
  - WHAT TO DO WHEN NEEDS ARE IDENTIFIED
  - WHAT TO DO WHEN CONCERNS/GRIEVANCES ARE IDENTIFIED
  - WHAT TO DO WITH COMPLETED AUDITS TOOLS
  - HOW TO FOLLOW UP ON AUDITS/ROUNDS

This report may contain privacy protected data and should not be released to the public.
SURVEY READINESS BINDER

- CREATE AND MAINTAIN A BINDER WITH THE FOLLOWING:
  - ALL ITEMS REQUIRED WITHIN 1 HOUR OF THE ENTRANCE OTHER ITEMS MAY INCLUDE:
    - LIST OF MANAGEMENT PERSONNEL & LOCATIONS
    - NAME OF RESIDENT COUNCIL PRESIDENT
    - SCHEDULE OF MEAL TIMES AND LOCATIONS OF DINING ROOMS
    - SCHEDULE OF MEDICATION ADMINISTRATION TIME
    - CLOSED RECORDS FROM ADMISSION LIST
    - FEEDING ASSISTANT PROGRAM INFORMATION
    - LIST OF RESIDENTS WHO SMOKE AND SMOKING TIMES
    - PASRR, DIALYSIS AND HOSPICE RESIDENTS LIST
    - INFLUENZA/PNEUMOCOCCAL IMMUNIZATION POLICY AND PROCEDURE
    - LIST OF ROOMS WITH VARIANCES
    - QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) INFORMATION
    - EXPERIMENTAL RESEARCH OCCURRING IN THE COMMUNITY
    - NAME OF CONTACT PERSON FOR ABUSE PROHIBITION / P&P/GRIEVANCES/COMPLAINTS

TIPS:

- PAGE 3 OF THE ENTRANCE CONFERENCE WORKSHEET REQUESTS A LIST OF RESIDENTS WHO RECEIVE PASRR LEVEL II SERVICES, VENTILATOR, DIALYSIS (WHETHER IN OR OUT OF THE FACILITY) AND END OF LIFE SERVICES (INCLUDING RESIDENTS RECEIVING COMFORT CARE OR CERTIFIED MEDICARE HOSPICE). THE SURVEYORS WILL PICK ONE RESIDENT FROM EACH OF THESE CATEGORIES TO REVIEW.
- FOR RESIDENTS RECEIVING PASRR LEVEL II SERVICES, PROVIDE THE LOCATION OF PASRR INFORMATION.
- FOR RESIDENTS RECEIVING DIALYSIS, BE PREPARED TO PROVIDE ACCESS TO THE WRITTEN CONTRACT, POLICIES/PROCEDURES, AND PLAN OF CARE, SPECIFYING HOW DIALYSIS CARE IS COORDINATED, TO ASSIST WITH THE EVALUATION OF CARE.
- PAGE 4 SHOULD ONLY BE COMPLETED IF DIALYSIS IS PROVIDED IN THE FACILITY.
- MAINTAIN THE Binder IN AN ACCESSIBLE PLACE, I.E. ADMINISTRATOR’S OFFICE
- KEY PERSONNEL/DESIGNEES SHOULD KNOW THE LOCATION OF THE BINDER

RESIDENT/FAMILY READINESS

- COMPLETE RESIDENT/FAMILY QIS INTERVIEWS AND OBSERVATIONS (SEE CMS WEBSITE OR QIS MANUAL)/ABAQUIS ON A QUARTERLY BASIS AND FOLLOW UP ON ANY IDENTIFIED ISSUES
- ENCOURAGE RESIDENT PARTICIPATION IN RESIDENT COUNCIL AND REGULARLY ATTEND MEETINGS TO ADDRESS VERBALIZED CONCERNS
- ENCOURAGE FAMILY PARTICIPATION IN FAMILY COUNCIL AND PROVIDE TIMELY FEEDBACK ON CONCERNS
COMMUNITY READINESS

• KEEP THE STAFF INTERVIEW QUESTIONNAIRE UP TO DATE (SEE CMS WEBSITE OR QIS MANUAL)
• KEEP THE CMS-802 (MATRIX) AND CMS-672 (CENSUS AND CONDITIONS) FORMS UP TO DATE
  • ONLY PROVIDE THE 802 FOR COMPLAINT SURVEYS
• KEEP THE SURVEY BINDER UP TO DATE
• CONTINUALLY REMIND ALL LINE STAFF THAT WHEN A SURVEYOR SPEAKS TO THEM ABOUT ANY CONCERN, THEY ARE TO IMMEDIATELY REPORT THAT TO THEIR DIRECT SUPERVISOR, DON OR NHA

COMMUNITY READINESS

• REVIEW PAST SURVEY DEFICIENCIES AND PLAN OF CORRECTIONS
  • POC STILL IN PLACE?
  • WHAT HAS CHANGED?
  • TRENDS?
  • CONCERNS?
• REVIEW GRIEVANCE LOGS FOR OUTSTANDING, UNRESOLVED CONCERNS
• WE WANT TO IDENTIFY POTENTIAL CONCERNS BEFORE SURVEY TO PREVENT SOMETHING FROM TRIGGERING FURTHER INVESTIGATION.

DO’S

• QUICKLY MAKE COPIES OF DOCUMENTS FOR SURVEYORS
  • 1 TO GIVE SURVEYOR AND ALWAYS 1 TO KEEP
• ANSWER SURVEYOR QUESTIONS HONESTLY
• STAY CALM
• STAY ABRID OF THE SURVEYOR TASKS AND COMPLETIONS
• CHECK IN WITH SURVEYORS PERIODICALLY TO SEE IF THEY HAVE NEEDS/CHALLENGES
• ASK FOR CLARIFICATION AS NEEDED

DON’T’S

• ALLOW SURVEYORS TO MAKE THEIR OWN COPIES
• EXPAND ON ANSWERS AND PROVIDE MORE INFORMATION THAN IS ASKED
• ESCALATE BEHAVIOR OR SHOW FRUSTATION, ANGER, FEAR
• ARGUE WITH THE SURVEYORS
STAFF READINESS

- EDUCATE FRONT-LINE STAFF ON SURVEY PROCESS
- REVIEW WHEN SPEAKING WITH SURVEYORS
  - DON'T GUESS IF YOU DON'T KNOW AN ANSWER
  - IT IS AN OPEN BOOK TEST!!
- DON'T OFFER MORE INFORMATION THAN ASKED FOR
- DO REFER THE SURVEYOR TO THE MOST APPROPRIATE PERSON TO ANSWER THE QUESTIONS
- DON'T MAKE UP AN ANSWER IF THEY KEEP ASKING THE SAME QUESTION DIFFERENT WAYS
- DO REFER TO DOCUMENTATION BEFORE ANSWERING

ELDER JUSTICE ACT (EJA)

- IT PROVIDES FEDERAL RESOURCES TO "PREVENT, DETECT, TREAT, UNDERSTAND, INTERVENE IN AND, WHERE APPROPRIATE, PROSECUTE ELDER ABUSE, NEGLECT, AND EXPLOITATION."
- THE FEDERAL EJA DEFINES AN ELDER AS A PERSON 60 YEARS OF AGE OR OLDER
- THE COLORADO REPORTING LAW DEFINES AN ELDER AS 70 YEARS OLD OR OLDER.
- WE MUST REPORT BASED ON THE MORE STRINGENT REGULATION!
EJA COMMUNITY RESPONSIBILITIES

• There are three responsibilities for long-term care providers under the EJA:
  • Notify Covered Individuals: Providers must notify of reporting obligations
  • Post Notice: Providers must post a notice for its employees specifying rights, including the right to file a complaint with the state survey agency
  • Refrain from Retaliation: Providers may not retaliate against an individual who lawfully reports a reasonable suspicion of a crime under the EJA. Policies and procedures should include provisions against retaliation.

EJA “COVERED INDIVIDUALS” RESPONSIBILITIES

• Covered individuals that have reporting obligations under the EJA are owners, operators, employees, managers, agents, and contractors
  • Covered individuals must report any reasonable suspicion of a crime against an elder to the state survey agency and to law enforcement
  • There are two reporting time frames:
    • If the resident suffers serious bodily injury, it must be reported immediately
    • If there is no serious injury, a report must be made within 24 hours of the event

KEEP CALM AND BE READY!

When surveyors arrive...
WHEN SURVEYORS ARRIVE...

- Let your team know and notify your parent company.
- Assign a point person to the surveyors (help them with EHR and other housekeeping items, such as location of bathroom, secured door codes, etc.).
- Be proactive! This helps decrease stress!
- Look at current staffing and staffing for next couple days (look at med. nurses and treatment nurses — if you have some concerns with your scheduled staff, provide additional support prior to shift).
- Look at all incident reports for the current month. Surveyors will note any visual injuries and ask for corresponding incident reports — don’t wait until the end of the month — look at them this first day to make sure they are ready for the surveyors.
- Check for expired meds and treatment supplies!

QIS MANAGEMENT TIP

- The very best way to manage your QIS survey is to manage the stage 1 tasks. Repeat stage 1 tasks often — throughout the year, not just during survey time.
- If an area does not trigger a stage 2 investigation, the surveyors won’t even look at the issue.
- Manage stage 1...
- Prevent care areas from triggering and you will have better survey outcomes!!

SURVEY MANAGEMENT ASSIGNMENTS

- Specific assignments for all key personnel.
- Continues throughout each day and entire survey.
- Assignments begin prior to surveyor arrival and end after they leave.
- Immediately notify administrator/director of nursing of any concerns.
THROUGHOUT THE SURVEY

- Continue your daily stand up meetings
- Continue your daily stand down meetings
- Round, round, round!!!
- Communicate – with staff and surveyors
- Clarify questions, information
- Provide information in a timely manner. Do not make surveyors wait if possible!
- Take notes

THROUGHOUT THE SURVEY

- Make environmental rounds to observe for:
  - Call lights within reach
  - Fresh fluids within reach
  - Safety hazards: unlocked Med or treatment carts, open janitorial closets, oxygen rooms with flammable materials, accessible chemicals/drugs/OTC medications, tangled cords on the floor, etc.
  - Check for hot water temperatures throughout the building (<120°)
  - Check temperature of hot liquids (<150°)

THROUGHOUT THE SURVEY

- Make infection control rounds to observe for:
  - Bagged, uncovered catheter bags, catheter bags or tubing touching the floor
  - And labeled urinals/bedpans
  - Labeled toilets
  - Proper handwashing and glove use
  - Proper use of cleaners (ensuring “dwell time” on surfaces – how long it should be on the surface prior to being wiped off in order to effectively kill germs)
  - Supplements/Pudding/Yogurt on Med carts are dated when opened and stored at the proper temperature, with good system in place for temperature control
  - Staff is aware of proper cleaning techniques for medical equipment (e.g. BP cuffs, glucometers, stethoscopes, etc.)
  - Proper use of PPE (personal protective equipment), especially when isolation precautions are in place
  - Laundry washed at the proper temperature (over 160° for 25 minutes) or with a chlorine concentration of at least 125 PPM
THROUGHOUT THE SURVEY

- Make resident observations to observe for:
  - Resident fall prevention equipment in place and care planned
  - Residents are well-groomed, clean, positioned properly, have all necessary devices (such as splints or oxygen), and that we are offering them toileting and repositioning assistance often
  - Dignity concerns, such as names visibly written on personal effects, personal effects in disrepair, staff not knocking before entering rooms, wheelchair unclean or in disrepair, calling residents pet names, etc.
  - Be conscious of scents during survey and provide assistance if unpleasant smell is noted
  - Since the surveyors will be making observations of the low-functioning residents, it is very important to make sure that all cognitively impaired residents are observed in an activity according to their preferences and care plans.
  - If you see a resident sleeping during an activity, offer to assist them to bed.
  - If you see a resident not engaged and appearing bored, engage them and/or offer an activity.

- Make dining observations to observe for:
  - Proper positioning of residents at dining tables
  - Hand sanitation
  - Mechanical, soft, and puree textures are served appropriately
  - Adaptive equipment is provided
  - Thickened liquids are provided as ordered
  - Food is served timely
  - Residents are assisted to eat or provided their meal in a timely and dignified manner
  - Residents are offered choices at meals
  - Is the dining room homelike (e.g., proper lighting, temperature, has ambiance)

UNIT MANAGERS OR DEPARTMENT HEADS SHOULD BE POINT PERSON FOR THEIR UNITS TO:

- Record names of residents asked about during stage I staff interviews.
- Report whose charts the surveyors pull, so we can anticipate what questions they will ask and be prepared to obtain additional information as needed.
- We need to watch what surveyors are copying - again. So we can anticipate potential questions and provide additional information.
- Daily after surveyors exit, leadership should meet with department heads/unit managers to conduct an internal exit review, issues identified, etc.
COMMUNICATION IS KEY

- Survey management is all about communication
- Communicate with your community team
- What is going on
- What to expect next
- How is the survey going
- What are the surveyors asking
- What has been said to the surveyors
- Communicate with the surveyors
- What do they need
- What can you clarify
- Anything you need to address

IJ MANAGEMENT

- Plan of removal
  - Development begins as soon as the administrator is notified that an IJ exists
  - Plan of removal must be submitted as quickly as possible and approved by state agency
  - Community implements POC with evidence of corrective measures in place

- Follow up
  - Once IJ is abated, community management staff should continue doing rounds to ensure that all staff are aware of new education and new systems implemented to prevent recurrence

MANAGING SUBSTANDARD QUALITY OF CARE AND/OR IJ

- If the surveyor team coordinator mentions the potential or actual substandard quality of care (SQC), the survey orchestration will continue by all team members.
- The NHA takes “command” of that piece of the survey where the surveyor has stated concern regarding potential or actual substandard quality of care or immediate jeopardy.
- The NHA works in partnership with the DON. The NHA will focus on this key area of the survey while the DON/designee remains in command of the overall survey.
- It is imperative the community continues to eliminate the possibility of other SQCs or IJS. After abatement, the community will continue to work the plan and the staff will manage the survey and not allow the survey to manage the community.
POINTS TO REMEMBER

• RESIDENT CARE IS ALWAYS THE PRIMARY FOCUS REGARDLESS OF SURVEY ACTIVITY. THINK OF THE RESIDENT FIRST, MEET THE NEEDS OF THE RESIDENT, THEN ADDRESS THE SURVEY.

PLAN OF CORRECTION (POC) DETERMINATION

• THROUGHOUT THE SURVEY AND DURING THE EXIT STAFF ARE IDENTIFYING POSSIBLE NEGATIVE FINDINGS (DEFICIENCIES) AND SHOULD BE CORRECTING THOSE ISSUES RIGHT AWAY OR WORKING WITH IDT ON WAYS TO CORRECT.
• DO NOT WAIT FOR EXIT OR SURVEYORS TO INFORM YOU OF A PROBLEM - IF YOU SEE IT, FIX IT.
• FOLLOWING THE SURVEY, THE MANAGEMENT TEAM OF THE COMMUNITY MEET AND DISCUSS THE DETAILS OF EACH NEGATIVE FINDING AND START DEVELOPING THE POC.
• USING THE QAPI PROCESS, BEGIN PROBLEM SOLVING AND DETERMINING PLAN OF CORRECTION ACTIVITIES.
2567 ARRIVES
• 2567 = STATEMENT OF DEFICIENCIES
• READ ALL ACCOMPANYING LETTERS; NOTE DATES; NOTE PENALTIES; NOTE REFERRALS
• COMMUNICATE LIST OF F-TAGS WITH S/S AND DPNA DATES; PENALTIES, ETC. TO TEAM
• READ THROUGH THE ENTIRE DOCUMENT AND TAKE NOTES
• COMPARE POC ACTIVITIES THAT HAVE BEEN INITIATED WITH THE DEFICIENCIES WRITTEN

WHY IS A POC IMPORTANT?
• LITIGATION PURPOSES
  • OUR 2567 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) ARE OFTEN USED TO SUPPORT ARGUMENTS IN A COURTROOM TRIAL.
  • A WELL-WRITTEN POC CAN NOT ONLY STRENGTHEN AN ATTORNEY’S CASE AGAINST A FACILITY, IT CAN ALSO CAUSE CONSUMERS TO LOOK ELSEWHERE FOR THE SERVICES THEY DESIRE.
  • EVERYONE NEEDS TO BE AWARE THAT WRITING A POC IS MORE THAN JUST A FORMALITY; IT IS A LEGAL DOCUMENT.
  • IT IS A PUBLIC DOCUMENT AVAILABLE TO CONSUMERS.
  • IT IS THE FRAMEWORK FOR CITATION CORRECTION.
  • A WELL-WRITTEN POC ADDRESSES THESE ISSUES HEAD-ON, WHILE SUPPORTING THE HARD WORK PERFORMED ON A DAILY BASIS.

RESPONSIBILITY FOR POC
• THE ADMINISTRATOR IS THE GATEKEEPER FOR ALL POC RELATED ACTIVITIES.
• THE POC CAN BE WRITTEN BY ANY COMMUNITY LEADERSHIP STAFF BUT NEEDS APPROVAL AND REVIEW BY THE ADMINISTRATOR.
POC WRITING 101

STEP ONE - ANALYZE EACH CITED F TAG
- WHAT IS THE ALLEGED FAILURE OF THE COMMUNITY?
- WHY DID THE PROBLEM OCCUR?
- ARE THE FACTS CORRECT?
- IS THERE REASON TO FILE AN INFORMAL DISPUTE RESOLUTION?
  - WAS INFORMATION PROVIDED TO THE SURVEYORS THAT WAS NOT TAKEN INTO ACCOUNT IN THE 2567?

STEP TWO - CONSIDER THE FOLLOWING
- WHAT IS THE POLICY AND PROCEDURE RELATED TO THIS PRACTICE?
  - ARE APPROPRIATE STAFF MEMBERS FAMILIAR WITH THEM?
- WHAT ARE THE STAFF PRACTICES RELATED TO THE DEFICIENCY?
  - ARE STAFF MEMBERS FOLLOWING THE POLICY AND PROCEDURE?
  - DO THEY NEED COUNSELING AND TRAINING?
- IS THE PERFORMANCE IMPROVEMENT PLAN ADEQUATE?
  - ARE REGULAR AUDITS BEING PERFORMED TO IDENTIFY PROBLEM AREAS?
  - ARE AUDIT RESULTS REPORTED AND ACTED UPON IN A TIMELY MANNER?
- WHAT FORMS AND TOOLS ARE BEING USED?
  - DO THE FORMS CONTAIN ALL OF THE ESSENTIAL INFORMATION?
  - ARE THE FORMS ACCESSIBLE AND EASY TO USE?

STEP THREE - WRITE YOUR PLAN OF CORRECTION
- USE THE INFORMATION GATHERED IN STEPS 1 AND 2 TO DETERMINE CORRECTIVE ACTION
- AVOID USE OF THE WORDS ALWAYS, ALL, AND EVERY
- BE CERTAIN THAT YOU CAN MEET, LIVE WITH, AND SUSTAIN THE POC
- REFER TO RESIDENTS BY RESIDENT ROSTER # ONLY
- ADDRESS THE FIVE REQUIRED AREAS FOR EACH CITATION
PLAN OF CORRECTION – 5 COMPONENTS

1. CORRECTIVE ACTION ACCOMPLISHED FOR RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE.
   • IF THE RESIDENT NO LONGER RESIDES IN THE FACILITY, STATE WHY
   • IF THE DEFICIENCY WAS BASED ON A CLOSED RECORD REVIEW, STATE SO AND MOVE ON TO PART TWO
   • MAKE SURE THE CORRECTIVE ACTIONS LISTED ARE DETAILED AND ENSURE ALL THE FINDINGS IN THE DEFICIENCY WERE ADDRESSED.

2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS AT RISK.
   • PROVIDE SPECIFICS, SUCH AS RESIDENT INTERVIEW, OBSERVATION, MDS REVIEW, CARE PLAN REVIEW, CHART AUDIT, INPUT FROM THE IDT AND/OR SPECIALIZED COMMITTEES.
   • INCLUDE WHETHER THE FACILITY IDENTIFIED OTHER RESIDENTS WHO WERE AFFECTED, OR AT RISK? HOW MANY ADDITIONAL RESIDENTS WERE IDENTIFIED?

3. SYSTEMIC CHANGES/MONITORING TO ENSURE DEFICIENT PRACTICE DOES NOT RECUR.
   • WAS STAFF TRAINING CONDUCTED?
   • WHEN, HOW OFTEN, BY WHOM AND FOR WHICH STAFF (NURSING STAFF, ALL STAFF)?
   • WILL THIS TRAINING BE ADDED TO ORIENTATION FOR NEWLY HIRED STAFF?
   • WERE POLICIES REVIEWED AND UPDATED, OR NEW POLICIES DEVELOPED?
   • THE MONITORING PLAN SHOULD INCLUDE OBSERVATION, INTERVIEW, AND RECORD REVIEW.
   • HOW OFTEN WILL MONITORING BE CONDUCTED, AND FOR HOW LONG?
   • WHAT WILL IT ENTAIL?
   • WHO IS RESPONSIBLE FOR TRACKING RESULTS?
   • WILL THE ISSUE BE INCLUDED IN THE RESIDENT COUNCIL AGENDA TO GET THE RESIDENTS’ PERSPECTIVE ON WHETHER THE POC WAS EFFECTIVE?
   • WILL INDIVIDUAL RESIDENTS BE INTERVIEWED (FOR THOSE WHO DON'T ATTEND RESIDENT COUNCIL), AND/OR WILL FAMILY MEMBERS BE INTERVIEWED?

4. HOW WILL THE POC BE FOLLOWED BY THE QA COMMITTEE?
   • QA SHOULD REVIEW THE POC, DEVELOP AND REVIEW ACTION PLANS, AND MONITOR RESULTS UNTIL THE PROBLEM IS RESOLVED, NOT JUST FOR 90 DAYS OR A SET TIME PERIOD, WHICH MIGHT EXPIRE TOO SOON AND ALLOW THE PROBLEM TO RECUR OR CONTINUE.
   • WHAT MONITORING TOOLS ARE REVIEWED BY THE COMMITTEE?

5. GOAL DATE FOR COMPLETION
   • ALLOW ENOUGH TIME TO IMPLEMENT THE POC OR, FOR LARGER ENVIRONMENTAL PROJECTS, TO SET THE TIMELINE AND INITIATE BIDDING PROCESS.
   • UNLESS ABSOLUTELY NECESSARY, DO NOT EXCEED 30 DAYS FROM EXIT DATE.
COMMON POC MISTAKES

• Avoid use of the words “always”, “all”, “any”, “each” and “every”.
• Insufficient response to the basic federal requirement of a POC.
• Attempting to refute the deficiencies on the POC.
• Not writing the POC to the specific concern cited.
• The POC should be something that is doable and sustainable.
• The date of correction should be attainable, however with consideration of timeline and DPNA (Denial of Payment for New Admissions) date.
• Discussing surveyor behavior in the POC.

INFORMAL DISPUTE RESOLUTION (IDR) PROCESS

• The purpose of informal dispute resolution (IDR) is to provide long-term care communities a voice one informal opportunity to dispute the facts and evidence surrounding disputed deficiencies that are cited for facility noncompliance with pertinent federal and/or state regulations.
• Final determination of all deficiencies reviewed under the IDR processes is vested in the division and/or the Center for Medicare and Medicaid Services (CMS) regional office.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

• The IDR process is also an opportunity to refute deficiencies that have a civil monetary penalty (CMP) associated in a private and smaller group/individual setting.
• The IDR committee is made up of three people.
• Final determination of all deficiencies reviewed under the IDR processes is vested in the division and/or the Center for Medicare and Medicaid Services (CMS) regional office.
COMPONENTS OF A SUCCESSFUL IDR/IIDR

- A strong, easily understandable initial statement that summarizes your basic argument for refuting the tag.
- All further points should expand and explain this initial statement.
- Keep it simple - explain why the issue is not deficient clearly and concisely.
- Provide documentation to support your valid argument. Exhibits should be copies from the record, notes written by providers, or copies from a reference book/website.
- Refer to the regulation in the IDR and why the issue is not deficient.
- You must refute every resident in the tag, even if they are different issues.
- Obtain outside, professional reviews to help support your position (medical director, physician, therapy, etc.)
- You cannot refute only scope and severity unless you were cited at IJ or substandard care.
- An explanation as to why any missing pertinent information was not presented at survey without talking negatively about the surveyor or the process.

SUBMITTING IDR/IIDR

- In Colorado, one copy of the request and statement of deficiencies must be redacted with all textual and numerical identifiers (such as names and phone numbers) removed and one clean copy will also be submitted.
- Removing identifiers with a black marker is sufficient; however, this may not remove the identifiers fully — you may need to make a copy of the redacted copy and submit the second copy.
- The facility documentation submitted with the IDR request should be clearly identified: labeled and cross-referenced to the disputed deficiency.
- Note what is relevant to the disputed deficiency on the second copy. Circling relevant information is preferable to highlighting which may not copy well.
- Isolate the appropriate narrative in the documentation and reference it in the summary statement addressing the nature of the facility dispute.
- The facility may organize the IDR request in any manner that meets the above requirements. Please place a blank sheet of paper between exhibits and label the blank sheet of paper with the exhibit number.

REVISITS

- Onsite or documentation (desk review)
  - Onsite revisit will occur for Harm, SQC, or IJ level citations
  - Desk revisit will occur if all tags were low level.
- Preparing for revisit
  - Survey revisit book
    - Tab for each tag
    - A copy of your plan
    - Section for all of your inservices
      - Include list of participants
      - Include content and competency testing
    - Section for any materials that support your allegation of compliance
    - Keep up to date and ready for presentation to surveyors on revisit
**OCCURRENCE REPORTING**

- In Colorado, we have the Occurrence Reporting Manual which was created by the Health Facilities and Emergency Medical Services Division (HFEMSD) of the Colorado Department of Public Health and Environment (CDPHE).
- It is available on the website at:
- It goes over all of the reportable occurrences as well as the elements required in order to report an occurrence.

**REPORTABLE OCCURRENCES**

- **What are reportable occurrences?**
  - Abuse
    - Physical, Sexual, Verbal
    - Neglect
  - Brain Injuries
  - Burns & Burn Charts
  - Death
  - Diverted Drugs
  - Misappropriation of Resident/Patient Property
  - Missing Persons
  - Malfunction or Misuse of Equipment
  - Life Threatening Complications of Anesthesia
  - Life Threatening Transfusion Errors or Reactions
  - Spinal Cord Injuries

**ABUSE - PHYSICAL**

- "Any occurrence involving physical... abuse of a patient or resident, as described in Section 18-3-202, 18-3-203, and 18-3-204,... C.R.S., by another patient or resident, an employee of the facility, or a visitor to the facility.” 25-1-124 (2)(d), C.R.S.
- Two elements needed:
  - Intent or knowingly or recklessly
  - Bodily injury and/or serious bodily injury,
  - And/or
  - Unreasonable confinement or restraint (18-3-1-101 (4)(a)(B), C.R.S.)

Note: Bodily Injury means physical pain, illness, or any impairment of physical or mental condition (18-1-101 (2)(j), C.R.S.)

Note: Serious Bodily Injury is defined as "bodily injury which involves a substantial risk of death, a substantial risk of serious permanent disfigurement, or a substantial risk of protracted loss or impairment of the function of any part or organ of the body." 18-1-101 (2)(M), C.R.S.
ABUSE - SEXUAL

• "ANY OCCURRENCE INVOLVING SEXUAL ABUSE OF A PATIENT OR RESIDENT, AS DESCRIBED IN SECTION 18-3-402, 18-3-403, 18-3-404, OR 18-3-405 C.R.S., BY ANOTHER PATIENT OR RESIDENT, AN EMPLOYEE OF THE FACILITY, OR A VISITOR TO THE FACILITY." 25-1-124 (2)(D) C.R.S.

• THREE ELEMENTS NEEDED:
  • KNOWINGLY
  • CONSENT NOT GIVEN
  • SEXUAL INTRUSION OR PENETRATION OR, TOUCHING INTIMATE PARTS OR THE CLOTHING COVERING THE INTIMATE PARTS OR, EXAMINES OR TREATS RESIDENT/PATIENT FOR OTHER THAN BONA FIDE MEDICAL PURPOSES OR, OBSERVES OR PHOTOGRAPHS ANOTHER PERSON'S INTIMATE PARTS OR, PHYSICAL FORCE/THREAT.

ABUSE - VERBAL

• "ANY OCCURRENCE INVOLVING VERBAL ABUSE OF A PATIENT OR RESIDENT, AS DESCRIBED IN SECTION 18-3-206 C.R.S., BY ANOTHER PATIENT OR RESIDENT, AN EMPLOYEE OF THE FACILITY, OR A VISITOR TO THE FACILITY." 25-1-124 (2)(D) C.R.S.

• "A PERSON COMMITS THE CRIME OF MENACING IF, BY ANY THREAT OR PHYSICAL ACTION, HE KNOWINGLY PLACES OR ATTEMPTS TO PLACE ANOTHER PERSON IN FEAR OF IMMINENT SERIOUS BODILY INJURY." 18-3-206 C.R.S.

• THREE ELEMENTS NEEDED:
  • KNOWINGLY
  • THREAT OR PHYSICAL ACTION (INCLUDES THREATENING GESTURE)
  • FEAR OF IMMINENT SERIOUS BODILY INJURY

  • NOTE: "SERIOUS BODILY INJURY" IS DEFINED AS "BODILY INJURY WHICH INVOLVES A SUBSTANTIAL RISK OF DEATH; A SUBSTANTIAL RISK OF SERIOUS PERMANENT DISFIGUREMENT; OR A SUBSTANTIAL RISK OF PROTRACTED LOSS OR IMPAIRMENT OF THE FUNCTION OF ANY PART OR ORGAN OF THE BODY." 18-1-901(3)(P), C.R.S.

ABUSE - NEGLECT

• "ANY OCCURRENCE INVOLVING NEGLECT OF A PATIENT OR RESIDENT AS DESCRIBED IN SECTION 26-3-101 (4)(B) C.R.S." 25-1-124(E) C.R.S.

• CARETAKER NEGLECT WHICH OCCURS WHEN ADEQUATE FOOD, CLOTHING, SHELTER, PSYCHOLOGICAL CARE, PHYSICAL CARE, MEDICAL CARE, OR SUPERVISION IS NOT SECURED FOR THE PATIENT OR RESIDENT (AT RISK ADULT) 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, EXCEPT THAT THE WITHHOLDING OF ARTIFICIAL NOURISHMENT IN ACCORDANCE WITH THE COLORADO MEDICAL TREATMENT DECISION ACT, ARTICLE 18 OF TITLE 15, C.R.S., SHALL NOT BE CONSIDERED AS ABUSE.

• ONE ELEMENT NEEDED:
  • FAILURE TO PROVIDE ANY CARE OR SERVICES AS PROVIDED ABOVE RESULTING IN ACTUAL HARM OR
  • STAFF MEMBER HAS A HISTORY IN THE PAST 12 MONTHS OF SIMILAR NEGLECT AND HAD BEEN COUNSELED AND/OR RE-EDUCATED OR
  • STAFF MEMBER INTENTIONALLY FAILED TO FOLLOW STANDARD OF PRACTICE AND/OR FACILITY POLICY WITH SIGNIFICANT POTENTIAL FOR HARM
**BRAIN INJURY**

*ANY OCCURRENCE THAT RESULTS IN ANY OF THE FOLLOWING SERIOUS INJURIES TO A PATIENT OR RESIDENT: (i) BRAIN INJURIES...*. 25-1-124 (2)(B)(i) C.R.S

**TWO ELEMENTS NEEDED:**

- RESULT OF OCCURRENCE AND
- CHANGE IN LEVEL OF CONSCIOUSNESS AND/OR LOSS OF BODILY FUNCTION OR
- DIAGNOSTIC TEST WHICH SHOWS BRAIN INJURY

---

**DEATH**

*ANY OCCURRENCE THAT RESULTS IN THE DEATH OF A PATIENT OR RESIDENT OF THE FACILITY AND IS REQUIRED TO BE REPORTED TO THE CORONER PURSUANT TO SECTION 30-10-606, C.R.S., AS ARISING FROM AN UNEXPLAINED CAUSE OR UNDER SUSPICIOUS CIRCUMSTANCES.* 25-1-124(2)(a), C.R.S.

**TWO ELEMENTS NEEDED:**

- OCCURRENCE RESULTING IN DEATH
- REPORTABLE TO THE CORONER AS UNEXPLAINED OR SUSPICIOUS

---

**BURNS AND BURN CHARTS**

*ANY OCCURRENCE THAT RESULTS IN ANY OF THE FOLLOWING SERIOUS INJURIES TO A PATIENT OR RESIDENT SECOND OR THIRD DEGREE BURNS INVOLVING TWENTY PERCENT OR MORE OF THE BODY SURFACE AREA OF AN ADULT PATIENT/RESIDENT, OR FIFTEEN PERCENT OR MORE OF THE BODY SURFACE AREA OF A CHILD PATIENT/RESIDENT.* 25-1-124(2)(b), C.R.S.

**TWO ELEMENTS NEEDED:**

- SECOND OR THIRD DEGREE BURNS INVOLVING TWENTY PERCENT OR MORE OF BODY SURFACE IN AN ADULT OR FIFTEEN PERCENT OR MORE OF BODY SURFACE IN A CHILD
DIVERTED DRUGS

• "ANY OCCURRENCE IN WHICH DRUGS INTENDED FOR USE BY PATIENTS OR RESIDENTS ARE DIVERTED TO USE BY OTHER PERSONS" 25-1-124 (2)(G) C.R.S.

• ONE ELEMENT NEEDED:
  • DELIBERATE

MISSING PERSONS


• ONE ELEMENT NEEDED:
  • AT RISK AND MISSING AFTER SEARCH CONDUCTED OR
  • MISSING MORE THAN EIGHT HOURS, REGARDLESS OF RISK

MISAPPROPRIATION OF RESIDENT/PATIENT PROPERTY

• "ANY OCCURRENCE INVOLVING MISAPPROPRIATION OF A RESIDENT’S OR RESIDENT’S PROPERTY FOR PURPOSES OF THIS PARAGRAPH." 25-1-124 (2)(G) C.R.S.

• ONE ELEMENT NEEDED:
  • AT RISK AND MISSING AFTER SEARCH CONDUCTED OR
  • MISSING MORE THAN EIGHT HOURS, REGARDLESS OF RISK
MALFUNCTION OR MISUSE
OF EQUIPMENT

• “ANY OCCURRENCE INVOLVING THE MALFUNCTION OR INTENTIONAL OR ACCIDENTAL MISUSE OF PATIENT OR RESIDENT CARE EQUIPMENT THAT OCCURS DURING TREATMENT OR DIAGNOSIS OF A PATIENT OR RESIDENT AND THAT SIGNIFICANTLY ADVERSELY AFFECTS OR IF NOT AVERTED WOULD HAVE SIGNIFICANTLY ADVERSELY AFFECTED A PATIENT OR RESIDENT OF THE FACILITY.” 25-1-124 (2)(H), C.R.S.

• THREE ELEMENTS NEEDED:
  • MALFUNCTION OR INTENTIONAL OR UNINTENTIONAL MISUSE
  • ADVERSE EFFECTS OR POTENTIALLY ADVERSE EFFECTS
  • OCCURRING DURING TREATMENT OR DIAGNOSIS

LIFE-THREATENING
COMPLICATIONS
OF ANESTHESIA

• “ANY OCCURRENCE THAT RESULTS IN ANY OF THE FOLLOWING SERIOUS INJURIES TO A PATIENT OR RESIDENT: LIFE-THREATENING COMPLICATIONS OF ANESTHESIA.” 25-124-12(B)(II) C.R.S.

• TWO ELEMENTS NEEDED:
  • OCCURRANCE AS A RESULT OF ANESTHESIA
  • LIFE-THREATENING COMPLICATION REACTION

LIFE-THREATENING
TRANSFUSION ERRORS OR REACTIONS

• “ANY OCCURRENCE THAT RESULTS IN ANY OF THE FOLLOWING SERIOUS INJURIES TO A PATIENT OR RESIDENT: LIFE-THREATENING TRANSFUSION ERRORS OR REACTIONS.” 25-1-124 (B)(II) C.R.S.

• TWO ELEMENTS NEEDED:
  • ERRORS OR REACTION FROM TRANSFUSION OF BLOOD OR BLOOD PRODUCTS
  • LIFE-THREATENING
SPINAL CORD INJURY

• "ANY OCCURRENCE THAT RESULTS IN ANY OF THE FOLLOWING SERIOUS INJURIES TO A PATIENT OR RESIDENT: (I) OR SPINAL CORD INJURIES. . . ." 25-1-124 (2)(B)(I) C.R.S.

• ANY TRAUMA TO THE CENTRAL NERVOUS SYSTEM WITHIN THE SPINAL COLUMN, INCLUDING THE CERVICAL SPINE, THORACIC SPINE, LUMBAR SPINE, AND SACRAL NERVES WHICH CAUSE: MOTOR OR SENSORY LOSS WHICH MAY BE PERMANENT OR TEMPORARY (HFEMS Guideline).

• THREE ELEMENTS NEEDED:
  * RESULT OF AN OCCURRENCE
  * FUNCTIONAL LOSS CONSISTENT WITH SPINAL CORD INJURY
  * PERMANENT OR TEMPORARY