# Predictable Success
# and
# The New Gold Standard

4.9.21

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# Predictable Success and The New Gold Standard

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"HHI C.A.R.E.S. About Care"

# C.A.R.E.S.™

**HHI C.A.R.E.S. About Care**

**Compliance | Analysis | Audit | Regulatory | Rehabilitation**

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President and CEO

Owns and operates
Harmony Healthcare International (HHI) a Nationally recognized, premier Healthcare Consulting firm specializing in C.A.R.E.S.
There are no nonfinancial disclosures to share.

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C Compliance ™
A Analysis Audit
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# Learning Objectives

1. The learner will be able to state the 5 elements of Predictable success
2. The learner will be able to define Organizational Growth Track
3. The learner will provide an examples of how reimbursement/regulatory policies are driving provider decision-making
4. The learner will apply The New Gold Standard's 3 steps of service to their organization





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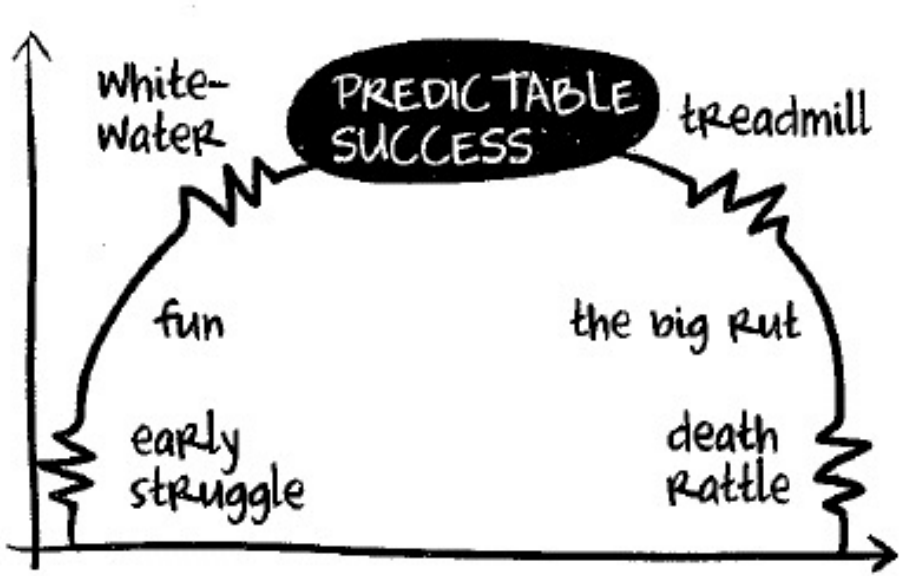
# Taking the Journey

- Having a map means you know where you are going

  Where are you on this map?





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# The Principles of Predictable Success Are Universal

- Will work for any group, in any situation
- Division or department
- Project team
- Not for profit
- Government Agency
- Nongovernmental organization
- Charity
- Soccer team
- Church committee or a family
- Any group of people who are trying to achieve something together

# Agenda

- Early Struggle
- Fun!
- Whitewater
- Success!  What is Predictable Success?
- Treadmill
- The Big Rut
- Death Rattle




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# Predictable Success

- Reallocation of Services




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# What Early Struggle Is

- The option is binary:  Up or out
- About two-thirds of all registered businesses don't survive past the first three years.  As any practicing CPA will tell you, the actual figure is much higher.
- A truer estimate is that about 80% of all new ventures never make it through Early Struggle
- Many of those businesses failed simply because they were unfunded to begin with




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# Fun

- Sell, Sell, Sell – Fast Growth and Early Success

*"I want to run a company where we are moving too quickly and trying too much. If we **don't [make] any Mistakes,** we're not taking enough risk."*

–Larry Page, Google Cofounder





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# Whitewater

- Your organization becomes complex, and the key **emphasis shifts** once more, from **sales to profitability**
- Put in place **consistent processes**, policies and systems
- Identify crisis
- **Doubting** your **leadership** and **management** skills




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# Whitewater

- Why isn't this Fun anymore?  Battling  complexity to become efficient.

*"You found a company, you run it, then it runs you."*
–David Neeleman, former CEO of JetBlue




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# Whitewater

- Getting Out of Whitewater
  - Creating the right organization structure




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# Whitewater

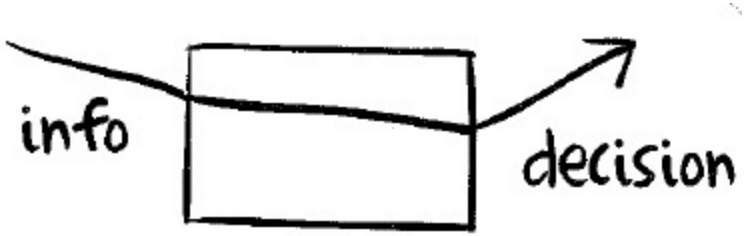
- Working for an Organization in Whitewater
  - During Whitewater the organization often experiences its first serious levels of employee turnover. As a "them and us" attitude develops between sales and operations, some of the more loyal non-sales employees leave or are pushed out.
  - In its desire to ensure a greater adherence to systems and processes, management replaces those who leave with people from larger organizations who are more accustomed to working with – and more comfortable with – systems and processes than were the more loyal "old-timers"

# Whitewater

- Manifested by **increasing errors** and **emergencies** in the organization
- Management **rarely recognizes** the arrival of Whitewater – it thinks the errors and emergencies are merely "bumps in the road"
- When it does address Whitewater, management's first reaction is often to go to a **"Heart and Kidney"** organization structure
- This only makes the situation worse, with a "no man's land" fueling an increasingly **vitriolic "sales versus operations" conflict**

# Overcoming Complexity

- Decision Making
  - In Fun, decisions are made frequently and almost instantly, often based on instinct







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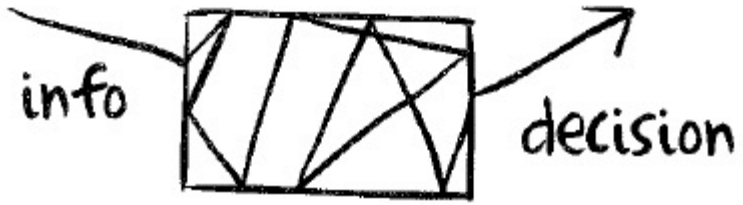
# Overcoming Complexity

- It becomes more and more difficult for the organization to make and implement effective decisions, until eventually the decision-making process slows to a crawl, and in the worst cases may grind to a halt







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# Overcoming Complexity

- An organization that is in itself a machine for decision-making
- Six primary areas:
  1. Org chart
  2. Lateral managers
  3. Alignment
  4. Cross-functional team
  5. Empowerment
  6. Ownership and responsibility

# Cross-Functional Teams

- Start with hiring
  - The importance of involving people from throughout the organization in order to make successful hires, and most employees can see the benefits immediately.




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# Empowerment

- To trust, but increasingly to depend on the cross-functional process to produce effective decisions and successfully implement them

# Ownership and Self-Accountability

- The concept of **ownership** and **self-accountability** is the single most important factor contributing to Predictable Success
- It denotes an innate belief on the part of the employees that they **"own" all aspects of their job**, and that aside from any form of accountability they may be subject to, the employee hold **themselves** accountable for their performance and for the successful completion of tasks delegated to them

# Ownership and Self-Accountability

- It will be resisted by some managers
  - The transition of an organization from Whitewater to Predictable Success is, as we've already seen, a litmus test for some managers.
  - Those managers who see their role as authority-based rather than leadership-based may resist emerging ownership and self-accountability in their direct reports because it appears (to them at least) to erode their own position by reducing their team members' reliance on them.

# Ownership and Self-Accountability

- It will isolate poor hires
  - Lack of ownership and self-accountability becomes increasingly apparent as the organization moves into Predictable Success




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# Whitewater to Predictable Success

- Six specific changes to the way in which the organization makes decisions
  - First, it must redesign its **organization chart** into a **machine** for **decision-making**
  - Second, managers must **learn** to relate **laterally** – to each other – in addition to **retaining** their existing **"vertical"** relationships to their boss and their direct reports





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# Summary

- Third, the newly aligned managers must **push alignment down** through the whole organization, renewing and invigorating their employees' understanding of and commitment to the organization's mission, vision and values
- Fourth, management must implement and enforce **cross-functional decision making** throughout the organization
- Fifth, the groups that are working cross-functionally must (over time) be **empowered** to assume more delegated authority and responsibility

# Summary

- Sixth, and finally, ownership and self-accountability will spontaneously reemerge in the workforce as a result of the first five steps, providing the final push into Predictable Success
- There will be managers and employees opposed to each of the six steps, and management may need to consider if these individuals can remain with the organization if it is to get to Predictable Success

# What Predictable Success Is

- Predictable Success is a state reachable by any group of people – in which they will consistently (and with relative ease) achieve their common goals




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# What Predictable Success is Not

- It is not about size
- It is not about age
  - Litle & Co., a credit card payment processing company, was number one on the Inc. 500 just five years after it was founded
- It is not about money or other resources
- It is not a culture
- It is not about how meetings are held
- It is not about the industry you are in

# Predictable Success as a Natural Stage in Organizational Development

- Predictable Success is the **apex** of the growth curve
  - Organizations **cannot "jump"** a stage.
  - However, by taking the right steps, it is possible to minimize the time spent in a specific stage
- Organizations can move **back** as well as **forward** in the growth cycle
- It is possible for an organization to **remain in Predictable Success indefinitely**

# The New Gold Standard
# "Ritz-level" Customer Service

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# The New Gold Standard

## Motto

"Ladies and Gentlemen

Serving Ladies and Gentlemen"

THE RITZ-CARLTON





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# The New Gold Standard

# Ladies and Gentlemen

## Horst Schulze,
## Busboy 14 years old

"we could never go to this hotel, it is only for important people"





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# The New Gold Standard

- As he watched the maitre d' over time, he realized that the staff were as important as the guests.  Every guest was proud when he spoke to them.  Why? Because the maitre d' was a first class professional!  He was somebody exceptional because of the excellence he created for his guests.

# The New Gold Standard

- All of us who serve, can be Ladies and Gentlemen just like our Guests!
- Treat our guests and each other with respect and dignity




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# The New Gold Standard Leadership Qualities

Ritz offers a rich tapestry of leadership successes

- **Respect** for staff
- **Quality** Improvement
- **Brand** Repositioning
- Corporate **Adaptability**
- Cultural **Consistency**
- Unparalleled **Service Excellence**




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# The New Gold Standard
## Define and Refine

- Define the pillars of enduring excellence that are **fundamental to original success** and longevity
- Refine strategic changes for **growth and evolution**




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# The New Gold Standard

"If we could **turn back the time** to two months before the opening, what would we do to better?"





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# The New Gold Standard
## Stay Relevant

- Shanghai 24 hour club level
- Club level - family and business-separate spots
- Suit and tie, leave the resort




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# The New Gold Standard
# Cultural Considerations

- Omaha
- Indoor playground




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# The New Gold Standard
## Scenography

- San Francisco wine country
- Local relevance
- It's the experience




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# The New Gold Standard

## Curiosity

- Everyone you come in contact within business should be considered a valued customer, whether it's the janitors, the chairman of the board, salespeople, or defined clients




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# The New Gold Standard

## Messaging

- Meet the needs of the customer and message accordingly





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# The New Gold Standard Messaging

- Motto
- Credo
- 3 Steps of Service




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# The New Gold Standard

- Culture versus Cult, carrying around the Credo Card-1986
  1. The Ritz Carlton is a place where the genuine care and comfort of our guests is our highest mission
  2. We pledge to provide the finest personal service and facilities for our guests who will always enjoy a warm, relaxed, yet refined ambiance
  3. The Ritz-Carlton experience livens the senses, instills well-being, and fulfills even the unexpressed wishes and needs of our guests

# The New Gold Standard
# 3 Steps to Service

1. A warm, nice greeting.  Use the guests' **name.**
2. **Anticipation and fulfillment** of each guests needs
3. Fond Farewell.  Give a warm goodbye and use the guests' **name.**




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# The New Gold Standard
# Customer Centered

"The Art of Anticipation"




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# The New Gold Standard

## The Basics

- Annual Training Certification on each position
- Each employee will continually identify defects
- Each employee has responsibility to create a work environment teamwork
- Uncompromising levels of cleanliness
- Recording guest preferences
- Whoever receives a complaint, will own it, record it
- Be an Ambassador in and out
- Never point, always escort
- Take pride and care of your personal appearance
- Smile and eye contact





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# The New Gold Standard
## The Basics

- Guidelines, not Treadmill
- Follow the cues of the guest




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# The New Gold Standard
# Starbucks

Starbucks 5 principles of turning ordinary into extraordinary; "coffee staged in an environment of affordable luxury"

- Name on the cup
- Free wifi
- Ample seating and leather couches
- Free coffee if wrong order
- Looking to produce transformational customer experiences




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# The New Gold Standard

- Looking to produce transformational customer experiences




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# The New Gold Standard

## The Daily Huddle

- The “Lineup”
  - 3 x per day,
  - motivational quotes,
  - guest feedback throughout the world,
  - includes the top




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# The New Gold Standard

- Repetition of Values
- Common Language
- Visual Symbols
- Oral Traditions
- Positive Storytelling
- Modeling by Leaders




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# The New Gold Standard
# You Must Fail to Succeed

Just because they have a great reputation does not mean they do not make mistakes

- The pen, not tested fully
- Pool in the shade all day




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# Employee Retention

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# Employee Retention





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# QAPI
# What Is It and
# Where Do I Begin?

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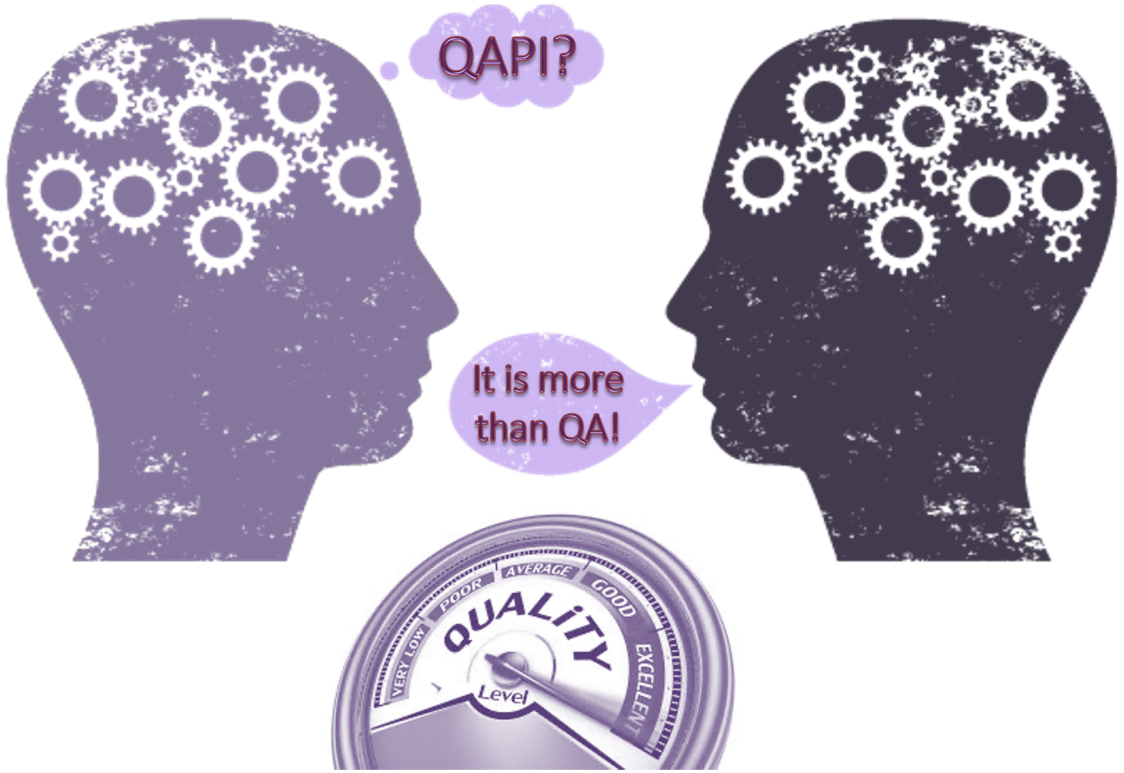
# Let’s Talk QAPI





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# Are You Already Doing QAPI?

- Does your facility…
  - Investigate problems and try to prevent their recurrence systemically?
  - Track and report adverse events?  To whom?
  - Compare the quality of your home to that of other homes in your state or company?
  - Create systems that focus on improving care and achieving healthcare regulation compliance?

# What is QAPI?

- QAPI is a data-driven, proactive approach to improving the quality of life, care, and services provided to residents in healthcare organizations
- The activities of QAPI involve members at all levels of the organization to:
  - Identify opportunities for improvement
  - Address gaps in systems or processes
  - Develop and implement data-driven improvement/corrective action plans
  - Continuously monitor effectiveness of interventions

# What is QAPI?

- Quality Assurance and Performance Improvement (QAPI)
- "QAPI is about critical thinking.  It involves figuring out what is causing certain problems and implementing interventions and solutions that address the root causes of the problems, rather than just the symptoms."
  - Karen Schoeneman, Past Technical Director, CMS Division of Nursing Homes

# What is QAPI?

| Quality Assurance | Performance Improvement |
| --- | --- |
| • Reactive<br>• Single episode<br>• Organizational mistake<br>• Prevents something from happening again<br>• Sometimes anecdotal<br>• Retrospective<br>• Monitoring based on audit<br>• Sometimes punitive | • Proactive<br>• Aggregate Data<br>• Organizational process<br>• Improves overall performance<br>• Always measureable<br>• Concurrent<br>• Monitoring is continuous<br>• Positive change |




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# 2014 QAPI Performance to Date

(*) = Measured as rate of occurrence per 1000 participant days.

| QAPI Area Addressed | Measure | Baseline | Target | 1st Q 2014 Results | 2nd Q 2014 Results | 3rd Q 2014 Results |
|---|---|---|---|---|---|---|
| **Utilization of Services** | Hospital Readmission within 30 Days | 22.26% | 21.16% | 12.2% | 18.6% | **16.8%** |
| **Participant Satisfaction** | Improve Participant Satisfaction Rating | 29th percentile | 40th percentile (Oct. 2014) | NR | NR | **NR** |
| **Caregiver Satisfaction** | Improve Family Satisfaction Rating | 83% | 85% (Oct. 2014) | NR | NR | **NR** |
| **Data collected during Participant Assessments** | Fall Prevention | 5.28* | 5.02* | 4.75* | 4.47* | **4.54*** |
| | Pressure Wound Prevention | 0.37* | 0.35* | 0.33* | 0.26* | **0.30*** |
| | Appropriate Use of Antipsychotic Medications | 20% | 50% | NR | N/A | **41% YTD** |





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# QAPI Regulatory Update

- "Quality Assurance and Performance Improvement (QAPI)" (§ 483.75) per the Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities; Final Rule (10/4/16)
- In accordance with the statute, we **require** all LTC facilities to develop, implement, and maintain an effective comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care and quality of life

# QAPI Regulations

- §483.75(a) Requires each facility develop, implement and maintain an effective, comprehensive, data-driven QAPI program, reflected in it's QAPI Plan that focuses on systems of care, outcomes and services for residents and staff
- The facility must maintain documentation and demonstrate evidence of its QAPI program
- Submit QAPI (Work) plan to surveyors during survey process

# QAPI Regulations

- Required to address all systems of care and management and always include:
  - Clinical Care
  - Quality of Life
  - Resident Choice

# QAPI Regulations

- As part of QAPI, each facility is **required** to use the best available evidence to define and measure indicators of quality and set facility goals that identify processes/operations that is improved, result in improved resident care and outcomes
- **Must** obtain and use feedback from direct care and access workers, residents, and families to identify areas of opportunity for improvement
- **Must** involve all departments and be added to any facility-based policy and procedures accordingly

# QAPI Regulations

- The SNF QAPI must include initiatives that address any adverse events - preventable and non-preventable – such as:
  - Failure to diagnose or treat
  - Medication variance (less than 5%)
  - Injury due to falls
  - Failure to identify change of condition
  - Spread of disease due to infection control errors
  - Pressure Ulcers due to inappropriate care

# 12 Action Steps
# QAPI

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# The 12 Action Steps to QAPI

- The 12 steps do not need to be achieved sequentially, but each step builds on other QAPI principles
- The most important aspect of QAPI is effective implementation





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# QAPI 12 Action Steps

Step 1
- Leadership Responsibility & Accountability

Step 2
- Develop a Deliberate Approach to Teamwork

Step 3
- Take Your QAPI “Pulse” With a Self-Assessment




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# QAPI 12 Action Steps

**Step 4**
- Identify Your Organization's Guiding Principles

**Step 5**
- Develop Your QAPI Plan

**Step 6**
- Conduct a QAPI Awareness Campaign




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# QAPI 12 Action Steps

**Step 7**

- Develop a Strategy for Collecting and Using QAPI Data

**Step 8**

- Identify Your Gaps and Opportunities

**Step 9**

- Prioritize Quality Opportunities and Charter Performance Improvement Plan (PIP's)





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# QAPI 12 Action Steps

**Step 10**
- Plan, Conduct and Document PIP's

**Step 11**
- Getting to the "Root" of the Problem

**Step 12**
- Take Systemic Action!!




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# QAPI

# The Five Elements

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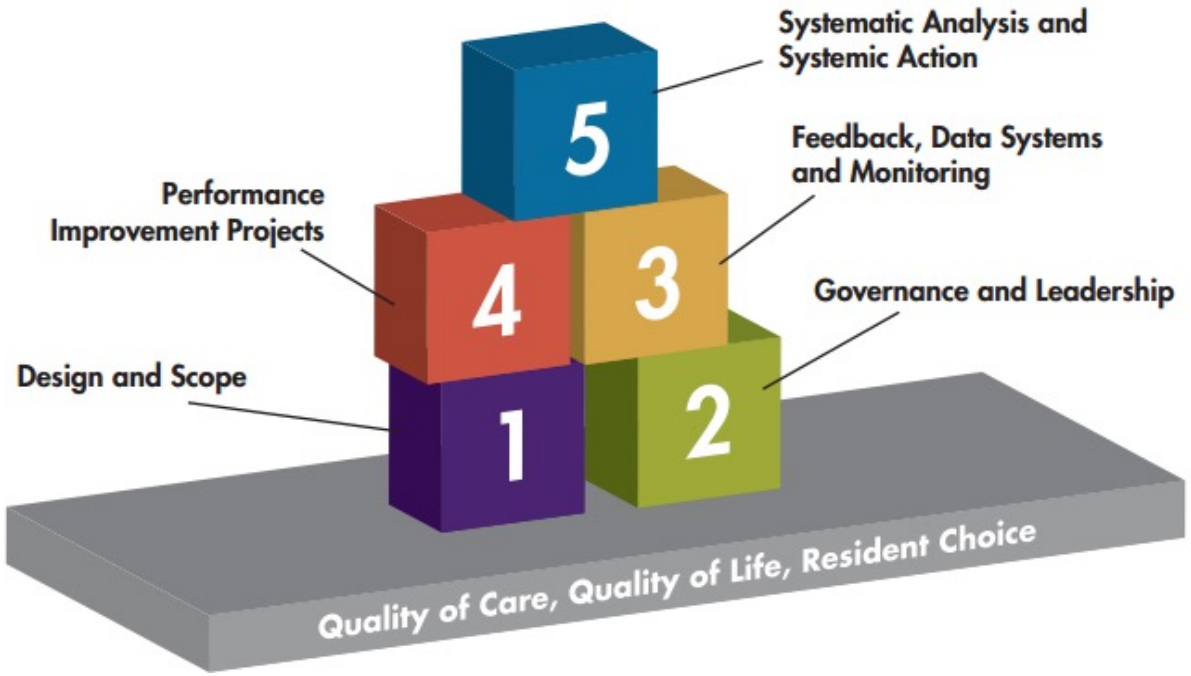
# CMS' QAPI: The Five Elements





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# QAPI Program Five Elements

## Element 1: Governance and Leadership

Quality Assessment and Assurance Committee:

- Committee must meet quarterly
- Committee's MAIN objectives:
  - Remove barriers that prevent subcommittee's from reaching QAPI Work Plan initiative targets and lead the development of annual QAPI based on areas that present the most risk to the residents and facility!

# QAA Committee Development

- Change Team Leader
- Committee members must approve QAPI (Quorum)
- Facility-specific Policy required that describes how the QAPI program works
- Meeting minutes, Sign-In sheet and binder creation and maintenance for Survey readiness
- Regulators will be allowed to look at all QAPI Program materials including committee approved, written work plan, working papers and data tracking tools

# QAPI Five Elements

## Element 2: Feedback, Data Systems, and Monitoring

- Identify areas to monitor based on your facility assessment and specific service areas
- Utilize available performance measures to monitor clinical outcomes
- Develop systems to monitor care utilizing multiple data sources
- Implement systems to obtain feedback from resident, family, staff, physicians and other identified stakeholders
- Identification and monitoring of adverse events

# Data Sources

- Data Integrity is a must!
- Data needs to valid, reliable, reproducible, and  measurable
- What are the current mechanisms for data collection?
  - Record reviews/audits
  - Direct observations/competencies
- Sources – Internal versus External

# Data Sources

## Sample Internal Data Sources:

- Wound reports
- Weight variance reports
- 24 hour reports
- Incident reports
- Medication Administration Audit
- Consultant pharmacy reports
- Infection surveillance reports
- Resident Grievances
- Family, patient satisfaction surveys

## Sample External Data Sources:

- Nursing Home compare:
  - QMs and Five-Star rating
- CASPER reports
- PEPPER reports
- Health Inspection survey results (2567)
- Advancing Excellence
- Abaqis
- My Innerview
- Press Ganey




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# Data Monitoring

- Who is responsible for the collection?
  - Identify gatekeeper of data
- How will the data be measured?
  - Set a target and determine an acceptable threshold for the data
- How often will data be collected?
  - Initially to establish baseline and at least quarterly to measure progress toward target and whether maintaining acceptable threshold
- What corrective action will be taken when data falls below acceptable threshold?

# QAPI Five Elements

## Element 3: QAPI Work Plan

- The written, QAA Committee (Governing Body) approved, QAPI Work Plan is the core of the QAPI process
- A concrete QAPI Work Plan describes the areas of focus/risk that the QAA committee agrees require a long-term solution to improve overall quality of care
- Remains in place for at least one year – nothing added, nothing removed* (see next slide)
- HHI Ten Elements for a thorough QAPI

# Annual QAPI Plan

- The QAPI steering committee submits its annual plan for the coming year to the CEO and governing board for review, modifications and approval by January 15th
- The final approved plan becomes the basis by which the committee will direct its efforts over the coming year
- *The plan may be modified during the year, with CEO/Governing Board approval, based on circumstances

# QAPI Work Plan Domains

- Domain:  A specified sphere of activity or knowledge
- Work Plan initiatives are selected to reflect a global approach to quality improvement
- HHI (CMS) Suggested Domains:
  - Clinical Care (Safety)
  - Resident Choice (Rights)
  - Quality of Life and Care Transitions (Quality)
  - Utilization of Services (Choice)
  - Non-Clinical Areas (Respect/Satisfaction)

# Initiative Suggestions

| Domain | Initiative |
|---|---|
| Clinical Care | • Pressure Injury Prevention<br>• Fall Prevention:  Reduce Falls with Major Injury<br>• Appropriate Use of Antipsychotic Medication - gradual dose reduction documentation by physicians<br>• Appropriate Monitoring of Anticoagulation Status<br>• Medical Record/EMR will provide an accurate and up to date comprehensive diagnosis list<br>• Adverse Event Identification and Reporting<br>• Medication Variance Reporting Compliance |
| Residents' Choice (Dignity) | • Incontinence Reduction<br>• Meaningful Choices - dining, activities, scheduling of care<br>• Participation in Care plan<br>• Pain Management<br>• Call bell response time |

# Initiative Suggestions

| Domain | Initiative |
|---|---|
| Quality of Life and Care Transitions | • Unintended Weight Loss<br>• Safely Reduce Hospital Readmissions within 30 days (AHCA/NCAL recommends a rate of 10% by 03/2018)<br>• Hand Hygiene - infection prevention<br>• Resident Satisfaction<br>• Family Satisfaction<br>• Employee Satisfaction<br>• Employee perceptions of whether necessary information is communicated during hand-offs<br>• Medical Record Documentation Compliance<br>• Gradual Dose Reductions - Antipsychotic medications |
| Utilization of Services | • Polypharmacy: Reduce Resident Medication Utilization including antipsychotics, antibiotics, hypnotics and opioids in general |





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# Initiative Suggestions

| Domain | Initiative |
|---|---|
| Utilization of Services (cont.) | • Antibiotic Utilization<br>• Emergency room visits<br>• Reduce Worker's Compensation Utilization<br>• Reduce the utilization of overtime in CNA staffing patterns (Improve CNA regular staffing)<br>• UB-04 coding compliance<br>• Significant Change Identification and Completion |
| Non-Clinical Areas | • Policy and Procedure Maintenance<br>• Employee Retention and Staffing:  Open Clinical Positions<br>• Property Loss Reduction<br>• Housekeeping service |





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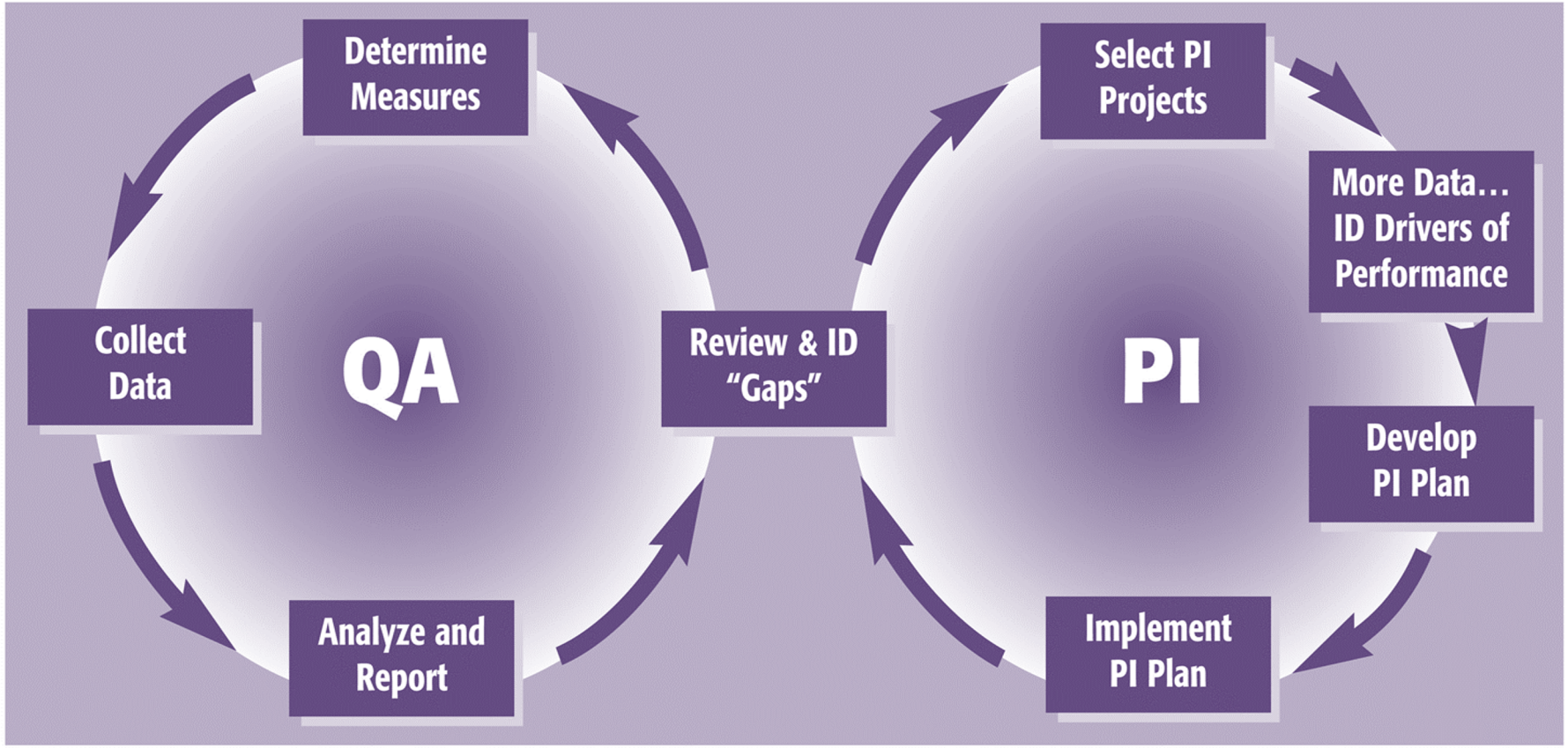
# QAPI





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# QAPI Work Plan Scorecard Example Slide for QA Meeting

| Domain | Measure | Baseline | Target | 1st Q 2016 |
|---|---|---|---|---|
| Quality of Life and Care Transitions | Unintended Weight Loss | 12.2% | 7.4% (2016 National average ) | 12.2% |
| | Hospital Readmission within 30 days | 11.0% | 13.0% or less | TBD |
| Utilization of Services | Unnecessary Medications (Antianxiety, hypnotics) | 22.8% | 16.4% | TBD |





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# The Goal of "What We Do"

- The goal of providing **the best possible quality of care and life** for those entrusted to our care does not change
- Success depends on us **evolving** and always striving to **redefine and achieve excellence**
- Successful QAPI will not be a **department**, it will be a **way of life** in the organization

# Enjoy the Journey!

"Don't judge each day by the harvest you reap, but by the seeds you plant"

-Robert Louis Stevenson





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# Final Thoughts….

- The future of healthcare is all about **partnerships** – solidify relationships
- Be aware of and **transparent** about your quality outcomes, benchmark and continuously “move the needle”
- Be willing to provide **all levels of care** and market your strengths




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# Colorado Assisted Living Regulations

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# Emergency Preparedness
# Policies and Procedures

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# Emergency Preparedness
# Policies and Procedures

- Facilities will have **resident rosters available**; these rosters will include:
  - Room assignments
  - Emergency contacts
  - Facility diagram showing room locations

# Emergency Preparedness
# Policies and Procedures

- Risk assessments are to be completed for all hazards, including but not limited to:
  - Measures to address natural and human caused crisis.
  - Weather, violence, fire, power outages, etc.

# Emergency Preparedness
## Policies and Procedures

- Facilities will have **written policies and procedures** to ensure that the necessary care is available and provided to all residents for at least **72 hours immediately following any emergency**
- Policies and procedures will be **geared to the location** of the facility and the type of residents
- Any **unique risks or circumstances** of the resident should also be identified

# Emergency Preparedness
# Policies and Procedures

- Each facility must **hold routine drills** to provide training and education to staff in the case of a true emergency
- **Documentation of the drill** shall be recorded describing the event and participants

# Emergency Preparedness Policies and Procedures

- Each assisted living facility emergency policies and procedures, at a minimum, must address the following:
  - Written instructions for each identified risk.
    - Persons to be notified
    - Steps to be taken
    - These must be available 24 hours a day, in more than one location, clearly marked and identifiable.
  - A map of the facility must be posted in centrally located, visible area. These maps must indicate:
    - Evacuation routes
    - Smoke and fire stop doors
    - Exit doors
    - Location of fire extinguishers
    - Location of fire alarms

# Emergency Preparedness Policies and Procedures

- Each assisted living facility emergency policies and procedures, at a minimum, must address the following (continued):
  - When to evacuate the building
  - An established process for communicating with residents, staff, vendors, and families.
  - Storage of Medications
  - A plan that shows the availability or access for emergency power, resident required medial devices or auxiliary aids.
  - Pre-determined assignment list showing various team members responsibilities
  - A means to transfer resident health information that is necessary to meet the needs of the resident.
  - Relocation opportunities, written agreements and transportation plans.

# Emergency Preparedness
# Emergency Equipment

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# Emergency Preparedness
## Emergency Equipment

- First aid equipment must remain readily available, in central locations and up to date
- Ensure that the expiration date has not been exceeded
- Make sure the staff are aware of the locations and use of First Aid Equipment




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# Emergency Preparedness
# Emergency Equipment

- Each First Aid Kit should contain:
  - Latex free disposable gloves
  - Scissors
  - Adhesive Bandages, sterile gauze, flexible roller gauze.
  - Bandage tape
  - Triangular bandages with safety pins
  - Note pad with a pen or pencil
  - CPR barrier mask or barrier device
  - Soap or waterless hand sanitizer

# Emergency Preparedness
## Emergency Equipment

- When available, Automated External Defibrillator (AED), will be maintained according to manufacturers guidelines along with evidence of staff training on the use of the AED
- There must be at least one telephone that is not powered by household electrical current, for emergency use
  - Contact information for police, fire poison control, and ambulance must be readily accessible
- Assisted living facilities will have back up generator powered alternatives in the case of power failures

# Resident Rights

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# Resident Rights

- The Assistive Living residence and staff shall observe these rights in care, treatment, and oversight of residents

- The right to privacy and confidentiality
  - To have a private and unrestricted communications with any person of choice
  - To have a private telephone calls or use electronic communication
  - To receive mail unopened
  - To have visitors at any time
  - To have private, consensual sexual activity

# Resident Rights

- The right to **civil** and **religious liberties**
  - To be treated with dignity and respect
  - To be **free from sexual, verbal, physical or emotional abuse, humiliation, intimidation, or punishment**
  - To be free from **neglect**
  - To live **free from financial exploitation, restraint, and involuntary confinement** (except as allowed by the secure environment)
  - To **vote**
  - To exercise **choice** in attending and participating in **religious activities**
  - To **wear clothing of choice** unless otherwise indicated in the care plan
  - To **care and services that are not conditioned or limited** because of the resident's disability, sexual orientation, ethnicity and/or personal preferences

# Resident Rights

- The right to **personal and community engagement**
  - To socialize with other residents and participate in assisted living residence activities in accordance with the applicable care plan
  - To use the **common areas** in compliance with the house rules
  - To **participate in resident's meetings, voice grievances and recommend changes** in the polices and service **without fear of reprisal**
  - To **participate in activities outside** the assisted living residence and request assistance with transportation
  - To use the **telephone** including access to operator and placing collect calls
  - At **least one telephone access** to residents utilizing an **auxiliary aid**

# Resident Rights

- The right to choose and personal involvement regarding care and services
  - To be informed and participate in decision making regarding care and services, in coordination with family members who may have different of opinions.
  - To be informed about formulate advance directives
  - The freedom of choice in selecting a health care service or provider
  - To expect cooperation of the assisted living residence in achieving the maximum degree of benefit from those services which are made available
  - English proficiency or impairment that inhibit communication the assisted living residence shall find a way to facilitate communication of care needs
  - To make decisions and choices in the management of personal affairs, funds, and property in accordance with resident ability
  - To refuse to perform tasks requested by the assisted living residence or staff in exchange for room, board, other goods, or services

# Resident Rights

- The right to choose and personal involvement regarding care and services
  - To have advocates, including members of community organizations whose purposes include rendering assistance to the residents.
  - To receive services in accordance with the resident agreement and the care plan
  - To 30 calendar day written notice of changes in services provided by the assistive living residence including but not limited to involuntary change of room or changes in charges for a service; Except:
    - Change in the resident medical acuity that result in a documented decline in condition and that constitute an increase in care necessary to protect the health and safety of the resident
    - Request by the resident or the family for additional services to be added to the care plan

# Resident Rights
# Ombudsman Access

- In accordance with the Older Americans Act Reauthorization Act of 2016 (P.L 114-144) and 26-11.5-118 and 25-27-104(2)(e), C.R.S and assisted living residence shall permit access to the premises and residents by the state ombudsman and designated local long term care ombudsman at any time during ALR's regular business hours or regular visiting hours and at any other time when access may be required by the circumstance to be investigated

# Resident Rights
# House Rules

- The house rules **must be visible** and always available to residents and visitors
- All the **possible actions** which may be taken by the ALR's if any rule is knowingly **violated by a resident**
- The house rules shall **not supersede or contradict** any regulation herein or in any way discourage or hinder a resident's exercise of his or her rights

# Resident Rights
# House Rules

- The Rules
  - Smoking including the use of electronic cigarettes and vaporizers
  - Cooking
  - Protection of valuables on premises
  - Visitors
  - Telephone Usage including frequency and duration
  - Use of common areas and devices such as television, radio, and computer
  - Consumption of alcohol and marijuana
  - Pets

# Resident Rights
## Resident Meetings

- Each assisted living residence shall **hold regular meetings** with residents, staff, family, and friends of residents so that all have opportunity to voice concerns and make recommendations concerning ALR services, activities, policies and procedures
- Held **at least quarterly** with an opportunity for more frequent meetings
- **Written minutes** to be maintained made readily available for review by residents and visitors.
- **Respond to any suggestions** or issued raised from the prior meeting before the start of the next meeting
- Residents and family members shall have the **opportunity to meet without the presence of ALR staff**

# Resident Rights
# Internal Grievance and Complaint Resolution Process

- The process for raising and addressing grievance and complaints shall be placed in a visible on-site location along with full contact information for the following agencies:
  - The state and local long-term care ombudsman
  - The Adult Protection Services of the appropriate county Department of Social Services
  - The advocacy services of the area's agency on aging
  - The Colorado Department of Public Health and Environment
  - The Colorado Department of Health Care Policy and Financing in those cases where the ALR is licensed to provide services specifically for persons with intellectual and developmental disabilities

# Resident Rights
# Investigation of Abuse and Neglect Allegations

- The ALR shall **investigate all allegations of abuse, neglect**, or **exploitation** of residents in accordance to Section 5 and the written policy shall include:
  - Reporting requirements to the appropriate agencies as the adult protection services of the appropriate county Department of Social Services and the ALR administrator.
  - Notify the legal representative about the allegation within 24 hours of the ALR becoming aware of the allegation
  - The process for investigating such allegations
  - How to document the investigation process to evidence the required reporting and that a thorough investigation was conducted
  - The resident will be protected from potential future abuse and neglect while the investigation is being conducted
  - If the neglect or abuse is verified what are the appropriate corrective actions
  - The copy of the report with the investigation findings shall be retained by the facility and available for the Department review

# Resident Care Services

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# Resident Care Services

- Facility shall make available, either directly or indirectly through a resident agreement, the following services, sufficient to meet the needs of the residents
  - Safe and clean environment. Including measures to prevent hazards and risks
  - Room and Board
  - Personal services such as a system for identifying and reporting resident concerns that require either an immediate or ongoing individualized approach and possible ongoing re-assessments.
  - Appropriate measures with and unanticipated situation or event involving one or more residents and the ability to identify urgent issues or concerns that require immediate individualized approach
  - Social care and resident engagement

# Resident Care Services

- Nursing services may provide support to the residents provided they do not rise to the level that becomes 24 hour medical or nursing care
  - Other staff may assist with nursing services if they are trained and evaluated for competency and they are supervised by a nurse
  - Only staff employed or contracted by the facility may provide assistance with nursing care
  - Arrangements for discharge may be necessary if:
    - An acute illness arises that cannot be managed by medication or therapy
    - Physical limitations that cannot be compensated for with intermittent staff or auxiliary aids.
    - Incontinence episodes that cannot be managed by staff or the resident
    - Stage 3 or 4 pressure sores
    - Disorientation or behavior that rises to the level that jeopardizes safety of self or others (ex: Elopement risk)

# Resident Care Services

- Additional occasional services may be provided by an external provider
  - Syringe or tube feeding
  - IV medications
  - Catheter care
  - Ostomy care
  - Wound care for a Stage 1 or Stage 2 pressure sore if the wound or condition is stable or healing
    - An assisted living residence shall not admit or keep a resident with a Stage 3 or 4 pressure sore unless the resident has a terminal condition and is receiving continuing care from an external provider

# Resident Care Services

- The facility shall have policies and procedures identifying when a Practitioner assessment of a resident is appropriate. At a minimum this will include contacting the Practitioner under any of the following circumstances:
  - Significant change from baseline
  - Physical signs of infection
  - In the event of an injury or accident
  - Known exposure to communicable disease
  - Development of any condition which would have precluded admission to the assisted living residence

# Resident Care Services

- Comprehensive assessments are required and include all the following:
  - A description of the residents' physical, mental and social needs, cultural, religious and activity needs, preferences and capacity for self-care.
  - Resident overall health and physical functioning ability
  - Advanced Directives
  - Communication abilities/needs
  - Current diagnoses with needs or anticipated needs
  - Food and dining preferences
  - Daily routines including bathroom use, sleep patterns, interest, etc
  - Environmental preferences including responses to change, roommates
  - Physical history including physical, mental, and social support needed.
  - Personal background including falls, supportive family or friends, cultural and religious preferences
  - Assessments will be maintained as part of the residents health information and updated at least annually or when there is a change in condition

# Resident Care Services

- Resident Care Plans
  - Must reflect input from the resident or resident's representative
  - Reflect the most current assessment information
  - Promote independence, mobility, safety and resident choice
  - Identify specific personal services or preferences needed
  - Reflect coordination of care and interventions for goals
  - Identify formal and informal opportunities that match the resident's personal choices and needs

# Resident Care Services

- Care Coordination
  - The residence will coordinate resident care services with external providers as needed
  - The residence will notify the residents representative whenever there is a significant change from baseline

# Resident Care Services

- Restraints of any kind shall not be used for purposes of care unless certified to provide services specifically for the mentally ill or facilitates a residents well being and or independence with the following criteria:
  - The resident has the functional ability to alter his/her position
  - The resident can remove the device to allow for normal movement
  - The device improves the residents physical or emotional state and allows for participation in activities that would otherwise be difficult or impossible, and
  - There is an order from the Practitioner for the use of the device
  - Interdisciplinary  documentation describing the benefits
  - Evidence of re-evaluation at least annually or whenever there is a significant change

# Resident Care Services

- Falls Management Program
  - Policies and Procedures to establish a fall management program that includes:
    - Education for residents' staff and families
    - Details within resident care plans that reflect individualized approaches to address risks, strengths, possible medication side effects, vision, and balance
    - Interventions to improve patient strength and balance
    - Routine environmental safety inspections
    - Staff training on fall prevention
    - Staff education regarding Lift Assistance for those that may have fallen and are unable to get up from the floor

# Resident Care Services

- Lift Assistance
  - Staff will remain informed regarding the facility policy on resident handling when they are unable to get up from the floor.  This policy shall be made available to all staff and emergency responders
  - Trained Staff will remain available to evaluate residents who have fallen. Once evaluated, the staff will determine how to proceed. (Call 911, assist from floor with mechanical lift, etc)
  - Facility will notify all involved parties as appropriate (Physician, Families, etc)
  - Documentation of incident will be maintained along with preventative actions

# Resident Care Services

- Resident Engagement
  - The ALR will encourage residents to maintain and develop their fullest potential
  - The ALR will provide all residents regular opportunities to participate in areas of interest
  - The ALR will assist residents with access to outside services or community events and encourage participation.  Opportunities will be posted. (ex: recreation, arts, educational opportunities, religious events, etc)
  - The ALR will evaluate resident involvement at least every three months

# Resident Care Services

- Use of Volunteers
  - The participation of Volunteers with resident engagement will be encouraged.
  - All volunteers will be supervised by the administrator or designee




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# Resident Care Services

- Physical Space and Equipment
  - An ALR shall have sufficient space, both indoor and outdoor, to accommodate resident engagement
    - Common areas should be comfortable, furnished, and available for all to relax and socialize with others
    - Outdoor areas need be easily accessible and safe.  With recreational equipment and supplies to meet the needs of all residents.  Including those with special needs that can be reasonably accommodated.
  - Each ALR will ensure staff that accompany residents away from the facility have easy access to resident information in the case of an emergency.

# Infection Control

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# Infection Control

- Assisted Living Residences must have an infection control program that provides initial training upon hire and annual staff training that includes at least the basic principles of infection prevention including modes of transmission, hand hygiene, PPE use, and cleaning/disinfection techniques.
- Assisted Living Residences must have and follow written policies and procedures that address the transmission of communicable diseases that have a significant risk of transmission to other persons.
  - The policy must include criteria and guidelines for monitoring/encouraging staff wellness, tracking and responding to patterns and trends, seeking assistance from and reporting to state/local health departments, and isolation techniques, including how to handle linen and clothing of residents with communicable disease.
- The disposal of items containing blood, body fluid or body waste from a resident with a contagious condition will be placed in a sturdy plastic bag inside the room where it is used, then re-bagged in the hallway and disposed of as medical waste.

# Physical Plant Standards

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# Physical Plant Standards

- Comply with applicable local zoning, housing, fire and sanitary codes and ordinances of the city, county where the ALR is located in accordance with the "Fair Housing Amendment Act of 1988."
- Constructed in conformity with the standards adopted by the Director of the Division of Fire Prevention and Control at the Colorado Department of Public Safety
- An ALR applying for an initial license on or after June 1, 2019 or renovations on or after this date will comply with specific parts of the building codes and the Guidelines for Design and Construction of Residential Health Care and Support Facilities, Facility Guidelines Institute unless otherwise indicated
  - Small model facilities of 10 beds or less are exempt from compliance with the Facility Guideline Institute guidelines that each resident have access to a bathroom without entering a corridor and that the building have an elevator that is sized to accommodate a gurney and/or medical carts

# Exterior Environment

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# Exterior Environment

- Grounds will be kept free of high weeds, garbage and rubbish
- Grounds maintained to protect residents from slopes, holes or other hazards and be consistent with any landscaping plan approved by the local jurisdiction
- Exterior stairs lighted at night
- Porches, stairs, handrails and ramps in good repair
- Porches and exterior areas with more than one step within a linear 6 foot run will have a handrail.
- Parking spaces determined by the local requirements and the resident population and the functional need of the resident population
- ALR must submit building plans for newly constructed or existing building prior to being issued a license.  Existing licensees must submit plans for renovations, additional square footage and replacement building before beginning construction.

# Interior Environment

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# Interior Environment
## General

- All interior areas free of extraneous materials including unused or discarded furniture and potentially combustible materials
- Cleaning compounds and hazardous substances stored in secure location with no access to confused residents
- Maintain a readily available list of safety data sheet for potentially hazardous substances used by staff
- Utility room for storing disinfectants, detergent concentrates, caustic bowl and tile cleaners and insecticides will be locked.
- Designated area for smoking where allowed will be equipped with fire resistant wastebaskets, including resident's room where smoking is allowed

# Interior Environment
# Heating, Lighting and Ventilation

- **Heating, lighting and ventilation** in each room will meet the needs of the room and the residents' needs
- All interior spaces and stairs will be **adequately lighted**




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# Interior Environment
## Water

- Adequate supply of **safe, potable water** available for domestic purposes
- Sufficient supply of **hot water** during peak usage demand
- Hot water will **not measure more than 120F** at taps that are accessible to residents

# Interior Environment
## Common Areas

- Sufficient in size to reasonably accommodate all residents
- All common areas and dining areas accessible to a resident using an auxiliary aid without requiring a transfer from a wheelchair to walker or from a wheelchair to a stationary chair for use in the dining area
- All doors leading to common areas must be at least 32 inches wide
- An ALR that has one or more residents that use an assistive device must have a minimum of 2 means of access and egress from the building unless local code requires otherwise

# Interior Environment
## Sleeping Room

- Must be designated for sleeping
- No more than 2 residents per bedroom
- 100 square feet for single occupancy and 60 square feet per person for double occupancy
- Each resident will have storage space such as a closet for personal articles
- At least one window with 8 square feet which can be opened
- ALR that provides furnishings for residents per agreement will provide a standard-sized bed with a comfortable, clean mattress, mattress protector, pad and pillow (rollaway type beds, folding beds, futons, bunk beds are prohibited) and a standard sized chair in good condition

# Interior Environment
# Bathroom

- Full bathroom for every 6 residents that includes:
  - Toilet
  - Handwashing station
  - Mirror
  - Private, individual storage for resident personal effects
  - Shower
- Bathtubs and showers will have proper safety features to prevent slips and falls
- Toilet seats constructed of non-absorbent materials and free of cracks
- ALR will provide toilet paper in each resident bathroom unless resident agrees to supply their own due to specific preference
- If one or more residents use an assistive device, ALR provides at least one full bathroom with fixtures positioned for full accessibility to any resident using an aid
- Grab bars properly installed at all tubs and showers and adjacent to at least one toilet in every multi-stall toilet room if any resident uses an assistive device or as indicated by the patient population needs

# Interior Environment
## Heating Devices

- Use of **portable heating devices** are **prohibited** as well as the use of fireplaces, space heaters and like units that produce heat are prohibited in common areas unless they are UL approved, i.e., do not present a resident burn risk and are used in accordance with manufacturer instructions
- Use of **electric blankets** and or **heating pads** in resident rooms are **prohibited** unless supervised by staff or the Administrator has assessed the resident and determine the resident is capable of using the device in a safe and appropriate manner and documents this

# Interior Environment
## Oxygen Use

- Handling and storage of oxygen  complies with all applicable local, state and federal requirements
- Smoking prohibited in areas where oxygen is stored and or used and must post a conspicuous “No Smoking” sign in those areas
- ALR must ensure O2 tanks are not rolled or dragged on their side
- O2 tanks are stored upright and prevented from falling over, being dropped or strike each other
- O2 tank valves closed when not in use
- Not placed against electrical panels, live electrical cords or near radiators or heat sources.  If stored outdoors, tanks must be protected from weather extremes and damp ground to prevent corrosion

# Interior Environment
## Smoking

- ALRs must comply with the Colorado **Clean Indoor Air Act**
- **Designated outdoor smoking** areas must be **monitored** whenever residents are present
- Designated outdoor smoking areas must have **fire resistant waste disposal containers**

# Interior Environment
## Cooking

- Cooking is **not permitted** in **sleeping rooms**
- Residents must have **access** to an **alternative area** where minimal food preparation is permitted
- When there are **dwelling units** versus simply sleeping rooms, cooking is **allowed in accordance with house rules**
- Only **residents who are capable of cooking safely** are allowed to do so and the ALR must document such assessment
- If cooking equipment is available in dwelling units, the ALR must have a **definite way** to **disable the equipment** if the resident becomes unable to use it

# Interior Environment
# Electrical Equipment

- Electric socket **adaptors** or **connectors** designated to multiply outlet capacity are prohibited
- **Extension cords** are permitted for **temporary use only**
- **Power strip surge protectors** are permitted with the following limitations:
  - Power strip has overcurrent protection in the form of a circuit breaker or fuse
  - Power strip has UL (Underwriters Laboratories) or similar certification label
  - Power strips are not linked together

# Interior Environment
## Personal Electric Appliances

- Appliances that do not require the use on an extension cord or multiple use electrical sockets
- Appliances are in good repair as evaluated by the Administrator or designee
- Written documentation to support that the resident has been assessed and determined to be capable of using such appliance in a safe and appropriate manner

# Environmental Pest Control

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# Environmental Pest Control

- Written policies and procedures that provide for effective control and eradication of insects, rodents, and other pests
- Must have a contract with a licensed pest control company or an effective means for pest control using the least toxic and least flammable effective pesticides. The pesticides must not be stored in resident or food areas and kept under lock and only properly trained responsible personnel allowed to use them
- Screens or other pest control measures must be provided on all exterior openings except where prohibited by fire regulations
- Doors, door screens and window screens must fit with a sufficient tightness at their perimeters to exclude pests

# Administrative, Personnel, and Staffing Requirements

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# Administrative Requirements

- **Background Checks for an Administrator**
  - To ensure the administrator is of good, moral, and responsible character
  - Fingerprint-based criminal history record check
- **Qualifications for an Administrator**
  - At least 21 years old,
  - Possess a high school diploma or equivalent
  - At least one year of experience supervising the delivery of personal care services that includes Activities of Daily Living

# Administrative Requirements

- Training Requirements
  - Completion of an Administrator Training Program with written proof
  - The Administrator Training Program is conducted by an accredited organization
    - Training program must have competency testing to demonstrate understanding of the regulations and topics

# Administrative Requirements

- Duties
  - Day to day delivery of services
  - Directing the ongoing functions including physical maintenance
  - Ensuring services conform to the requirements set forth
  - Employing, training, and supervising qualified personnel
  - Providing continuing education to all personnel
  - Establishing and maintaining an organizational chart with lines of responsibility and adequate supervision of all personnel
  - Reviewing marketing materials and information published
  - Managing the business and financial aspects, ensuring an adequate budget
  - Completing, maintaining, and submitting all reports and records required
  - Complying with all applicable federal, state, and local laws regarding licensure and certification
  - Appointing and supervising a designee who is capable of fulfilling the Administrator's duties when the Administrator is unavailable

# Personnel Requirements

- Background checks
  - To ensure the staff members and volunteers are of good, moral, and responsible character, request, prior to hire, a name-based criminal history record check
- Background Check Policies and Procedures
  - Updated criminal history check required if the ALR becomes aware that an Administrator, staff member, or volunteer could pose a risk to the health, safety and welfare of the residents or is not of good, moral, and responsible character
  - Implement P & P regarding the hiring or continued service of any Administrator, staff member or volunteer providing ALR services who could pose a risk to the health, safety and welfare of the residents or is not of good, moral, and responsible character

# Personnel Requirements

- Ability to Perform Job Functions
  - Physically and mentally able to safely perform all job functions essential to resident care
  - Base selection of direct care staff on factors such as the ability to read, write, carry out directions, communicate, and demonstrate their competency to safely and effectively provide care and services
  - Establish written P & P regarding pre-employment physical evaluations and employee health, restricting on-site access of staff or volunteers with drug or alcohol abuse that would adversely impact their ability to provide resident care and services

# Personnel Requirements

- Orientation Topics shall include
  - Care and services provided by ALR including palliative and/or end of life care if applicable
  - Resident Rights
  - Overview of state regulatory oversight
  - Hand hygiene and infection control
  - Recognizing emergencies, emergency response policies and procedures and relevant emergency contact numbers
  - House Rules
  - Person-centered care
  - Reporting requirements

# Personnel Requirements

- Staff Training within 30 days of hire that includes
  - Assignment of duties and responsibilities
  - ALR P & P
  - Occurrence of reporting
  - Recognizing behavioral expression and management techniques
  - Effectively communicating with residents who have hearing loss, limited English, dementia or other conditions impairing communication
  - Emergency procedures such as fire response, basic first aid, AED use, and if applicable practitioner assessment and serious illness, injury and/or death of a resident
  - Role of and communication with external providers
  - Training related to fall prevention and ways to monitor residents for fall risk
  - Where to locate each resident's advance directive
  - Maintenance of a safe, clean, and healthy environment
  - Understanding end of life care
  - How to safely provide lift assistance, accompaniment, and transport of residents
  - Food safety

# Personnel Requirements

- Personnel Policies, written job descriptions and other requirements regarding the condition of employment, management of staff and resident care to be provided

# Personnel Requirements

- Personnel Files
  - For each of its employees and volunteers who provide ALR services
  - Each file shall include description of duties, date of hire or acceptance of volunteer duties date, orientation and training, verification of active license or certification if applicable, results of background checks and TB test if applicable
  - Additional documentation if the employee or volunteer is a qualified medication administration person
  - Personnel files will be retained for three years following an employee's or volunteer's separation from service and must include the reason for the separation

# Personnel Requirements

- Personal Care Worker
  - Must attend initial orientation and additional orientation before providing care with these topics included:
    - Personal care worker's duties and responsibilities
    - Differences between personal services and skilled care
    - Observation, reporting, and documentation regarding a resident's change in function along with the ALR residence's response requirements.
  - Training and observation is not required for a personal care worker returning to a facility after a break in service of 3 years or less if they meet specified conditions
  - An ALR shall designate an Administrator, a nurse or other capable individual to be responsible for the oversight and supervision of each personal care worker.

# Personnel Requirements

- Personal Care Worker (continued)
  - A personal care worker shall only be allowed to perform tasks that have a chronic, stable, and predictable outcome and that do not require routine nurse assessment.
  - Competency of a personal care worker must be observed and documented for every personal task assigned prior to their independent performance of it.
  - Only appropriately skilled professional may train personal care workers and their supervisors on specialized techniques beyond general person care and assistance with activities of daily living.
  - The ALR shall ensure that each personal care worker complies with all ALR P & P and not allow them to perform functions that are outside of their job descriptions, written agreements, or a resident's care plan.

# Staffing Requirements

- **Minimum Staffing**
  - Whenever one or more residents are in the ALR, there shall be at least one staff member present who is capable of responding to an emergency and who has **current certification in CPR** or first aid.
- **Staffing Levels**
  - Based on the **acuity and needs of the residents**, their care plans and the services in the resident agreement
  - Staff shall be sufficient to help residents needing or potentially needing assistance

# Staffing Requirements

- First Aid, Obstructed Airway Technique, and Cardiopulmonary Resuscitation (CPR) Trained Staff
  - ALR shall have sufficient staff members who are currently certified in first aid and CPR to meet requirements
  - Each ALR shall have onsite at all times one staff member who has current certification in first aid from a nationally recognized organization
  - Each ALR shall have onsite at all times one staff member who has current certification in CPR from a nationally recognized organization
  - Each ALR will place in a visible location a list of all staff who have current certification in first aid or CPR so the information is readily available to staff
  - Each ALR shall require that all staff who are certified in first aid or CPR promptly provide those services in accordance with their training unless with CPR the resident has a do not resuscitate order
  - Each ALR shall require that staff, even if not certified in first aid or CPR, promptly respond to an emergency and follow the instructions for a 911 emergency call operator until a medically trained provider can assume care

# Staffing Requirements

- Use of Volunteers and Residents
  - Volunteers and residents may assist with the provision of resident care and services but the ALR shall not consider the use of either volunteers or resident helpers in determining the appropriate staffing level
- Use of Hospice Providers
  - There will be a written agreement signed by the authorized representatives of the hospice and ALR prior to the provision of hospice care
  - The agreement will specify at a minimum how they will communicate and coordinate care
  - The hospice will assume responsibility for determining the appropriate course of hospice care and the ALR will provide room and board and other services as required
  - If the hospice provider fails to provide services when they are necessary, the ALR shall follow requirements in Colorado's regulations, section 12.5 regarding a resident's significant change in baseline status and request a practitioner assessment

# Staffing Requirements

- Contracted Personnel and Services
  - An ALR that uses a separate agency, organization or individual to provide services for the ALR or residents shall have a written agreement that sets forth the terms of the arrangement
  - If contract personnel or services are used, the contractor shall meet all applicable requirements of the ALR regulations
  - The ALR shall retain the responsibility for oversight of all contracted personnel and services to ensure the health, safety, and welfare of the residents

# Medication and Medication Administration

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# Medication and Medication Administration General Requirements

- ALR shall **not allow** an **employee or volunteer** to **administer or assist with administrating** medication to a resident unless such individual is a
  - practitioner,
  - nurse a qualified medication administration person (QMAP)
  - or a certified nurse medication aid (CNA-Med) acting within his or her scope of practice.
- A practitioner is authorized if state law allows the practitioner to prescribe treatment, medication, or medical devices. (for purposes of section 14)

# Medication and Medication Administration General Requirements

- A QMAP or a CNA-MED is not allowed to assist a resident with medication administration unless the resident is able to consent and participate in the consumption of the medication
- If a CNA-MED is used to administer or assist with administrating medication to a resident, the ALR shall ensure that the CNA-MED complies with the medication administration procedures listed in Section 14, except may perform additional task associated with medication administration as authorized by his or her certification

# Medication and Medication Administration General Requirements

- The ALR must comply with the requirements of 6 CCR 1011-1, chapter 24, Medication Administration Regulations, in addition to the requirement set in Section 14 if use a qualified medication administration person
- Shall comply with all federal and state laws and regulations relating to the procurement, storage, administration, and disposal of controlled substances
- Shall ensure that each resident receive proper administration and/or monitoring of medications

# Medication and Medication Administration General Requirements

- The ALR is responsible for **ensuring compliance** with all safety requirements regarding **oxygen use**, handling, and storage as set forth in section 22.29 through 22.34
- **No medication** shall be administered by a qualified administration person on a **pro re nata (PRN)** or as needed basis except
  - In a **residential treatment facility** that is licensed to provide services to for the mentally ill
  - Where the **resident understands the purpose of the medication**, is capable of voluntarily requesting a medication and the ALR has documentation from an authorized practitioner that the use of such medication in this manner is appropriate or
  - Specifically allowed by statute

# Medication and Medication Administration General Requirements

- The qualified medication administration person, unless otherwise allowed by statute, is unable to perform
  - IV
  - IM
  - Subcutaneous injections
  - Gastrostomy or jejunostomy tube feeding
  - Chemical debridement
  - Administration of medication for purpose of restraint
  - Titration of oxygen
  - Decision making regarding PRN or as needed medication administration
  - Pre pouring of medication
  - Assessment of residents or use of judgement including medication effect.
  - Masking or deceiving administration of medication including but not limited to concealing in food or liquid
- Only medication that has been ordered by an authorized practitioner shall be prepared for or administered to residents

# Medication and Medication Administration
## Training, Competency and Supervision

- All qualified medication administration persons must be trained and adhere to the following medication guidelines:
  - Identification of the right resident for each medication administration or monitoring be asking the residents name or comparing the resident to a photograph maintained specifically for medication administration identification
  - Provide the correct medication by the correct route at the correct time and in the correct dose as ordered by the authorized practitioner
  - Implementing any changes in medication orders upon receipts

# Medication and Medication Administration
## Training, Competency and Supervision

- The ALR will **designate a QMAP supervisor** who is a nurse, practitioner or meets the requirements of a Qualified Administration person
- The **QMAP supervisor** before initial assignment of each qualified medication administration person, conduct a **competency assessment** with the direct observation of all medication administration tasks that the QMAP will be assigned to perform
- When a QMAP is **assigned additional medication administration tasks,** the QMAP supervisor shall conduct a competency assessment with **direct observation** of **each new task** that the QMAP will be assigned

# Medication and Medication Administration
## Resident Rights

- All personal medication is the property of the resident and no resident shall be required to surrender the right to possess or self-administer unless deemed unable to do so by the authorized practitioner
- Right to privacy and dignity with respect to medication monitoring and administration
- Right to refuse medication

# Medication and Medication Administration Orders

- The ALR shall ensure that each authorized practitioner's order for medication include the correct name of the resident, date of order, medication name, strength of medication, dosage to administer, route of administration along with the timing and/or frequency of administration, any specific considerations, if substitutions are allowed or restricted, and the signature of the practitioner
- All medication orders shall be documented in writing by the authorized prescribing practitioner verbal orders for medication shall not be valid unless received by a licensed staff member who is authorized to receive and transcribe such orders.
- Any orders received from medical staff on behalf of an authorized practitioner must be countersigned by said practitioner as soon as possible.
- The ALR shall contact the authorized practitioner for clarification of orders which are incomplete, unclear and obtain new orders in writing.
- The ALR shall be responsible for complying with authorized practitioner orders associated with medication administration except for those medications which a resident self-administers
- The ALR shall coordinate care and medication administration with external providers

# Medication and Medication Administration
## Medication Reminder Boxes

- For **medication reminder boxes** that the ALR is responsible for the ALR shall ensure that the box contains:
  - **No more than 14 calendar** day of supply of medication at a time
  - **No PRN medication** including PRN controlled substances
  - Only medication intended for **oral ingestion**
  - **No medication** that requires administration **within specific timeframes** unless the medication reminder box is specifically designed and labeled with specific instructions to address this situation
  - Medication reminder boxes **shall be stored** in a manner that **ensures access** for the designated resident and **prevents access from unauthorized persons**

# Medication and Medication Administration
## Medication Preparation and Handling

- The ALR shall maintain **medication storage** and **preparation areas** which are **clean and free from clutter**
- All reusable medical devices shall be **cleaned** according to the manufacturer instructions and appropriately stored
- **No stock medication shall be stored** or administrated by QMAP
- All over the counter medication prescribed for administration shall be **labeled or marked** with the **individual resident's full name**
- The ALR shall ensure that **QMAP are trained** in and apply nationally recognized protocols for **basic infection control and prevention** when **preparing and administering medications**

# Medication and Medication Administration Record Keeping

- All **prescribed and PRN medication** shall be listed and recorded on a **medication administration record (MAR)** which contains the name and date of birth of the resident, the resident's room location, any known allergies and the name and telephone number of the resident's authorized practitioner
- The **medication administration record** shall reflect the **name, strength, dosage** and **mode of administration** of each medication, the **date** the order was received, the **date and time of administration,** any **special consideration** related to administration and the signature or initial of the person administrating the medication
- As part of the medication administration record, the ALR shall maintain a **legible list of names** of the persons **utilizing the record for medication administration**, along with each of their signatures and, if used, their initials
- Each qualified medication administration person, nurse or practitioner shall accurately **document each medication administration** or monitoring event at the time the event is completed for each resident
- **Each QMAP, nurse or authorized practitioner** shall **document accurate information** in the medication administration record including any medication omission, refusals and resident reported responses to medications

# Medication and Medication Administration Record Keeping

- The ALR shall maintain a **record on separate sheet** for each resident receiving **controlled substance** which contains the name of the controlled substance, strength and dosage, date and time administrated, resident name, name of authorized practitioner and the quantity of the controlled substance remaining
- The Administrator and the QMAP supervisor shall, on a **quarterly basis audit** the accuracy, and completeness of the **medication administration records**, **controlled substance list, medication error reports and medication disposal records**. Any irregularities shall be investigated and resolved. The results of the audits shall be documented and routinely included as part of the ALR Quality Management Program Assessment and review
- The ALR shall have **policies and procedures** for **documenting, investigating, reporting, and responding to any errors** related to accurate accounting of controlled substances and/or medication administration

# Medication and Medication Administration
## Record Keeping

- The ALR shall ensure that a resident's authorized practitioner and resident's legal representative is promptly notified of:
  - A decline in resident's baseline
  - A resident's pattern refusal
  - A resident's repetitive request for and use of PRN medication
  - Any observed or reported unfavorable reactions to medications
  - The administration of medications used to emergently treat angina
  - Medication errors that affect the resident

# Medication and Medication Administration
## Self Administration

- The ALR shall compile a list of all resident medications along with any known allergies and verify the accuracy and completeness of the list with the resident and authorized practitioner at the time of admission
- The ALR shall review this list with the resident and authorized practitioner at least once a year and maintain documentation of such review
- The ALR shall report non-compliance, misuse, or inappropriate use of known medications by a resident who is self-administrating to that residents authorized practitioner

# Medication and Medication Administration

## Medication Storage

- All medications shall be **stored in the original prescribed/manufacturer containers** with the exceptions of mediations placed in medication reminder boxes pursuant to section 14.23
- All medications shall be stored in a **locked cabinet, cart or storage area** when unattended by QMAP or licensed staff.
- **Controlled substances shall be kept in double locked storage**
  - Two individuals who are either QMAP, nurses or practitioners shall jointly count all controlled substances at the end of each shift and sign documentation regarding the results of the count at the time it occurs
  - Any discrepancy in the controlled substance count shall be immediately reported to the administrator
- All **refrigerator medication** shall be stored in a **refrigerator** that **does not contain food** and that **not accessible to residents**
  - All medication stored in a refrigerator shall be clearly labeled with the residents' name and prescribing information

# Medication and Medication Administration

## Medication Storage

- The ALR shall not store or retain for more than 30 calendar days any outdated, discontinued and/or expired mediations
  - Outdated, discontinued and/or expired medications that are not returned to the resident or legal representative shall be stored in a locked storage area until properly disposed of.
  - Any controlled substance medications which are designated for destruction shall be kept in a separated locked container within the locked storage unit they are destroyed.
- The ALR shall conduct, monthly a joint two-person audit of medications designated for disposal
  - At least one of the persons conducting the audit shall be a QMAP.
  - The results of the audit shall be documented and signed by both staff members conducting audit
  - Audit records shall be maintained for a minimum of three years. Any discrepancy in the list and count of medications designated for disposal shall be immediately reported to the administrator

# Medication and Medication Administration
## Medication Destruction and Disposal

- **Medication shall be returned** to the resident or resident's legal representative, **upon discharge or death**, except that return of medication to the resident may be withheld if specified in the care plan of a resident of a facility which is licensed to provide services specifically for the mentally ill or if a practitioner had determined that the resident lacks the decisional capacity to possess or administer such medication safely
- A resident of resident's legal representative may authorize the ALR to return unused medication and medical supplies and used or unused medical devices to a prescription drug outlet or donate to a nonprofit entity in accordance with 12-42.5-133, C.R.S. and 6 CCR 1011-1, Chapter 2, Part 7.202.
  - The ALR shall request and maintain signed documentation from the resident or resident's legal representative regarding the return of donation of all medications, medical supplies, or devices.

# Medication and Medication Administration
## Medication Destruction and Disposal

- The ALR shall have **policies and procedures** regarding the **destruction and disposal** of outdated, unused, discontinued, and/or expired medications which are not returned to the resident or legal representative
- At a minimum, the policies and procedures shall include the following requirements:
  - Medication shall be destroyed in the presence of two individuals, each of whom are a QMAP, nurse or practitioner.
  - Medication shall be destroyed in a manner that renders the substances totally irretrievable
  - There shall be documentation which are identifies the medications, the date of destruction and the signatures of the witnesses performing the medication destruction and
  - All destroyed medications shall be disposed of in compliance with sections 24.2 and 24.3 regarding medical waste disposal

# From The Field

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# From The Field

- "Ensure staff working more than one shift in a row are screened between shifts. It is possible to develop symptoms during the shift without being aware given the intensity of care being provided by the staff. Consider screening all staff after their shift and working day to identify symptoms to assist with proactive staffing management."
- "Provide good hand hygiene to residents prior to meals. Place an alcohol wipe on each tray, use the alcohol wipe for all of the residents prior to eating or being fed their meal. Track the use of the alcohol wipes to determine compliance and develop a QAPI program for resident hand hygiene prior to meals."

# From The Field

- "SPEAK UP! Other staff not donning and doffing PPE correctly, not enough PPE, N95 masks not fit tested? Now is not the time to go with the flow, alert someone to your concerns, they may not be aware that the situation exists and it may be putting you and the residents at risk."
- "Establish an efficient tracking system for the dates of testing, results and room moves, along with a daily census sheet by room number. Keep all this in a separate binder that is easy to get to."

# From The Field

- "Give as much support and love as you can to your residents. They will be frightened and confused, especially if they are moved around in the facility during an outbreak. If they are moved to a different unit, make sure they have a few personal items that are very comforting and orienting to them. Assess them in their new room for tripping hazards and help orient them to the layout, especially if they have vision or cognitive impairments. If they had a particular type of siderail in their prior room, make sure they have the same kind available for the new bed. Help them learn the layout of the new room, especially getting from the bed to the bathroom and back. Make sure the tv is in good working order."

# From The Field

- "Support your teammates and let them support you. Lean on each other. An outbreak is very difficult to go through, especially if there are any deaths."

- "Make sure you take time away from the COVID unit or facility, just to get a break from it. Your mental and physical health will depend on this. Don't hesitate to reach out to support staff for help if you are struggling. You are not alone."



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# From The Field

- “When you are faced with something new, like this novel virus, and guidance and advice seems to be coming from everywhere and sometimes it seems contradictory, do what you know to do.”

- “Until the modes of transmission are understood, follow the most stringent precautions that you can.”

# From The Field

- “If you're set up for airborne precautions, do it. If not, enhance droplet measures without leaving out the basics. Masks are important, but they are not the foundation of precautions. Each escalation over standard precautions is an enhancement. **We don't stop washing our hands because masks are going to save us.”**
- “Health care facilities are under more scrutiny through infection control survey than they have ever been. A strong facility usually sees their surveyors once a year for annual, and the rare complaint survey that merits an onsite survey. Now, **many facilities are seeing surveyors twice in one week during an outbreak**.”

# From The Field

- “Why haven't the local health departments followed suit?  Instead of closing down restaurants, why haven't they provided better guidelines and more oversight?  We can pay people who didn't make $600 per week to begin with $600 + their standard unemployment to stay home, but we use some of that money to pay for basic infection prevention training and send some of these "non-essential" workers out to survey these establishments?”
- “There is a great opportunity to provide better infection prevention information to the public, to the worker and stop with the "feel good" measures that protect nobody from anything.”

# From The Field

- "The plastic cover on the credit card machine doesn't protect people from anything by itself. It protects the machine from moisture damage when the staff sanitizes it between every customer, but that isn't happening. Use a faster acting product.
  - Contact time for Lysol is 2 minutes.
  - Bleach solution is 5minutes.
  - 70% alcohol-based sanitizer is 30 seconds.

  What a difference choice of product makes. If restaurants used the alcohol product, the table would be dry and ready for the next guest in 30 seconds. Product choice directly affects compliance."

# From The Field

- “I know that data is supporting that most sick people are inhaling the virus, so it seems like masks trump all.  But, it really doesn't. The route into the body and how much virus is introduced in the initial exposure makes a difference. One measure is not more important than the others. Masks enhance, not replace standard precautions.”

# From The Field

- “The initial exposure - the viral inoculum - usually has a direct effect on severity of illness. Suddenly, having all these asymptomatic people walking around makes sense, doesn't it?
- And that's great for herd immunity, right? People getting some immunity built up with no symptoms? Except...they can spread the virus. They take dad to his doctor's appointment. Neither of them wears a mask in the car. And they cough, or sneeze, or laugh, and dad inhales a larger viral inoculum...and then goes back to the nursing home.”

# From The Field

- "It is so important to live for today, while also taking time to look at the past and future."
- "The necessity for self-care has never been more evident than now, both physically and mentally."
- "Follow federal, state, and local guidelines, don't apologize for change."
- "Communicate with honesty, empathy, authenticity, and consistency."

# From The Field

- “One of the things we implemented early on that has worked well for us is our contact tracing sheets. We have the residents listed on the sheet for each of our communities and at the end of every shift, staff note the residents they spent at least 10 minutes with during their shift. Staff also write down the names of other staff members they were within 6 feet for 10 minutes or more. As employees leave for the day, they file the sheets under the letter of their last name in a file folder located at the exit door. When we have had a staff member test positive, we have been able to pull up these sheets and conduct our contact tracing immediately rather than waiting to contact the employee. Also, in the heat of the moment, staff have a hard time remembering who they took care of and the form helps them to recall.”

# From The Field

- "What I have learned about COVID
  - It is not predictable
  - Can have it twice
  - Hand sanitizer /Mask /social distancing is effective
  - Isolation to one unit/floor, with designated staff member to the Covid unit only is effective
  - Cleaning and disinfecting is critical
  - The practices/guidelines by the federal government/CDC /Health department are ever changing
  - It is important to have resources like Harmony (HHI) to assist with the mountain of changes
  - Harmony (HHI) has helped greatly with the process of coding, 3-day waivers and keeping the facility abreast of changes as they occur"

# Key References


- McKeown, Les (June 2010) Predictable Success: Greenleaf Book View Press
- Michelli, J. A. (2008). The new gold standard: 5 leadership principles for creating a legendary customer experience courtesy of the Ritz-Carlton Hotel Company. New York: McGraw-Hill.






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# Our Process

- Prescribed medical record review process that encompasses HHI's core business
- HHI Specialists provide expertise through teaching and training and an extensive chart audit process in order to ensure:
  - MDS Accuracy
  - MDS Supporting Documentation
  - Billing Accuracy
  - Nursing Documentation
  - Therapy Documentation
  - Clinically Appropriate Care



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# HHI
# Services and Plans

Gold C.A.R.E.S.
2 Year Service Plan

Platinum C.A.R.E.S.
3 Year Service Plan

## List of HHI Services

PDPM Training and Audits | Medicare | Compliance | Rehab Program Development | Seminars | MMQ Audits | Mock RAC Audits | Rehab Certification | Mock Health Inspection Survey | MDS Competency | Talent Management | Denials Management | Compliance Certification | Clinically Appropriate Stay | QAPI | QIS | Medicare Part B Program | MDSC Mentor Program | Case Mix Consulting | Professional Development | Leadership Trainings | Regulatory and Survey Assistance | Five Star | PBJ | Quality Measures | Analysis | Staff Training | Infection Control and More!

Silver C.A.R.E.S.
1 Year Service Plan

A La C.A.R.E.S.
Customized Service Plan



Harmony Healthcare INTERNATIONAL

# Our Senior HHI Specialists

- Founded in 2001
- Privately owned and operated
- Ranked among Inc. Magazine's top 5,000 fastest growing private companies in America three years in a row
- Active monthly contracts in 24 states
- Over 1,000 Skilled Nursing Facilities serviced
- Over 3,000 Clinicians Certified on the MDS



Harmony Healthcare INTERNATIONAL

https://www.harmony-healthcare.com/harmonyhelp

Live Support Available
8:00 a.m. – 5:00 p.m. EST

# HarmonyHelp

With **HarmonyHelp**, Harmony Healthcare International (HHI) provides an invaluable resource for the entire interdisciplinary team. Imagine having questions answered by a HHI Specialist within minutes of the inquiry. Fill out the form on the right to learn more about HarmonyHelp and our various Service Plans.

The **Knowledge Center** is loaded with **information** that will assist with your daily responsibilities at your facility. This self-help site is broken up into **5 Sections:**

## Manuals I Tools I C.A.R.E.S. Community I Hot Topics I FAQ (Frequently Asked Questions)



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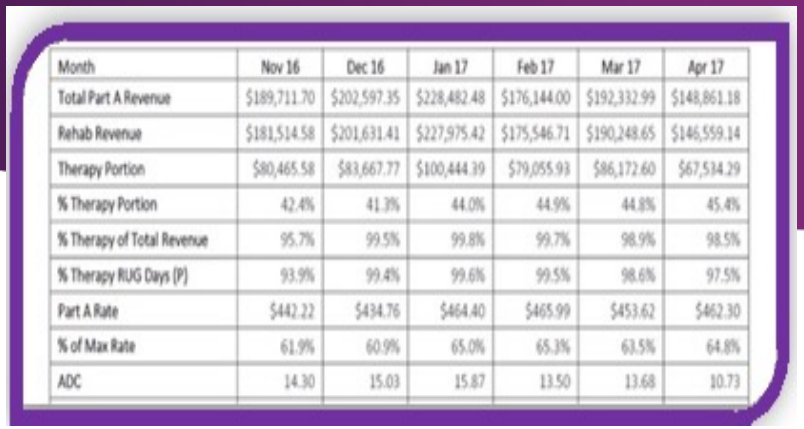
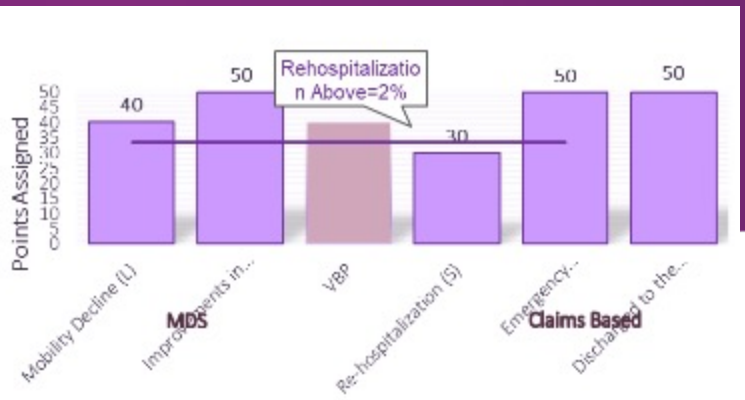
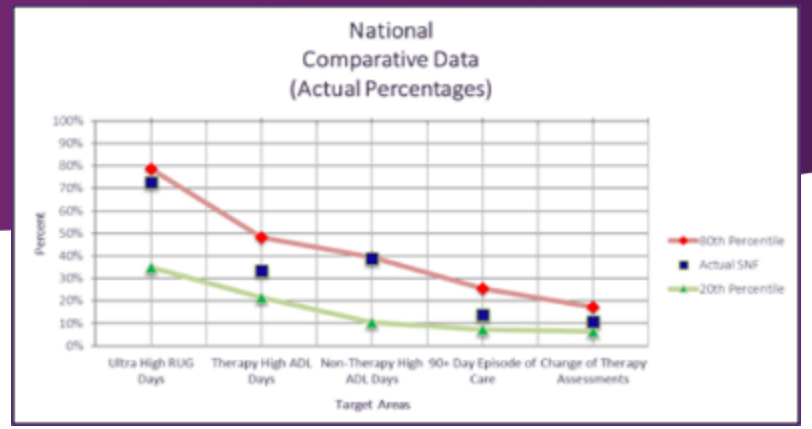


| Month | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | Apr 17 |
|---|---|---|---|---|---|---|
| Total Part A Revenue | $189,711.70 | $202,597.35 | $228,482.48 | $176,144.00 | $192,332.99 | $148,861.18 |
| Rehab Revenue | $181,514.58 | $201,631.41 | $227,975.42 | $175,546.71 | $190,248.65 | $146,559.14 |
| Therapy Portion | $80,465.58 | $83,667.77 | $100,444.39 | $79,055.93 | $86,172.60 | $67,534.29 |
| % Therapy Portion | 42.4% | 41.3% | 44.0% | 44.9% | 44.8% | 45.4% |
| % Therapy of Total Revenue | 95.7% | 99.5% | 99.8% | 99.7% | 98.9% | 98.5% |
| % Therapy RUG Days (P) | 93.9% | 99.4% | 99.6% | 99.5% | 98.6% | 97.5% |
| Part A Rate | $442.22 | $434.76 | $464.40 | $465.99 | $453.62 | $462.30 |
| % of Max Rate | 61.9% | 60.9% | 65.0% | 65.3% | 63.5% | 64.8% |
| ADC | 14.30 | 15.03 | 15.87 | 13.50 | 13.68 | 10.73 |




# Complimentary HHI Offerings

- PDPM Revenue and Risk Analysis
- Medicare Part A Revenue and Risk Analysis
- Five-Star Quality Measure Points Analysis
- PEPPER Analysis



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# Connect With Us and Follow Our Weekly Blog

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