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Colorado Department  
of Public Health  
and Environment

**DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT**  
**Health Facilities and Emergency Medical Services Division**

**6 CCR 1011-1**

**STANDARDS FOR HOSPITALS AND HEALTH FACILITIES**  
**(PROMULGATED BY THE STATE BOARD OF HEALTH)**

**CHAPTER XXI**  
**HOSPICE**

**Amended 7/18/12, effective 8/30/12**

**DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT**

**Health Facilities Regulation Division**

**STANDARDS FOR HOSPITALS AND HEALTH FACILITIES**

**CHAPTER XXI - HOSPICES**

**6 CCR 1011-1 Chap 21**

*[Editor's Notes follow the text of the rules at the end of this CCR Document.]*

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**SECTION 1 STATUTORY AUTHORITY AND APPLICABILITY**

- 1.1 The statutory authority for the promulgation of these rules is set forth in Section 25-1.5-103, *et seq.*, C.R.S.
- 1.2 A provider of hospice services, as defined herein, shall comply with all applicable federal and state statutes and regulations, including but not limited to, the following:
- (A) This Chapter XXI as it applies to the type of services provided.
  - (B) 6 CCR 1011-1, Chapter II, General Licensure Standards, unless otherwise specifically modified herein.
- 1.3 These regulations incorporate by reference (as indicated within) materials originally published elsewhere. Such incorporation does not include later amendments to or editions of the referenced material. The Department of Public Health and Environment maintains copies of the complete text of the incorporated materials for public inspection during regular business hours, and shall provide certified copies of the incorporated material at cost upon request. Information regarding how the incorporated material may be obtained or examined is available from:

Division Director

Health Facilities and Emergency Medical Services Division

Colorado Department of Public Health and Environment

4300 Cherry Creek Drive South

Denver, CO 80246

Phone: 303-692-2800

Copies of the incorporated materials have been provided to the State Publications Depository and Distribution Center, and are available for interlibrary loan. Any incorporated material may be examined at any state publications depository library.

**SECTION 2 DEFINITIONS**

- 2.1 "Bereavement counseling" means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment.

- 2.2 “Comprehensive Assessment” means a thorough evaluation of the patient’s physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. This includes a thorough evaluation of the caregiver’s and family’s willingness and capability to care for the patient.
- 2.3 “Core Services” means physician, nursing, counseling and medical social services. These services are routinely and substantially provided by hospice employees except for physician services that may be contracted.
- 2.4 “Department” means the Colorado Department of Public Health and Environment.
- 2.5 “Employee” means paid staff or volunteers providing hospice services on behalf of the hospice.
- 2.6 “Hospice Care” means a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and family members as delineated in a specific patient plan of care. Hospice care services are available 24 hours a day, 7 days a week in the patient's place of residence and/or licensed health facility.
- 2.7 “Hospice Inpatient Facility” is a unit or building operated by a licensed hospice delivering hospice services 24 hours a day, 7 days a week, in a homelike setting.
- 2.8 “Interdisciplinary Group (IDG)” means a group of qualified individuals, consisting of at least a physician, registered nurse, social worker, chaplain or other counselor who collectively have expertise in meeting the special needs of the hospice patient/family.
- 2.9 “Palliative Care” means specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain and stress of serious illness, whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of physicians, nurses and other specialists who work with a patient’s other health care providers to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided together with curative treatment. Hospice providers may perform palliative care services that are separate and distinct from hospice care services.
- 2.10 “Patient/Family” means the patient and those individuals who are closely linked with the patient including the immediate family, the primary caregiver and/or other individuals with significant personal ties.
- 2.11 “Terminally Ill” means that the individual has a medical prognosis that includes a limited life expectancy of days, weeks or months if the illness runs its anticipated course. Palliative care patients may fall outside of a payer’s coverage guidelines for the hospice benefit.

### **SECTION 3 GOVERNING BODY**

- 3.1 The governing body is the person or group of persons who exercises all corporate or other power and manages the business and affairs of the entity which is licensed to operate a hospice pursuant to these regulations. The Governing Body assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement.
- 3.2 The governing body of a hospice shall be responsible for assuring that the hospice complies with all applicable regulations and standards for the operation and maintenance of a hospice license.

- 3.3 The governing body shall appoint and employ an administrator who shall possess education and experience sufficient to qualify the person to be a hospice administrator. The Governing Body may delegate to such administrator the responsibility for the management of the hospice on a day-to-day basis.
- 3.4 The governing body shall provide or arrange for the facilities, qualified personnel and services which are sufficient and necessary to provide effective hospice care, including physical, emotional, psychosocial and spiritual care for terminally ill patients and their families and, if it chooses, palliative care as a separate and distinct service from hospice care services.

#### **SECTION 4 ADMINISTRATION**

- 4.1 The hospice shall organize, manage, and administer its resources to provide hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness.
- 4.2 The hospice shall have an administrator who has training and experience in business or health service administration and at least two years of supervisory or administrative experience in hospice care or closely related health care services.
- 4.3 The administrator shall be responsible for the management of the hospice staff and operations and shall be accountable for and report to the Governing Body regarding the discharge of all delegated duties and functions. If the administrator delegates specific duties, the person responsible shall be clearly identified.
- 4.4 The duties of the administrator shall include but not be limited to:
- (A) Directing the hospice and ensuring implementation of policies and procedures regarding all activities and patient/family care services provided in the hospice, whether provided through staff employed directly by the hospice, by volunteers or through contract arrangement;
  - (B) Designating an alternate to act in his or her absence;
  - (C) Implementing administrative policies and procedures; and
  - (D) Implementing financial policies and procedures, approved by the governing body, according to sound business practice.
- 4.5 The hospice shall develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that complies with 6 CCR 1011-1, Chapter II, Part 3. In addition, the hospice's governing body shall ensure that the program:
- (A) Reflects the complexity of its organization and services;
  - (B) Involves all hospice services (including those services furnished under contract or arrangement);
  - (C) Focuses on indicators related to improved palliative outcomes, and
  - (D) Takes actions to demonstrate improvement in hospice performance.
- 4.6 The hospice shall maintain documented evidence that its quality assessment and performance improvement program has been implemented and is functioning effectively.

## **SECTION 5 PATIENT RIGHTS AND RESPONSIBILITIES**

- 5.1 Upon admission, each hospice patient/family shall receive a copy of the Hospice Patient's Bill of Rights and Responsibilities.
- 5.2 There shall be written documentation of receipt of the copy of the patient rights and responsibilities.
- 5.3 By written declaration the hospice shall affirm the following patient rights and responsibilities:
- (A) The right to be informed of the hospice concept, admission criteria, services to be provided, options available, and any charges which may be incurred.
  - (B) The right to participate in developing the patient plan of care.
  - (C) The right to expect that all records be confidential.
  - (D) The right to refuse service or withdraw from the program at any time.
  - (E) The responsibility to provide accurate information which may be useful to the hospice in delivering appropriate care.
  - (F) The right to express a grievance without fear of reprisal.
- 5.4 Hospice responsibilities shall include but not be limited to:
- (A) Providing quality care to individuals regardless of race, religion, sex, age, and/or physical or mental disabilities or ability to pay;
  - (B) Training all employees and volunteers adequately for the type of service they provide;
  - (C) Providing care that is ethical, is in the best interest of the patient, and is respectful of the patient/family life values, religious preference, dignity, individuality, privacy in treatment and personal needs; and
  - (D) Assuring special attention to patients who are infants, small children and adolescents in regard to their right to privacy, choice and dignity.

## **SECTION 6 PATIENT CARE SERVICES**

- 6.1 Interdisciplinary Group: The hospice shall establish an interdisciplinary group whose responsibility shall include but not be limited to:
- (A) Establishment of a plan of care which includes data elements that allow for measurement of outcomes;
  - (B) Provision and/or supervision of hospice care and services;
  - (C) The review and/or revision of the plan of care for each patient/family receiving hospice care; and
  - (D) Involvement of the patient/family in hospice care.
- 6.2 Admission Criteria:

- (A) Upon admission to the hospice there shall be an evaluation of the patient's immediate needs related to their terminal condition. An initial plan of care shall be developed based upon the results of the immediate needs evaluation.
  - (B) An initial assessment of the patient's physical, psychosocial, spiritual and emotional status related to the patient's terminal illness and related conditions shall be completed by a registered nurse within forty-eight (48) hours.
- 6.3 Within five (5) calendar days following admission, depending upon the patient's immediate needs, a comprehensive assessment shall be completed by the interdisciplinary group. The comprehensive assessment shall identify the patient's physical, psychosocial, emotional and spiritual needs related to the terminal illness and related conditions that shall be addressed in order to promote the patient's well-being, comfort and dignity throughout the dying process. This includes a thorough evaluation of the caregiver's and family's willingness and capability to care for the patient. The comprehensive assessment shall be updated as frequently as the patient's condition requires but no less than every fifteen (15) days.
- 6.4 An individualized written plan of care shall be developed to reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive and updated comprehensive assessments. The plan of care shall include all services necessary for the palliation and management of the terminal illness and include but not be limited to:
- (A) Interventions to manage pain and symptoms;
  - (B) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs;
  - (C) Measurable outcomes anticipated from implementing and coordinating the plan of care;
  - (D) Drugs and interventions necessary to meet the needs of the patient;
  - (E) Medical supplies and appliances necessary to meet the needs of the patient;
  - (F) Coordination of care;
  - (G) Patient/family understanding and agreement with the plan of care, and
  - (H) When applicable, plans to meet the special needs of patients who are infants, children and adolescents.
- 6.5 A designated registered nurse shall coordinate the overall plan of care for each patient.
- 6.6 The interdisciplinary group (in collaboration with the individual's attending physician or nurse practitioner) shall review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. A revised plan of care shall include information from the patient's updated comprehensive assessment and shall note the patient's progress toward outcomes and goals specified in the plan of care.
- 6.7 A system of effective communication shall be developed and maintained to assure that all services are coordinated and provided in accordance with the plan of care, including family, attending physician or nurse practitioner and others providing care.
- (A) To facilitate continuity of care when transferring within the hospice, to another hospice or to another provider, pertinent documentation shall be immediately forwarded to the receiving care provider.

(B) At the time of discharge, the hospice shall provide pertinent clinical records and any other documentation that may be requested to assist in post-discharge continuity of care.

6.8 Medical Director: The hospice shall designate a physician who shall act as medical director. The physician shall be a doctor of medicine or osteopathy who is an employee, or is under contract with the hospice, and has a current license in good standing to practice in the State of Colorado.

6.9 The medical director or physician designee shall be a member of the interdisciplinary group and be responsible for the medical component of the hospice's patient care program including, but not limited to, the following:

(A) Reviewing appropriate clinical material from the referring physician to validate the prognosis as anticipated by the patient's attending physician or nurse practitioner;

(B) Assisting in developing and medically validating the interdisciplinary plan of care for each patient/family with the coordination of the patient's attending physician or nurse practitioner;

(C) Rendering, as necessary, or supervising active medical care of the patient and maintaining a record of such care;

(D) Maintaining a regular schedule of participation in pertinent components of the hospice patient care program;

(E) Being readily available to the hospice program personally or naming a qualified physician designee;

(F) Acting as a consultant to and maintaining liaison with the attending physician or nurse practitioner and other members of the interdisciplinary group;

(G) Helping to develop and review patient/family care policies and procedures;

(H) Serving on appropriate committees;

(I) Reporting issues regarding the delivery of medical care; and

(J) Approving written protocols for symptom control such as pain or nausea.

6.10 Physician Services: The hospice shall ensure that each patient has an attending physician or nurse practitioner. If a patient has no attending physician or nurse practitioner, there shall be a mechanism for assuring the availability of one. The attending physician or nurse practitioner shall:

(A) Approve and sign the plan of care for the patient/family;

(B) Be available to the interdisciplinary group as necessary;

(C) Provide information to the interdisciplinary group in developing the plan of care; and

(D) Review the plan of care at least every 90 days.

6.11 Nursing Services: The hospice shall provide nursing care and services by or under the direction and supervision of a registered nurse with training and experience to direct hospice nursing care who shall be an employee of the hospice. Nursing services shall ensure that the patient's needs are met as identified in the patient's initial assessment, comprehensive assessment and updated assessments.

- 6.12 Highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive, may be provided under contract.
- 6.13 Medical Social Services: The hospice shall provide medical social services provided by a qualified medical social worker based on the initial and comprehensive assessments, the patient/family's needs and acceptance of services.
- 6.14 Volunteer Services: The hospice shall utilize volunteers in roles as defined by the hospice that support patient care and administrative services.
- 6.15 The hospice shall maintain a volunteer program which meets the operational needs of the hospice and demonstrates overall coordination of volunteer services. The program shall include recruitment, orientation, training, supervision, monitoring and evaluation.
- 6.16 Patient services provided by volunteers shall be in accordance with the plan of care and shall be documented in the clinical record.
- 6.17 Bereavement Counseling: Before and for one year following the patient's death, the hospice shall provide bereavement services to families and others including individuals in residential facilities where the patient resided. These services shall be provided in accordance with the needs of the individual and furnished under the supervision of a qualified professional with experience or education in grief or loss counseling.
- 6.18 Spiritual Counseling: The hospice shall provide spiritual counseling services based on the initial and comprehensive assessment of the spiritual needs and acceptance of this service by the patient, family and significant others.
- 6.19 Hospice Aide Services: The hospice shall ensure that hospice aides have successfully completed a state approved certified nurse aide (CNA) training program and are currently certified by the Colorado Department of Regulatory Agencies (DORA).
- 6.20 Hospice Aide Services: Hospice Aides shall be supervised by a registered nurse every 14 days to assess the quality of care and services provided by the aide. The hospice aide does not need to be present during this visit. On-site supervision and evaluation of the hospice aide will be completed by a registered nurse annually and when an area of concern is noted.
- 6.21 Nursing services, physician services, drugs and biologicals shall be available 24 hours a day, seven days a week. Other hospice services shall be available 24 hours a day when medically necessary to meet the needs of the patient and family.
- 6.22 Termination of care: The hospice shall establish specific criteria for termination of care, including, but not limited to, the following:
- (A) There shall be policies and procedures related to termination of care and/or referral; and
  - (B) The clinical record shall contain documentation of the reason care has been terminated.

## **SECTION 7 PERSONNEL**

- 7.1 The hospice shall provide physician services, nursing services, medical social work or counseling services, spiritual counseling, and trained volunteers. These services shall be consistent with acceptable standards of practice.
- 7.2 The hospice shall routinely provide substantially all core services directly by hospice employees.

- 7.3 There shall be written policies that govern employment and personnel practices.
- 7.4 The hospice shall require any prospective employee to submit to a criminal history record check that shall be conducted not more than 90 days prior to employment of the individual. The hospice shall develop and implement policies and procedures regarding the potential employment of any individual who is convicted of a felony or misdemeanor in order to ensure that the individual does not pose a risk to the health, safety and welfare of the patient.
- 7.5 Before employing any individual to provide direct patient care or services, the hospice shall verify with the Colorado Department of Regulatory Agencies (DORA) whether a license, registration or certification exists and is in good standing. A copy of the verification shall be placed in the individual's personnel file.
- 7.6 There shall be an initial orientation for each employee that includes:
- (A) History, philosophy and structure of the hospice concept;
  - (B) The interdisciplinary approach;
  - (C) Communication skills;
  - (D) Hospice services offered;
  - (E) Agency organizational structure;
  - (F) Access to agency policies and procedures;
  - (G) Personnel policies;
  - (H) Continuing educational requirements; and
  - (I) Infection control.
- 7.7 The hospice shall assess and document the competence and skills of each employee prior to providing direct patient care. The hospice shall have written policies and procedures describing its methods of assessment of competency.
- 7.8 The hospice shall ensure that each hospice aide is competent to carry out all assigned tasks in the patient's place of residence.
- (A) Prior to initial assignment, a registered nurse shall conduct a competency evaluation including, but not limited to, the tasks listed in this subsection:
    - (1) Bathing,
    - (2) Skin care,
    - (3) Hair care,
    - (4) Nail care,
    - (5) Mouth care,
    - (6) Shaving,

- (7) Dressing,
- (8) Feeding,
- (9) Assistance with ambulation,
- (10) Exercise and transfers,
- (11) Positioning,
- (12) Bladder and bowel care,
- (13) Medication reminding, and
- (14) The use of adaptive equipment.

7.9 The hospice shall have a program for education and training that offers a minimum of 20 hours of education annually to enhance hospice related skills for all employees who provide direct patient care. The hospice shall maintain documentation of the annual education and training offered.

7.10 There shall be documentation of each employee's application, verification of credentials, competency evaluations, staff education/training and performance appraisals.

## **SECTION 8 PHARMACEUTICAL SERVICES**

8.1 The hospice shall develop and maintain written policies and procedures for the administration and provision of pharmaceutical services that are consistent with the needs of the patient as determined by the hospice's medical director, patient's attending physician or nurse practitioner.

8.2 Medications ordered shall be consistent with the hospice philosophy which focuses on palliation and are consistent with professional practice and regulations of the Colorado Board of Pharmacy.

8.3 Managing medications and biologicals

(A) The hospice shall ensure that the interdisciplinary group confers with an individual with education and training in medication management as defined in hospice policies and procedures and State law, who is an employee of or under contract with the hospice to ensure that medications and biologicals meet each patient's needs.

(B) A hospice inpatient facility shall provide pharmacy services under the direction of a qualified licensed pharmacist who is an employee of or under contract with the hospice. The pharmacist services shall include evaluation of a patient's response to medication therapy, identification of potential adverse medication reactions, and recommended appropriate corrective action.

8.4 Ordering of medications

(A) Only a licensed health care professional with prescriptive authority may order medications for the patient.

(B) If the prescription medication order is verbal or given by or through electronic transmission:

- (1) The order shall be given only to a licensed nurse, nurse practitioner, pharmacist, or physician; and

- (2) The individual receiving the order shall record and sign it immediately and have the prescribing person sign it in accordance with state and federal law.

#### 8.5 Administration of medication and biologicals

- (A) The interdisciplinary group, as part of the review of the plan of care, shall determine the ability of the patient and/or family to safely self-administer medications and biologicals to the patient in his or her home.

#### 8.6 Dispensing and storage of medications and biologicals

- (A) The hospice shall obtain medications and biologicals in compliance with state and federal law including Colorado Board of Pharmacy rules.
- (B) Medications and biologicals shall be labeled in accordance with currently accepted professional practice and shall include appropriate usage, cautionary instructions, and an expiration date (if applicable).
- (C) The hospice shall have written policies and procedures specific to the patient's care setting for the management and disposal of the patient's medications. At the time medications are first ordered the hospice shall:
  - (1) Provide a copy of the hospice written policies and procedures on the management and disposal of medications to the patient or patient representative and family;
  - (2) Discuss the hospice policies and procedures for managing the safe use and disposal of medications with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of medications;
  - (3) Document in the patient's clinical record that the written policies and procedures for managing medications was provided and discussed; and
  - (4) Advise that if medications (including controlled substances) have been obtained by prescription for the patient, they are the property of the patient.
- (D) The hospice shall have a written policy regarding the management and use of emergency kits for as needed medications ordered for an individual patient. The use of an emergency kit that is not prescribed for an individual patient shall be consistent with the Colorado Board of Pharmacy regulations.

### **SECTION 9 CLINICAL RECORDS**

9.1 The hospice shall maintain a centralized and complete record on every individual receiving service in accordance with accepted principles of medical record practice.

9.2 The record shall include documentation of all services provided whether furnished directly or by contract.

9.3 Each record shall include but not be limited to:

- (A) Identification and demographic data;
- (B) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes;

- (C) History of terminal illness and other related conditions;
- (D) Documentation of all services and responses to treatments and interventions including lists of current medications and medication administration records (if applicable);
- (E) Signed consents, authorizations, and advance directives;
- (F) Orders from licensed providers with prescriptive authority and/or other licensed or qualified health care professionals, and
- (G) Discharge/transfer records.

9.4 All entries shall be completed in a manner that is legible and permanent; dated and authenticated in accordance with hospice policy and currently accepted standards of practice.

9.5 Hospice shall ensure the privacy, security and safety of the records against loss, destruction or unauthorized use, including compliance with protected health information in compliance with federal and state law.

9.6 All records shall be maintained for a period of six (6) years after death or discharge. In the case of a minor, the record shall be maintained for a period of six (6) years after death or for six years after the minor attains majority (18 years old).

9.7 If the hospice discontinues operation, hospice policies shall provide for retention and storage of clinical records according to state and federal law. The hospice shall inform the State licensing agency where such clinical records will be stored and how they may be accessed.

9.8 The clinical record, whether hard copy or in electronic form, shall be made readily available on request by an appropriate authority.

## **SECTION 10 CONTRACTUAL SERVICES**

10.1 The hospice may contract as defined by law with other health care providers for the provision of all but core services except the exclusions as outlined in Section 10.5.

10.2 A hospice that has a written agreement with another agency, individual, or organization to furnish any services under contract shall retain administrative and financial management, legal responsibility and oversight of staff and services for all contracted services, to ensure the provision of quality care.

10.3 Contracted services shall be supported by written agreements that require all services be:

- (A) Authorized by the hospice;
- (B) Furnished in a safe and effective manner by qualified personnel;
- (C) Delivered in accordance with the patient's plan of care; and
- (D) Evaluated as part of the quality management program.

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

10.5 The hospice may use contracted staff to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. Circumstances under which a

hospice may enter into a written arrangement for the provision of core services include: unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside of the hospice's service area.

#### 10.6 Hospice Services Provided To Residents of Non-Hospice Licensed Facilities:

- (A) When hospice services are provided in a long term care facility, assisted living residence or intermediate care facility for persons with developmental disabilities, there shall be a written agreement that specifies the provision of hospice services in the facility. The written agreement shall be signed by authorized representatives of the hospice and the non-hospice licensed facility prior to the provision of hospice services.
- (B) The written agreement shall include at least the following:
  - (1) The manner in which the facility and the hospice are to communicate with each other and document such communication to ensure that the needs of the patient are addressed and met 24 hours a day;
  - (2) A provision that the facility shall immediately notify the hospice if:
    - (a) There is a significant change in the patient's physical, mental, social, or emotional status that may necessitate a change to the plan of care;
    - (b) There is a need to transfer the patient from the facility, in such case, the hospice shall coordinate any necessary care related to the terminal illness and related conditions; or
    - (c) The patient dies.
  - (3) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided, and
  - (4) A provision stating that it is the facility's responsibility to provide 24-hour room and board care and to provide services as defined by the facility's license.

10.7 Short-term Inpatient Care: The hospice shall ensure that short-term inpatient care is available to meet the acute and respite needs of the patient as determined by the hospice. This short-term inpatient care may be provided in a Hospital, Long-Term Care Facility, or Hospice Inpatient Facility.

- (A) If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice, and at a minimum specifies that:
  - (1) The hospice supplies the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished;
  - (2) The inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the hospice plan of care;
  - (3) The hospice patient's inpatient clinical record includes all aspects of the patient's care, condition and services furnished during the patient's inpatient stay. A copy of the inpatient facility's discharge summary shall be provided to the hospice at

the time of the inpatient facility's discharge. A copy of the inpatient facility's complete clinical record shall be available to the hospice; and

- (4) The inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the written agreement.

## **SECTION 11 HOSPICE INPATIENT FACILITY**

### **11.1 Staffing**

- (A) The facility shall provide 24 hours a day nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient shall receive all nursing services as prescribed and shall be kept comfortable, clean, well groomed, and protected from accident, injury, and infection.
- (B) If at least one patient in the facility is receiving acute short-term inpatient care, then each shift shall include a registered nurse who provides direct patient care.
- (C) The facility shall also provide, as necessary, for the availability and prompt response of all other core services.

### **11.2. Environment**

The facility shall meet all state and local laws and regulations pertaining to health, safety, accessibility and zoning regulations.

#### **(A) Safety management**

- (1) The facility shall investigate and correct real or potential threats to the health and safety of the patients, others, and property.
- (2) The facility shall have a written disaster preparedness plan in effect for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. The plan shall be periodically reviewed and rehearsed with staff (including non-employee staff) with special emphasis placed on carrying out the procedures necessary to protect patients and others.

#### **(B) Physical plant and equipment**

The facility shall ensure:

- (1) Adequate light, comfortable temperature, and appropriate ventilation/air exchanges throughout the facility;
- (2) Emergency gas, electrical and water supply;
- (3) Availability of hot water at all times with plumbing fixtures that regulate the water temperature;
- (4) Scheduled and emergency maintenance and repair of all equipment;
- (5) A separate clean holding area equipped with:
  - (a) counter;

- (b) sink with mixing faucet;
- (c) sink with blade controls;
- (d) soap and hand-washing and drying equipment;
- (e) waste container; and
- (f) shelf space for supplies.

(6) A separate soiled holding area equipped with:

- (a) counter;
- (b) sink with mixing faucet;
- (c) sink with blade controls;
- (d) soap and hand-washing and drying equipment;
- (e) covered bio-hazard waste container;
- (f) covered waste container;
- (g) soiled linen hamper with impervious liner; and
- (h) shelf space for supplies.

(7) A custodial closet equipped with:

- (a) cleaning equipment and supplies;
- (b) floor-mounted sink with mixing faucets;
- (c) shelf space and appropriate storage; and
- (d) waste receptacles.

### (C) Sanitation

The facility shall provide:

- (1) A sanitary environment adhering to current standards of practice, including nationally recognized infection control precautions;
- (2) Routine storage and prompt disposal of trash and medical waste;
- (3) Clean linen in sufficient amounts for all patient uses that is handled in such a manner as to prevent the spread of contaminants;
- (4) Bed linen that is changed as often as necessary but no less than two times per week;
- (5) Patient medical supplies and equipment that are stored separately and handled in such a manner as to prevent the spread of contaminants; and

- (6) A program to effectively control insect, rodent and pest infestations.

### 11.3 Patient Areas

The facility shall provide:

- (A) Private space for patient/family visiting;
- (B) Adequate dining space;
- (C) Accommodations for family members to remain with the patient overnight;
- (D) Private space for family following a patient's death; and
- (E) Flexible visiting hours that do not exclude children or pets.

### 11.4 Patient Rooms

The facility shall provide:

- (A) Patient rooms designed and equipped to provide clinical care, comfort and privacy of patients;
- (B) Age and gender appropriate room assignments;
- (C) Accommodation for a single room when possible upon patient or family request;
- (D) Patient rooms that:
  - (1) Are at or above grade level;
  - (2) Provide at least 80 square feet for each patient in a double room and at least 100 square feet for each patient in a single room;
  - (3) Accommodate no more than two patients;
  - (4) Contain a suitable bed and other appropriate furniture for each patient;
  - (5) Have private closet space for clothing and personal belongings;
  - (6) Are equipped with an easily-activated device accessible to each patient to call for assistance; and
  - (7) Have toilet and bathing facilities that are easily accessible from each patient room and equipped with grab bars and an easily accessible device to call for assistance.
    - (a) For existing facilities, one toilet may service two patient rooms only if each patient room also has a sink.
    - (b) For new construction commencing on or after September 1, 2012, there shall be a minimum of one toilet for every two beds.

### 11.5 Staff Areas

The facility shall provide staff areas designed and equipped for documentation, medical records, communications, office supplies and equipment, and staff personal effects.

#### 11.6 Dietary

The facility shall provide meals and/or food choices at regular intervals or at a variety of times depending upon the needs of the patients. Food shall be available on a 24-hour, seven-day a week basis and be:

- (A) Consistent with the patient's choice, plan of care, nutritional needs, and therapeutic diet;
- (B) Palatable and attractive;
- (C) Served at the proper temperature, and
- (D) Obtained, stored, prepared, distributed, and served in compliance with local sanitary regulations.

Other forms of nourishment shall be provided according to the patient's plan of care.

#### 11.7 Pharmaceutical Services

- (A) The facility shall obtain drugs and biologicals in compliance with federal and state law including Colorado Board of Pharmacy regulations.
- (B) The facility shall:
  - (1) Have a written policy and procedure for accurate dispensing of pharmaceuticals; and
  - (2) Maintain current and accurate records of the receipt and disposition of all controlled substances.
- (C) The facility shall limit the administration of patient medications to the following individuals:
  - (1) A licensed nurse, physician, or other health care professional in accordance with their scope of practice and state law; or
  - (2) The patient, upon approval by the interdisciplinary group.
- (D) The facility shall dispose of medications in compliance with the hospice policy and in accordance with state and federal requirements. The facility shall maintain current and accurate records of the receipt and disposition of all controlled substances.
- (E) The facility shall comply with the following additional requirements:
  - (1) All medications and biologicals shall be stored in secure areas. All controlled substances listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1976, which is hereby incorporated by reference, shall be stored in locked compartments within secure storage areas. Only personnel authorized to administer controlled substances as noted in section 11.7(C) of this Chapter shall have access to the locked compartments; and
  - (2) Discrepancies in the acquisition, storage, dispensing, administration, disposal, or return of controlled substances shall be investigated immediately by the hospice

administrator or designee and/or the pharmacist and where required reported to the appropriate state authority. A written account of the investigation shall be made available to state and federal officials if required by law or regulation.

## **SECTION 12 INFECTION CONTROL**

- 12.1 The hospice shall maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.
- 12.2 The hospice shall evaluate the adequacy and effectiveness of its infection control program at least annually and implement necessary changes.
- 12.3 The hospice shall follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
- 12.4 The hospice shall provide infection control education to staff, patients, and family members or other caregivers.

## **SECTION 13 GENERAL BUILDING AND LIFE SAFETY CODE REQUIREMENTS**

- 13.1 COMPLIANCE WITH THE LIFE SAFETY CODE. Facilities with one or more inpatient beds shall be compliant with the National Fire Protection Association (NFPA) 101, Life Safety Code (2000), which is hereby incorporated by reference. Such incorporation by reference, as provided for in 6 CCR 1011-1, Chapter II, excludes later amendments to or editions of referenced material.
- (A) Facilities licensed on or before March 11, 2003 shall meet Chapter 19, Existing Health Care Occupancies, NFPA 101 (2000).
- (B) Facilities licensed on or after March 11, 2003 or portions of facilities that undergo remodeling on or after October 1, 2003 shall meet Chapter 18, New Health Care Occupancies, NFPA 101 (2000). In addition, if the remodel represents a modification of more than 50 percent, or more than 4,500 square feet of the smoke compartment, the entire smoke compartment shall be renovated to meet Chapter 18, NFPA 101 (2000).
- (C) Notwithstanding NFPA 101 Life Safety Code provisions to the contrary:
- (1) When differing fire safety standards are imposed by federal, state or local jurisdictions, the most stringent standard shall apply.
  - (2) Any story containing an exterior door or an exterior window that opens to grade level shall be counted as a story.
  - (3) Licensed facilities shall be separated from unlicensed contiguous occupancies by an occupancy separation with a fire resistance rating of not less than 2 hours.
  - (4) A health care occupancy shall be defined as the operation in such occupancy of one or more inpatient beds.
- 13.2 PLAN REVIEW AND PLAN REVIEW FEES. Plan review and plan review fees are required as listed below. If the facility has been approved by the Department to use more than one building for the direct care of patients on its campus, each building is subject to the applicable base fee plus square footage costs. Fees are nonrefundable and shall be submitted prior to the Department initiating a plan review for a facility.

(A) Initial Licensure, Additions, Relocations

- (1) Plan review is applicable to the following, and includes new facility construction and new occupancy of existing structures:
- (a) Applications for an initial license, when such initial license is not a change of ownership and the application is submitted on or after July 1, 2009.
  - (b) Additions of previously uninspected or unlicensed square footage to an existing occupancy and the building permit for such addition is issued on or after July 1, 2009 or if no permit is required by the local jurisdiction, construction began on or after July 1, 2009.
  - (c) Relocations of a currently licensed facility in whole or in part to another physical plant, where the occupancy date occurs on or after July 1, 2009.
- (2) Initial licensure, addition, and relocation plan review fees: Base fee of \$2,500, plus square footage costs as shown in the table below.

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

(B) Remodeling

- (1) Plan review is applicable to remodeling for which the application for the building permit from the local authority having jurisdiction is dated on or after July 1, 2009, or if no permit is required by the local jurisdiction, construction began on or after July 1, 2009. Remodeling includes, but is not limited to:
- (a) Alteration, in patient sleeping areas, of a structural element subject to Life Safety Code standards, such as egress door widths and smoke or fire resisting walls.
  - (b) Relocation, removal or installation of walls that results in alteration of 25% or more of the existing habitable square footage or 50% or more of a smoke compartment.
  - (c) Conversion of existing space not previously used for providing patient services, including storage space, to resident sleeping areas.
  - (d) Changes to egress components, specifically the alteration of a structural element, relocation, or addition of an egress component. Examples of egress components include, but are not limited to, corridors, stairwells, exit enclosures, and points of refuge.
  - (e) Installation of any new sprinkler systems or the addition, removal or relocation of 20 or more sprinkler heads.

- (f) Installation of any new fire alarm system, or addition, removal or relocation of 20 or more fire alarm system appliances including, but not limited to, pull stations, detectors and notification devices.
- (g) Installation, removal or renovation of any kitchen hood suppression system.
- (h) Essential electrical system: replacement or addition of a generator or transfer switch.

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

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

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

**SECTION 14 LICENSE FEES**

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

14.2 Initial License - \$6,370 per hospice.

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

14.3 Annual Renewal License

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

- (1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be \$2,400 per hospice.
- (2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be \$1,500 per hospice.
- (3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be \$750 per hospice.

- (4) A discount of \$300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location,
- (5) A discount of \$425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.
- (6) Upon request, the department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.
- (7) For hospices that have the same ownership and governing body and that provide hospice care in both the home and inpatient hospice settings, the fee shall be as follows and no other discounts shall apply:
  - (a) When both service models are contained in the same physical location, the license fee shall be \$6,400.
  - (b) When the services are not in the same physical location but are within a 10-mile drive of each other, the home care hospice and the inpatient hospice shall each pay a separate license fee of \$3,200.

#### 14.4 Workstation Fees

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

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

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#### Editor's Notes

6 CCR 1011-1 has been divided into separate chapters for ease of use. Versions prior to 05/01/2009 and rule history are located in the main section, 6 CCR 1011-1. Prior versions can be accessed from the History link that appears above the text in 6 CCR 1011-1. To view versions effective on or after 05/01/2009, select the desired chapter, for example 6 CCR 1011-1 Chap IV or 6 CCR 1011-1 Chap XVIII.