Colorado Department of Public Health and Environment
Health Facilities and Emergency Medical Services Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION BUILDING:	DATE SURVEY COMPLETED
	10J821		05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUUM OF COLORADO	11111 E. MISSISSIPPI AVENUE AURORA 80012

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
B 000	10 C.C.R. 2505-10, Section 8.600 Initial Comments An abbreviated survey prompted by complaint investigation Co #16567 was conducted March 30- April 30, 2015. Six deficiencies were cited. A plan of corrections is required.	B 000		
B 472	8.608.8 D Thoroughly Investigated All alleged incidents of abuse, mistreatment, neglect, or exploitation by agency employees or contractors shall be thoroughly investigated in a timely manner using the specified investigation procedures. However, such procedures must not be used in lieu of investigations required by law or which may result from action initiated pursuant to section C, herein. This REGULATION is not met as evidenced by: Based on record review and staff interview, the agency failed to ensure an allegation of abuse and/or neglect of one person receiving services (PRS) #1 was thoroughly investigated in a timely manner. The allegation of abuse and/or neglect of PRS #1 was not thoroughly investigated which created the potential for ongoing abuse and/or neglect of PRS #1 and abuse and/or neglect of others under the care of the host home provider. Findings: 1. Record review on 03/30/15 revealed the service agency was approved to provide comprehensive services to individuals under the Home and Community Based Services, Developmentally Disabled (HCBS-DD) waiver to PRS #1. A responsibility of this service provision is to	B 472	1. Continuum Colorado stands by our claim that we followed the correct procedure when asking the Community Center Board for an investigation. We will continue to follow the CCB's MANE reporting procedure. Continuum will receive the name of the person completing the investigation and the timeline of the investigation. The director or designated person will get an update from the Community Center board bi-weekly until the report is completed and Continuum receives the finalized MANE report. 2. Continuum Colorado stands by our claim that we followed the correct procedure when asking the Community Center Board for an investigation. We will continue to follow the CCB's MANE reporting procedure. Continuum will receive the name of the person completing the investigation and the	06/23/2015

I attest that the plan of correction will be implemented and monitored for compliance

AUTHORIZED PROVIDER REPRESENTATIVE'S SIGNATURE | TITLE | DATE

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B 472	Continued From page 1 ensure any allegations of mistreatment, abuse, neglect or exploitation are investigated. Service agency staff who monitor the host home include Program Manager C (PM-C) and Residential Supervisor-D (RS-D). Staff affiliated with the Community Centered Board that oversees investigations include Program Manager for Investigations (PMI-E) and Program Manager F (PM-F). 2. PRS #1 On 3/23/15, a record review of the service plan in effect for the dates of 10/1/14 through 9/30/15 indicated the following diagnoses for PRS #1: "Arthritis, Osteoporosis, Seizure disorder, Intellectual or Developmental Disability (IDD), Cerebral Palsy, H-Pylori, incontinence and Irritable Bowel Syndrome." Additional excerpts from this service plan include: "(PRS#1) requires almost total assistance due to balance problems, potential for falls, limited range of motion, lack of muscle tone, weakness and cognitive impairment." In the area of eating it states, "(PRS #1) is able to drink from a cup or glass. He can feed himself." In the area of mobility it states, "(PRS #1) has mobility in the home with someone next to him for occasional physical assistance...will go up and down 1-3 steps...can go very short distances without the (wheel) chair ...uses the wheelchair outside the home ...sometimes uses the walker ...has gait problems related to Osteoporosis that can cause pain. " 3. PRS #1's hospitalization for hypernatremia and acute kidney injury On 03/30/15 - 04/03/15, record reviews for PRS #1 revealed a hospitalization on 11/17/14 with a resulting diagnosis of hypernatremia and acute kidney injury. According to medical documentation by the hospital physician dated	B 472	timeline of the investigation. The director or designated person will get an update from the Community Center board bi-weekly week until the report is completed and Continuum receives the finalized MANE report. 3. The monitoring system will be the documentation from the emails where the CCB gives updates on the investigation until it is completed on a regular basis. The quality assurance manager will review the MANE report during the quarterly trend analysis. 4. Residential Supervisor, director, quality assurance manager, or designated person. 5. 6/23/15	

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11/17/14, the hypernatremia was "most likely related to prolonged dehydration" and it was also noted, "He (PRS #1) is not currently on any diuretics, and has no history of diabetes insipidus." The acute kidney injury was noted to be "most likely secondary to prolonged dehydration with likely acute tubular necrosis at this point."

A critical care progress note from the hospital dated 11/18/14 and signed by the attending physician noted, "Na (sodium) 172 at admit currently down to 156 on D5W> like(ly) a significant free water deficit due to inadequate intake."

A nephrology progress note on the assessment of PRS #1 dated 11/18/14 and signed by the nephrologist read, "Hypernatremia-due to dehydration/ volume depletion- again, not on diuretics and no known history of dehydration...AKI (acute kidney injury) -due to prolonged dehydration and possible hypotension? Now with a ATN (acute tubular necrosis) (although would expect higher urine Na if ATN) so hopefully it is prerenal."

The hospital discharge note transcribed by the Advanced Practice Nurse Practitioner (ANP) on 11/24/14 gave the diagnosis of "hypernatremia, resolved, secondary to dehydration" among several other diagnoses.

4. Allegation of abuse and/or neglect

A log note was documented on the benefits utilization system (BUS) written by Case Manager A (CM-A) dated 12/02/14. This log note referred to a communication with PRS #1's parent and guardian. This note stated the guardian had spoken with (CM-A) and said when he referred to the recent renal failure of his son, that a psychiatrist he had spoken to told him, "what host home provider B (HHP-B) did to

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B 472	Continued From page 3 PRS #1 was abuse." This log note indicated (CM-A) sent a follow-up email to Program Manager C (PM-C) and Residential Supervisor D (RS-D) who oversee the services at the host home. This log note also stated that (PM-C) had written a critical incident report regarding this incident. An email dated 12/09/14 from PRS #1's brother was sent to CM-A, RS-D, and PM-C. This email reiterated the family concerns about the HHP-B and stated, "We do have concerns about (PRS#1), stemming from the fact that he spent six days in ICU (intensive care) with a sky high sodium count that the doctors concluded resulted from (PRS#1) being unable to access sufficient water for several weeks at a minimum." An email dated 12/09/14 from RS-D responded to this email, saying that PM-C would speak with HHP-B regarding communicating only with the agency and also indicated the agency would continue to monitor the home until a new placement could be found for PRS #1 since the parents/ guardians had requested a new placement. An interview occurred with CM-A on 3/30/15 at 10:30 a.m. She indicated a conversation with PRS #1's guardians during the hospitalization of PRS #1 about their concerns he was not getting enough water to drink at the host home. CM-A said PRS #1 had not had his day program for two weeks prior to the hospitalization due to the vacation of his day program provider and she wondered if that had made a difference because, perhaps, the day program provider had assured PRS #1 had a water bottle during the day. CM-A said she thought she had talked with RS-D about the concerns expressed by the guardian. 5. Failure to thoroughly and timely investigate allegation of abuse and/or neglect	B 472		

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B 472	Continued From page 4 An interview with HHP-B was conducted on 3/31/15 at approximately 11 a.m. During this interview, HHP-B indicated that PRS#1 had begun having more difficulty walking the month prior to his hospitalization. HHP-B said for about three days prior to the hospitalization he had to sometimes carry PRS #1 to the bathroom. He indicated the need to carry PRS #1 was either due to PRS #1 being weak or just refusing to walk. When asked how he would know if PRS #1 was weak or just refusing to walk, HHP-B said, "I just knew when he refused and when he could walk." When asked how he had responded to PRS #1's weakness, HHP-B said he spoke with PM-C. HHP-B said that on 11/17/14, he felt he needed to take PRS #1 to the hospital. It was then that PRS #1 was admitted for hypernatremia and acute kidney injury. The incident report completed for this event documented PRS #1 was hospitalized after he did not respond to HHP-B. An interview was held with Program Manager of Investigations (PMI-E) at the case management agency that has oversight of the service agency on 03/30/15 at 8:15 a.m. PMI-E stated the agency "tried to investigate" the concerns of potential neglect following the hospitalization of PRS #1 but stopped the investigation when the family did not respond to their questions regarding the allegations. PMI-E produced an email dated 12/20/14, requesting further information from the family in the form of specific questions. A return email from the guardian and father of PRS #1 stated the family did not want this investigated until PRS #1 was moved out of the current host home into another home. An interview with the guardians of PRS #1 on 3/27/15 revealed they had responded to the agency's request for information regarding the potential neglect of their son by saying they did not want to make things worse for their son, so	B 472		

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they declined to answer any questions until their son was no longer living at the HHP-B's home. Their son moved on 12/30/14. They indicated the agency had not pursued questions about an investigation after their son moved. When asked about their son's ability to access water and drink on his own, they indicated he was able to drink on his own when a drink was provided; however, he had mobility problems and would not be able to get up, get to a sink and pour himself a drink.

An interview occurred with PM-C on 3/30/15 at 11 a.m. After reviewing the medical notes from PRS #1's hospitalization, PM-C indicated she was not aware of the seriousness of the hospitalization for PRS #1. She said that if she would have known PRS #1 needed to be carried to the bathroom for several days prior to the hospitalization, she would have advised he immediately go to the emergency room. PM-C stated she did not have a copy of a completed investigation regarding allegations of abuse and/or neglect of PRS #1. Regarding other residential options for PRS #1 after his hospitalization, PM-C indicated there were no open host homes available at the time but there was a group home opening that was offered as a residential option and the family refused this.

During an interview with RS-D on 4/1/15 at 11:00 a.m., RS-D reported she was not aware if an investigation had been completed regarding the events that led to PRS #1's hospitalization and the allegation of abuse and/or neglect. RS-D advised a contact with PM-F who had previously been in charge of investigations for the agency.

An interview with PM-F was completed on 4/1/15 at 12:35 p.m. During this interview, PM-F reported the allegation of neglect was received from the guardian and father of PRS #1 who reported the dehydration that resulted in

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B 472	Continued From page 6 hospitalization was neglectful. This caused PM-F to open an investigation. PM-F stated that the guardians and parents of PRS #1 chose not to answer questions from the investigators. The parent/guardians asked for a list of questions they could answer and this was provided to them. According to PM-F, the parent/ guardians did not respond to the emailed questions and the investigation did not go further. PM-F stated the investigation team questioned how far they could go with the investigation without information from the parents. PM-F also indicated the hospital typically informs the agency if they see signs of abuse or neglect with someone in their care and this did not occur in the case of PRS #1. In summary, service agency staff was notified 12/2/14 of potential abuse and/or neglect following PRS #1's hospitalization 11/17/14 for hypernatremia and acute kidney injury. Per the hospital records, PRS #1's medical condition was documented as "most likely related to prolonged dehydration," and as "a significant free water deficit due to inadequate intake." When PRS #1's guardians requested a delay in the investigation of the allegation until PRS #1 could be placed with a different HHP, staff failed to take any steps to investigate the allegation and to ensure the safety of PRS #1 as well as other PRS in HHP-B. Moreover, after PRS #1 was placed in another host home on 12/30/14, service agency staff again failed to pursue an investigation of the allegation of abuse and/or neglect.	B 472		
B 474	8.608.8 D1 Written IR w/in 24 hours Within twenty-four hours of becoming aware of the incident, a written incident report shall be made available to the agency administrator or designee and the community centered board or regional center.	B 474		06/23/2015

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B 474	Continued From page 7 This REGULATION is not met as evidenced by: Based on record review and staff interview, the service agency failed to document allegations of abuse and/or neglect in an incident report for one person receiving service (PRS) #1. This failure resulted in the allegations not being investigated for PRS #1 which created the potential for ongoing abuse and/or neglect of PRS #1 and others under the care of the same host home provider. Findings: 1. Record review on 03/30/15 revealed the service agency was approved to provide comprehensive services to individuals under the Home and Community Based Services, Developmentally Disabled (HCBS-DD) waiver to PRS #1. A responsibility of this service provision is to ensure that within twenty-four hours of becoming aware of an allegation of abuse or neglect, a written report is made available to the agency administrator and the Community Centered Board (CCB). As part of the incident reporting process, agencies are required to submit critical incident reports to the Division for Intellectual and Developmental Disabilities (DIDD) for any critical incidents including hospitalizations. 2. Hospitalization of PRS #1 and allegation of abuse and/or neglect On 03/30/15 - 04/03/15, record reviews for PRS #1 revealed a hospitalization on 11/17/14 with a resulting diagnosis of hypernatremia and acute kidney injury. According to medical documentation by the hospital physician dated 11/17/14, the hypernatremia was "most likely	B 474	1. To correct the deficiency Continuum will write a MANE incident report within 24 hours of hearing an allegation of MANE whether it is directly observed or heard second hand. It will be submitted to the community center board. Before a critical incident is submitted to the CCB a Continuum Agency Nurse will call the hospital and get a specific diagnosis and update for the report with information given from the doctor and nurse team over the client's care. When Continuum submits the report they will ask for an email confirmation from the Community Center Board stating that they report has been submitted. The director or designated person will get an update from the Community Center board bi-weekly until the report is completed and Continuum receives the finalized MANE report. 2. To correct the deficiency Continuum will write a MANE incident report within 24 hours of hearing an allegation of MANE whether it is directly observed or heard second hand. It will be submitted to the community center board. Before a critical incident is submitted to the CCB a Continuum Agency Nurse will call the hospital and get a specific diagnosis and update for the report with information given from the doctor and nurse team over the client's care. When Continuum submits the report they will ask for an email confirmation from the Community Center Board stating that they report has been submitted. . The director or designated person will get an update from the Community Center board bi-weekly until the report is completed and Continuum receives the finalized MANE	

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B 474	Continued From page 8 related to prolonged dehydration ..." A critical care progress note from the hospital dated 11/18/14 signed by the attending physician noted, "Na (sodium) 172 at admit ...like(ly) a significant free water deficit due to inadequate intake." In an interview on 3/31/15 at approximately 11 a.m. host home provider (HHP-B) where PRS #1 resided until 12/30/14 indicated that PRS#1 had begun having more difficulty walking the last month prior to his hospitalization. HHP-B said for about three days prior to the hospitalization he had to sometimes carry PRS #1 to the bathroom. He indicated the need to carry PRS #1 was either due to PRS #1 being weak or just refusing to walk. When asked how he would know if PRS #1 was weak or just refusing to walk, HHP-B said, "I just knew when he refused and when he could walk." A log note was documented on the benefits utilization system (BUS) written by Case Manager-A (CM-A) dated 12/02/14. This log note referred to a communication with PRS #1's parent and guardian. This note stated the guardian had spoken with CM-A and said, when he referred to the recent renal failure of his son, that a psychiatrist he had spoken to told him, "what host home provider (HHP-B) did to PRS #1 was abuse." This log note indicated CM-A sent a follow-up email to Program Manager-C (PM-C) and Residential Supervisor -D (RS-D). No incident report was completed for the allegations of abuse after the conversation with the parent/guardian. An incident report (IR) dated 11/18/14 and written by PM-C documents the hospitalization of PRS #1 on 11/17/14 as reported to her by HHP-B through an email and text message. However, this incident report did not include any concerns of prolonged dehydration and, significant water deficit due to inadequate intake as noted in the hospital records or documentation of PRS #1's	B 474	report. 3. The monitoring system will be the documentation from the emails where the CCB gives updates on the investigation until it is completed on a regular basis. The quality assurance manager will review the MANE report during the quarterly trend analysis, Residential Supervisor, director, quality assurance manager, or designated person. 4. 06/23/15	

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weakness, refusals to walk, or HHP-B's need to carry PRS #1 to the bathroom. Rather, the IR read that PRS #1 "had high sodium levels in the blood and PRS #1 kidneys were not functioning properly." The IR did not identify any potential causes of kidney failure.

The paper report of a critical incident report (CIR) submitted by PM-C dated 11/18/14 indicated a "medical crisis," resulting in "hospitalization." This report, too, did not include information on PRS #1's condition just prior to hospitalization or hospital concerns about his prolonged dehydration and significant water deficit due to inadequate intake. Moreover, it did not include any allegation of possible abuse and/or neglect reported to PM-C by CM-A. In addition, this CIR was not located within the Developmental Disabilities Website (DDWeb) that tracks all CIRs, indicating it was not submitted properly or was not submitted to the DDWeb.

3. During an interview with the Program Manager of Investigations (PMI-E) on 3/30/15 at 8 a.m., she indicated she did not have an IR that contained concerns about PRS #1's condition at HHP-B, hospital concerns regarding his prolonged dehydration, and possible abuse and/or neglect of PRS #1.

During an interview with PM-C on 3/30/15 at 11 a.m., she indicated she did not have an IR alleging abuse or neglect of PRS #1. PM-C provided the IR written on 11/18/14 (see above) that documented the hospitalization of PRS #1, but this IR did not contain concerns about PRS #1's condition at HHP-B and possible abuse and/or neglect reported by CM-A.

An interview with Residential Supervisor (RS-D) on 4/1/15 at 11 a.m. revealed she did not have an IR that contained concerns about PRS #1's condition at HHP-B and possible abuse and/or

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B 474	Continued From page 10 neglect of PRS #1 reported by CM-A.	B 474		
B 499	8.608.6 A Incident Reporting P & P Community centered boards, service agencies and regional centers shall have a written policy and procedure for the timely reporting, recording and reviewing of incidents. This REGULATION is not met as evidenced by: Based on record review and staff interview, the service agency failed to document medical conditions or safety or emergency control procedures for person receiving services (PRS) #1. This failure resulted in the interdisciplinary team being unaware of PRS #1's increasingly weakened physical condition or the host home provider (HHP-B)'s need to implement Emergency Control Procedures (ECPs)or Safety Control Procedures (SCPs) with PRS #1. Findings: 1. Record review on 03/30/15 revealed the service agency was approved to provide comprehensive services to individuals under the Home and Community Based Services, Developmentally Disabled (HCBS-DD) waiver to PRS #1. A responsibility of this service provision is to ensure that incident reports (IRs) are written for instances of medical emergencies; for any actions of the PRS that are unusual and require review or for any safety or emergency control procedures (procedures utilizing the use of a restrictive procedure that limits an individual's movement such as a staff member or provider having to carry someone) The IRs are to be made available to the agency administrator and the Community Centered Board (CCB). 2. Incident reports (IR) for PRS #1	B 499	1. 1. The Director and Regional Manager will meet with the host home provider and review the regulation that states when it is appropriate to use an emergency control procedure and what procedure to use following using an emergency control procedure. The host home provider who was cited for using an emergency control procedure and not documenting is no longer contracting clients through our agency. The regional Manager will also review the regulation with all Host Home Providers at a Host Home meeting which reviews the process when it is appropriate to use an emergency control procedure and what procedure to follow when using one. When supervisors complete their monthly house visits with the clients and host home providers they will ask provoking questions to ensure that emergency control procedures are not being completed and not properly documented. The supervisors will ask these questions during their home visits for three months. This will begin in the month of July being that the home visits have already been completed for the month of June. 2. The Director and Regional Manager will meet with the host home provider and review the regulation that states when it is appropriate to use an emergency control	06/23/2015

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B 499	Continued From page 11 Record review on 4/30/15 confirmed two IRs were generated for PRS #1 from September, 2014 through December 30, 2014. One IR from 9/22/14 was for an incident of self injury and one IR from 11/17/14 was when PRS #1 was hospitalized and diagnosed with hypernatremia and acute kidney injury. 3. Failure to document medical conditions or safety or emergency control procedures A nephrology consultation dated 11/17/14 while PRS #1 was hospitalized contained a narrative from the Nephrologist that documented the following: "He (PRS #1) was in his usual state of health until about three weeks ago when he started with generalized weakness which gradually progressed to the point that over the few days prior to this admission (to the hospital) caregiver had to carry him to the bathroom and back to bed." The hospital discharge note transcribed by the Advanced Practice Nurse Practitioner (ANP) on 11/24/14 gave the diagnosis of "hypernatremia, resolved, secondary to dehydration" among several other diagnoses. An interview with HHP-B occurred on 3/31/15 at approximately 11 a.m. HHP-B reported he had to carry PRS #1 at times for about the three days prior to his hospitalization on 11/17/14. He said sometimes PRS #1 would refuse to walk and needed to be carried and other times he was too weak, especially the last day before hospitalization. When asked how he would know if PRS #1 was weak or just refusing to walk, HHP-B said, "I just knew when he refused and when he could walk." Review of the incident report (IR) dated 11/18/14 written by (HHP-B) outlines the hospitalization of PRS #1 on 11/17/14. However, this incident report did not include any concerns of prolonged	B 499	procedure and what procedure to use following using an emergency control procedure. The host home provider who was cited for using an emergency control procedure and not documenting is no longer contracting clients through our agency. The regional Manager will also review the regulation with all Host Home Providers at a Host Home meeting which reviews the process when it is appropriate to use an emergency control procedure and what procedure to follow when using one. When supervisors complete their monthly house visits with the clients and host home providers they will ask provoking question to ensure that emergency control procedures are not being completed and not properly documented. The supervisors will ask these questions during their home visits for three months. This will begin in the month of July being that the home visits have already been completed for the month of June. 3. The residential supervisor or designated person will document these questions on the monthly home visit completed in the month of July, August, and September. 4. Residential Supervisor or designated person 5. 6/23/15	

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B 499	Continued From page 12 dehydration and, significant water deficit due to inadequate intake as noted in the hospital records or documentation of PRS #1's weakness, refusals to walk, or HHP-B's need to carry PRS #1 to the bathroom. Rather, the IR read that PRS #1 "had high sodium levels in the blood and PRS #1 kidneys were not functioning properly." An interview occurred with Program Manager C (PM-C) on 3/30/15 at 11 a.m. After reviewing the medical notes from PRS #1's hospitalization, PM-C indicated she was not aware of the seriousness of the hospitalization for PRS #1. PM-C said that if she would have known PRS #1 needed to be carried to the bathroom for several days prior to the hospitalization, she would have advised PRS #1 immediately go to the emergency room. On 4/30/15 PM-C was interviewed about PRS #1 needing to be carried. PM-C confirmed she had never heard about PRS #1 needing to be carried until this review occurred. PM-C confirmed there was no approved transfer in place for PRS #1 that included carrying him so an IR would be required if PRS #1 needed carrying. There was no incident report completed that showed an ECP had been completed which would have been required if PRS #1 needed to be carried due to a refusal to walk or if he were too weak to walk. PM-C confirmed PRS #1 did not have a SCP in place that would have allowed the HHP-B to carry him if this was required for safety reasons, however, an IR would still be required if the SCP was implemented. In summary, no IR ' s were completed for any instances of carrying PRS #1.	B 499		
B 612	8.609.5 B10 Information to Staff/Protocols Staff, providers and other support personnel shall have ready access to records and information required by them to carry out their responsibilities.	B 612		06/15/2015

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B 612	Continued From page 13 This REGULATION is not met as evidenced by: Based on record review and interview, the agency failed to provide host home provider (HHP-B) with information required to carry out their responsibilities for one (#2) of two persons receiving services (PRS) in the home. This failure resulted in HHP-B having no written instructions to assist PRS with their medical conditions and created the potential for inconsistent and/or inappropriate staff intervention for PRS #2's medical conditions including the potential for physical harm. Findings include: 1. Record review on 03/31/15 revealed that the service agency is approved to provide services and supports to individuals under the Home and Community Based Services Developmental Disabilities. Host Home Provider-B (HHP-B) contracts with the agency to provide residential services and supports for person receiving services including PRS #2 and these services include assisting him with his medical conditions. 2. PRS #2 required protocols or instructions to staff for his medical conditions. PRS #2 was admitted to HHP-B on 02/03/15. A review of PRS #2's record on 03/31/15 revealed a physician's order identifying the following medical diagnoses: a. High Blood Pressure (HTN) b. Cardiac Heart Failure c. History of Renal Failure d. Pulmonary Emphysema e. History of Pressure Sores f. Seizure Disorder	B 612	1.To correct the deficiency a new checklist for new clients moving into a residence for permanent or emergency placement was developed. The host Provider checklist has been updated to reflect the physicians order being reviewed and to ensure all medical equipment needed is brought over to the residence. The orientation checklist has also been added to the moving checklist. The orientation will be the time when the host home supervisor will review all the information the provider will need to support the client in their home. It will specifically list if the client has any medical equipment and any specific protocols that the client has. The orientation will be signed off by the host home provider, residential supervisor and the regional manager. The agency nurse will also review the orientations to ensure all of the client specific protocols and medical equipment are listed. 2. 1.To correct the deficiency a new checklist for new clients moving into a residence for permanent or emergency placement was developed. The host Provider checklist has been updated to reflect the physicians order being reviewed and to ensure all medical equipment needed is brought over to the residence. The orientation checklist has also been added to the moving checklist. The orientation will be the time when the host home supervisor will review all the information the provider will need to support the client in their home. It will specifically list if the client has any medical equipment and any protocols that the client has. The orientation will be signed off by the host home provider, residential supervisor and the regional manager. The agency nurse will also	

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B 612	Continued From page 14 g. Esophageal Stricture h. GERD Review of PRS #2's record on 03/31/15 revealed a document titled "Physician's Order " dated 02/13/15. This order documented need for the following: a. Oxygen use b. Low fat diet, low cholesterol diet, no added salt (NAS) and avoid caffeine products c. Administer Nitroglycerin as needed d. Administer an inhaler twice daily and another inhaler to be administered as needed 3. Failure to have protocols and/or instructions and client specific training for PRS #2's medical conditions. PRS #2's record did not contain protocols or instructions for staff to assist PRS #2 with how to use the oxygen equipment or how and when to change the tubing. There was no identification of signs or symptoms of high blood pressure, and no instruction on when the nitroglycerin would be needed. Although PRS #2 had a pressure sore being treated by home health, there was no information or instructions about any daily care that may be needed for this condition. No seizure protocol was found in the record and no specific instructions were available regarding any special needs PRS #2 would have for his diagnoses of esophageal stricture and GERD. Record review of PRS #2 on 03/31/15 revealed a document titled " Continuum of Colorado Residential Program Monitoring, " dated 11/17/14. This document is completed by the agency monitoring team to oversee PRS #2 appointments, medical services and supports and other areas of services provided. The section for monitoring protocols did not identify any medical related protocols PRS #2 should have in place. Additionally, there was no	B 612	review the orientations to ensure all of the client specific protocols and medical equipment are listed. Medical consults have been reviewed to ensure that all medical needs have been met for both of the resident's that live in the host home, the health care plans that are needed to serve client #2 have been reviewed with the Host Home Provider, and all missing medical equipment is available to client #2 that was previously missing. 3. The monitoring system is to have the client specific orientation and the checklist completed within 72 hours of the client moving in. On an on-going basis the client will be monitored quarterly with the nurse's quarterly medical book audits. 4. Residential Supervisors, Regional Managers or designated person, and agency nurse 5.6/15/15	

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B 612	Continued From page 15 documentation of client specific training for HHP-B. 4. An interview was conducted on 03/31/15 at 12:00 p.m. with HHP-B and Program Manager C (PM-C). They confirmed the protocols and instructions to address PRS #2 medical conditions and physician orders were not in place and the client specific training did not happen. PM-C stated the protocols and instructions and client specific training had not been completed because PRS #2 was an emergency placement; however, PRS #2 had been in HHP-B for 56 days. 5. An interview conducted on 04/01/15 at 1:25 p.m. with Residential Services Director (RS- D) confirmed HHP-B should have received client specific training by PM-C on the day PRS #2 was placed in the home.	B 612		
B 1030	8.609.6 A Comp.Services Assure Med/Dental Services Persons receiving comprehensive services and supports shall be assured of medical and dental services necessary to maintain the health of the person and to prevent further disability and shall have dentures, eyeglasses, hearing aids, braces and other aids or therapies as prescribed by an appropriate professional. This REGULATION is not met as evidenced by: Based on record review and interview, the agency failed to ensure one out of two persons receiving services (PRS #2) in a host home received the medical services necessary to maintain the health of the person and to prevent further disability. PRS #2 did not have access to prescription eye glasses and did not receive physician's ordered treatments.	B 1030	1. To correct the deficiency a new checklist for new clients moving into a residence for permanent or emergency placement was developed. The host Provider checklist has been updated to reflect the physicians order being reviewed and to ensure all medical equipment needed is brought over to the residence. The orientation checklist has	05/15/2015

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B 1030	Continued From page 16 Findings include: 1. Record review on 03/31/15 revealed that the service agency is approved to provide services and supports to individuals under the Home and Community Based Services Developmental Disabilities. Host Home Provider-B (HHP-B) contracts with the agency to provide residential services and supports for person receiving services, including PRS #2 and these services include assisting him with medical and dental services necessary to maintain his health. 2. Failure to ensure PRS #2 received ordered and planned interventions Review of PRS #2's record on 03/31/15 revealed he was admitted to HHP-B on 02/03/15 a. Pressure Sores Review of PRS #2's record on 03/31/15 revealed he had a history of pressure sores. A document titled "Medical/Dental Consult" dated 03/10/14, identified a pressure sore on the right hip. The document identified concerns for positioning and required PRS #2 to continue to keep pressure off the area and monitor. On 4/4/14, another medical consult form ordered "position changes at night." An interview conducted with HHP-B on 03/31/15 at 1:30 p.m. confirmed PRS #2 currently has a pressure sore that is being treated by a home health nurse. When asked about a positioning schedule for PRS #2, HHP-B stated positioning is occurring but it is not being documented. Program Manager C (PM-C) was present during this interview and confirmed there is no documentation for positioning to keep pressure off PRS #2's current pressure sore. b. Oxygen usage	B 1030	also been added to the moving checklist. The orientation will be the time when the host home supervisor will review all the information the provider will need to understand to support the client in their home. It will specifically list if the client has any medical equipment and any protocols that are specific to the client. The orientation will be signed off by the host home provider, residential supervisor and the regional manager. The agency nurse will also review the orientations to ensure all of the client specific protocols and medical equipment are listed. Client #2 has been seen by a physical therapist and checks throughout the night have been added to carasolva to ensure they are being completed to prevent pressure sores. Medical consults have been reviewed to ensure that all medical needs have been met for both of the resident's that live in the host home, the health care plans that are needed to serve client #2 have been reviewed with the Host Home Provider, and all missing medical equipment is available to client #2 that was previously missing. Since the investigation Client #2 has been reviewed with his physical therapist on 6/5/14 and there has been tracking added for repositioning on Carasolva. There will be a training held on when to contact nursing in regards to weights on 6/18/15 with all host home providers. 2. To correct the deficiency a new checklist for new clients moving into a residence for permanent or emergency placement was developed. The host Provider checklist has been updated to reflect the physicians order being reviewed and to ensure all medical equipment needed is brought over to the residence. The orientation checklist has also been added to the moving checklist.	

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B 1030	Continued From page 17 Record review of PRS #2 on 3/31/15 revealed a Pulse Oximetry Health Care Plan for PRS #2. This plan date 01/12 stated, "(PRS #2) has a history of Cardiomyopathy and tends to drop his O2 (oxygen) sats (saturation levels) in the afternoon requiring O2 supplementation. Also wears 2 LPM (liters per minute) O2 at night." Instructions said to, "Check pulse Ox (oxygen saturation level) two times daily. Refer to MAR (medication administration record) for times." Observation of the host home for PRS #2 on 3/31/15 revealed there was no a pulse oximeter in the home and there was no documentation that oxygen saturation levels for PRS #2 had been checked twice a day. Interview with PM-C on 4/30/15 revealed the pulse oximeter was brought to the host home for PRS #2 and this protocol of measuring his oxygen levels two times a day was implemented as of 4/1/15 (during the complaint investigation). PM-C reported she and HHP-B were unaware of this requirement for PRS #2 until after the surveyors were at the host home. PRS #2 was in HHP-B ' s host home for 56 days without his pulse ox checked twice a day as care planned. c. Vision Review of PRS #2's record revealed a document titled " Vision Consult " dated 11/20/14. On this document the ophthalmologist ordered new glasses for myopia and daily eyelid washes with baby shampoo to treat blepharitis. The document titled " Task Record " dated 02/28/15 recording each day of February 2015 did not list the eyelid washes ordered by the ophthalmologist. The document titled "Task Record" dated 03/31/15 recording each day of March 2015 instructed the provider to "clean lids with baby shampoo daily." All days in the month were marked with an X meaning not provided,	B 1030	The orientation will specifically list if the client has any medical equipment and any protocols that the client has. The orientation will be signed off by the residential supervisor and the regional manager. The agency nurse will also review the orientations to ensure all of the client specific protocols and medical equipment are listed. Client #2 has been seen by a physical therapist and checks throughout the night have been added to carasolva to ensure they are being completed to prevent pressure sores. Medical consults have been reviewed to ensure that all medical needs have been met for both of the resident's that live in the host home, the health care plans that are needed to serve client #2 have been reviewed with the Host Home Provider, and all missing medical equipment is available to client #2 that was previously missing. Since the investigation Client #2 has been reviewed with his physical therapist on 6/5/14 and there has been tracking added for repositioning on Carasolva.. There will be a training held on when to contact nursing in regards to weights on 6/18/15 with all host home providers. 3. The monitoring system is to have the client specific orientation and the checklist completed within 72 hours of the client moving in. On an on-going basis the client will be monitored quarterly with the nurse’s quarterly medical book audits. Client #2’s repositioning is tracked on Carasolva. 4. Residential Supervisors, Regional Managers or designated person, and agency nurse 5.6/15/15	

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until the 3/31/15 (during the complaint investigation) when the PM-C and HHP-B were alerted to this requirement.

An interview was conducted with PM-C on 03/31/15 at 1:30 p.m. and she confirmed the order for the daily eyelid washes for PRS #2 were not being provided. PM-C reported the nurse did not see the order for the daily eyelid washes although they had been on the "Task Record" for the month of March.

An interview with PM-C and HHP-B on 3/31/15 revealed the HHP-B was not aware, until alerted by the surveyor, that PRS #2 had glasses, even though (see above) he had a prescription for eyeglasses. PM-C indicated she thought she remembered she had seen PRS #2 wear glasses in the past at his prior residence but had not noted these were not in place at the current host home. . HHP-B confirmed PRS #2 had not worn his glasses since coming into the host home on 02/03/15.

On 4/30/15, in a subsequent interview with PM-C at 10:45 a.m., she confirmed PRS #2 now had his glasses available for use in the host home.

d. Weights

Review of PRS #2's record on 03/31/15 revealed a document titled "Vital Statistic Record" dated 02/28/15. Weights are recorded on this document daily. If there is a 5 lb increase or decrease in weight, the provider is instructed to notify the nurse.

The weight fluctuations documented by HHP-B on the "Vital Statistic Record" for PRS #2 were as follows:

02/13/15 was 146 pounds while using walker for

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B 1030	Continued From page 19 support 02/14/15 was 167 pounds without support 02/15/15 was 146 pounds while using walker for support 02/16/15 was 157 pounds while at doctor's office with support 02/17/15 was 147 pounds while using walker for support There was no documentation in PRS #2's record of the nurse being notified or follow up regarding PRS #2's weight fluctuations in February 2015. On 4/30/15 at 1 p.m. the agency nurse (H) was contacted regarding the weight fluctuations on the February, 2015 "Vital Statistic Record" for PRS #2. Nurse H said when there are discrepancies of more than five pounds in weight, the providers should contact her. She would assess the PRS and determine if there was any need for follow-up action. Nurse H said she was not contacted regarding these weight fluctuations for PRS #2.	B 1030		
B 1168	8.609.7 C5b Record: Results of Evals and Follow-up Records shall contain documentation of: b) results of medical evaluations/ assessments and of follow-up services required, if any; This REGULATION is not met as evidenced by: Based on record review and staff interview, the agency failed to document results of medical evaluations or assessments and follow-up services as required for one of two persons receiving services (PRS #1). Specifically the agency did not document fluid intake for PRS #1. This failure created the potential for re-hospitalization of PRS #1.	B 1168	1. To correct the issue if a doctor recommends fluid intake documentation for any client it will now be documented on the electronic medication administrations system, CaraSolva. This will prompt the provider to list the total fluids that the client receives for that day. 2. When the provider goes to a doctors appointment with a client they are requirec	05/20/2015

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B 1168	Continued From page 20 Findings: 1. Record review on 03/30/15 revealed the service agency was approved to provide comprehensive services to individuals under the Home and Community Based Services, Developmentally Disabled (HCBS-DD) waiver to PRS #1. A responsibility of this service provision is to ensure agency records contain documentation of results of medical evaluations or assessments and of follow-up services. 2. On 03/30/15 - 04/03/15, record reviews for PRS #1 revealed a hospitalization on 11/17/15 with a resulting diagnosis of hypernatremia and acute kidney injury. According to medical documentation by the hospital physician dated 11/17/15, the hypernatremia was "most likely related to prolonged dehydration" The documentation also noted, "He (PRS #1) is not currently on any diuretics, and has no history of diabetes insipidus." The acute kidney injury was noted to be "most likely secondary to prolonged dehydration with likely acute tubular necrosis at this point." A critical care progress note from the hospital dated 11/18/14 signed by a hospital physician noted, "Na (sodium) 172 at admit currently down to 156 on D5W> like a significant free water deficit due to inadequate intake." A nephrology progress note dated 11/18/14 and signed by the nephrologist on the assessment of PRS #1 indicated, "Hypernatremia-due to dehydration/ volume depletion- again, not on diuretics and no known history of dehydration...AKI (acute kidney injury) -due to prolonged dehydration and possible hypotension? Now with a ATN (acute tubular necrosis) (although would expect higher urine Na if ATN) so hopefully it is prerenal."	B 1168	to fax in the consult to the nurse within 24 hours of the doctor visit. If the doctor recommends to track fluid intake the nurse will add this as a prompt into CaraSolva as needed. 3. For any client that has a recommendation from a doctor for fluid intake the nurse will review monthly on CaraSolva. The nurse will also review on a quarterly basis and will document this on the quarterly Medical Book Audit. 4. The health services manager and the residential supervisor, or designated person. 5. 5/20/15	

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B 1168	Continued From page 21 The discharge note transcribed by the Advanced Practice Nurse Practitioner on 11/24/14 gave the diagnosis of "hypernatremia, resolved, secondary to dehydration" among several other diagnoses. On 11/25/14 PRS #1 visited his physician as a follow-up to his recent hospitalization. The note for this visit reads in part, "needs 60 oz of fluids daily." When asked for documentation of the fluid intake for PRS #1, the agency produced a liquid intake log for the dates of 11/26/14 - 11/30/14. This log documented a range of fluid intake for PRS #1 of between 52 and 70 ounces per day for these five days. There was no documentation of a fluid intake log for PRS #1 for the 30 days in December of 2014 while PRS #1 continued to reside in the host home (HHP-B) where he had been residing at the time of his hospitalization. 3. In an interview with Program Manager-C (PM-C) on 3/31/15, she said she did not have a fluid intake log for PRS#1 for December of 2014. She said she thought she had received it but said it must have "gotten lost." An interview with HHP-B confirmed there was no documentation for the fluid intake log for December of 2014 although he stated, "I did do it."	B 1168		
B 9999	10 C.C.R. 2505-10, Sec 8.600 Final Observations Each person receiving services has the right to communication and visits. This includes family member contact. When there are complaints or concerns indicated by guardians about accessing communication through visits, phone	B 9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUUM OF COLORADO	**11111 E. MISSISSIPPI AVENUE AURORA 80012**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
B 9999	Continued From page 22 contact or communication of oversight by the providers, it is a cause for further review. In this case there was minimal agency intervention regarding the increasingly strained communication between the provider and the guardians which resulted in a disrupted placement and possible neglect. The satisfaction survey completed for PRS #1 only noted that this person could not speak and no further attempts were documented to determine his satisfaction with services and supports. Alternative methods of surveying the parents/ guardians or having someone indicate how PRS who do not use words to communicate show satisfaction or dissatisfaction is advised. Anytime someone is being carried, where such maneuver is not part of a team sanctioned transfer by a staff or provider, an immediate review is required. In any case this would be considered a Emergency or Safety Control Procedure, an indication of illness that requires immediate attention or an indication the PRS requires a transfer protocol. Individual specific training is required prior to unsupervised contact with PRS. It was during the review of the absence of training for PRS # 2 that the many medical treatment needs were found that were not in place. The system for placement and training of staff during placement requires review by the agency.	B 9999		