

Advocating for Quality Nursing Home Care and Sufficient Staffing in Colorado

by Valerie L. Corzine

Imagine that you are a Director of Nursing in a Colorado nursing home. The parent corporation of the nursing facility you work for refuses to allocate necessary funds to hire sufficient staff. Frail and vulnerable residents depend on you to ensure quality care throughout the facility. Just having enough staff to get everyone fed, bathed, and turned to prevent pressure sores is a daily struggle. If a complaint is made to the health department, a plan of correction may require staff training on pressure sore prevention or additional documentation, such as that patients are being bathed on a regular schedule.

Unfortunately, it is unlikely that there will be any requirement that addresses the underlying problem—insufficient staffing. Nursing staff are morally implicated, their licenses are on the line, and their options are limited. The most reasonable course of action in their view may be to quit. This is what Directors of Nursing across this state are doing at an alarming rate. The average tenure of a Director of Nursing in a Colorado nursing home is only nine months.¹

Colorado attorneys who become aware of this situation may be morally implicated, but do not work for the nursing home corporation and do not have to worry about finding work in the industry. However, there are some legal tools available that Colorado attorneys might be able to use to address the underlying problem of insufficient staffing. Two legal and regulatory sources that could assist attorneys in improving quality of care in Colorado nursing homes include: (1) the Colorado Nursing Home Grievance Procedure (“Grievance Procedure”) (see the Appendix to this article, entitled “Colorado Nursing Home Grievance Procedure”);² and (2) the Federal Guidance for Insufficient Staffing—F-353,³ both of which are discussed below. First, some background is in order on the issue of quality of care in nursing homes.

Quality of Care and Abuse Problems in Nursing Homes

Government Accountability Office (“GAO”) reports have continued to document the persistence of quality of care and abuse problems, even several years after the passage of the federal Nursing Home Reform Law, amendments to the Omnibus Budget Reconciliation Act (“OBRA”)—technically, the 1987 nursing home reform amendments to the Medicare and Medicaid Acts: 42 U.S.C. § 1395i-3 (Medicare) and 42 U.S.C. § 1396r (Medicaid).

The nursing home reform amendments provide, among other things, significant federal requirements on nursing facilities relating to resident rights; admission, transfer, and discharge; prohibitions on abuse and employment of abusers; maintenance and enhancement of quality of life; resident assessments and comprehensive care plans; and a high standard of quality of care requiring that the facility ensure that the resident attains or maintains his or her highest practicable level of physical, mental, and psychosocial well being.⁴

Despite these impressive federal requirements, GAO reports conclude that nursing homes continue to have serious problems, such as malnutrition, abuse, pressure sores, and over-medication.⁵ After a survey of ten sample states, one GAO study reports inadequate staffing levels remain one of the major problems, which most officials believe lead to chronic quality of care problems.⁶ In another report,⁷ it was found that allegations of physical and sexual abuse of nursing home residents were not reported promptly and that local law enforcement officials were seldom summoned to nursing homes to immediately investigate such allegations. When they are summoned, evidence of this type of abuse has been compromised. Abuse al-

legations are supposed to be reported to state survey agencies immediately, but often are not.⁸

Moreover, the GAO found that as many as one in five nursing homes nationwide (about 3,500 homes) had deficiencies so serious that caused residents actual harm or placed them in immediate jeopardy.⁹ Along with this, the GAO discovered there was significant understatement of care problems that should have been classified as actual harm or worse. These included such problems as serious avoidable pressure sores, severe weight loss, and multiple falls resulting in broken bones and other injuries.¹⁰

In Arkansas, a state survey agency investigated coroner referrals that identified weaknesses in nursing home quality, mirroring the GAO’s nationwide findings.¹¹ These weaknesses included: (1) understatement of the seriousness of complaints and a failure to investigate serious complaints promptly; (2) predictable timing of state surveys, which could enable a nursing home to cover up deficiencies; (3) weaknesses in survey methodology that resulted in care problems that were overlooked; and (4) lack of accountability for neglect associated with a resident’s death.¹²

Experts, long-term care ombudsmen, and health survey agencies continually

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find that inadequate staffing is a primary cause of persistent quality of care problems in nursing homes.¹³

Although inadequate staffing is widely recognized as the primary cause of poor care in today's nursing homes, it is rarely cited by health survey agencies in recertification surveys.¹⁴ Weaknesses in survey methodology are prevalent not only in Colorado, but also across the country. This has resulted in plans of correction that fail to address problems of insufficient staffing.¹⁵ Attorneys representing clients who are living in nursing homes, as well as their families, may find a way to address this problem through the use of the state's nursing home grievance procedure.

Colorado Nursing Home Grievance Procedure

The Colorado Nursing Home Grievance Procedure provides a mechanism for residents and their legal representatives, as well as family members and resident councils, to submit grievances regarding nursing home care and challenge not only findings, but also remedies (*see* Appen-

dix).¹⁶ The Grievance Procedure is more than a mechanism to complain to facility management and the Colorado Department of Public Health and Environment ("CDPHE"). It is an administrative appeals process that begins at the facility staff designee level, but ultimately provides for an administrative hearing and the right to judicial review.¹⁷ However, the Grievance Procedure is not a substitute for private nursing home tort litigation; Colorado courts have ruled that litigants are not required to exhaust administrative remedies.¹⁸

The Grievance Procedure provides that grievances may concern "conditions, treatment, or violations of rights of any resident by the facility or staff."¹⁹ One of the most challenging aspects of the nursing home grievance process is that the time window for filing a grievance is fourteen days from the date of the incident.²⁰ Although there generally needs to be at least one incident within the fourteen-day time window before submitting a written or oral nursing home grievance, the Grievance Procedure itself contemplates it will be used to address problems with

"conditions" and evidence of past problems that should be relevant to the determination of an appropriate remedy.²¹ In many cases, the real issue is the remedy, and the real "condition" that needs to be remedied is insufficient staffing.

Federal Guidance for Insufficient Staffing Problems

Residents, their families, or resident councils may become aware that quality of care is affected by underlying problems of insufficient nursing home staffing. In this situation, the Centers for Medicare and Medicaid Services ("CMS") Guidance to Surveyors ("CMS Guidance") on insufficient staffing may be particularly helpful.²² The CMS Guidance provides that the determination of sufficient staff is to be made based on the staff's ability to provide needed care to residents. The staff must be able to provide residents with sufficient care so they may reach their highest practicable physical, mental, and . . . well being.²³ The ability to meet the following requirements determines the suf-



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iciency of nurse staffing, according to the CMS Guidance:

- *Resident Behavior and Facility Practices*: restraints, abuse, and staff treatment of residents²⁴
- *Quality of Life*: dignity, self-determination, participation in resident and family groups, participation in other activities, accommodation of needs, activities program, social services, and environment²⁵
- *Resident Assessment*: admission orders, comprehensive assessments, quarterly review assessment, use of assessments, coordination with Pre-admission Screen and Annual Resident Review ("PASARR"), automated data processing requirement, accuracy of assessments, penalty for falsification, comprehensive care plans, discharge summary, and PASARR generally²⁶
- *Quality of Care*: activities of daily living, vision and hearing, pressure sores, urinary incontinence, range of motion, mental and psychosocial functioning, prohibitions against improper resort to naso-gastric tubes and requirements for proper use when use is clinically unavoidable, nutrition and hydration issues, special needs, unnecessary drugs, and medication errors²⁷
- *Infection Control*: infection control program, preventing spread of infection, and proper handling of linens to prevent the spread of infection.²⁸

Attorneys should be aware of the probing questions surveyors are expected to ask to determine whether there is an insufficient staffing problem. The "probes" suggested by the CMS Guidance include the following:

- Is there adequate staff to meet direct care needs, assessments, planning, evaluation, and supervision?
- Do workloads for direct care staff appear reasonable?
- Do residents, family, and ombudsmen report insufficient staff to meet resident needs?
- Are staff members responsive to residents' needs for assistance, and are call bells answered promptly?
- Do residents call out repeatedly for assistance?
- Are residents, who are unable to call for help, checked frequently (for example, each half hour) for safety, comfort, positioning, and to offer fluids and provision of care?

- Are identified care problems associated with a specific unit or tour of duty?
- Is there a licensed nurse that serves as a charge nurse (such as supervises the provision of resident care) on each tour of duty? (The facility may have a waiver of this requirement.)²⁹
- What does the charge nurse do to correct problems in staff performance?
- Does the facility have the services of a registered nurse available eight consecutive hours a day, seven days a week? (The facility may have a waiver of this requirement.)³⁰
- How does the facility assure that each resident receives nursing care in accordance with the resident's plan of care on weekends, nights, and holidays?
- How does the sufficiency (numbers and categories) of nursing staff con-

tribute to identified quality of care, resident rights, quality of life, or facility practices problems?³¹

Attorneys may wish to use the CMS Guidance as a roadmap for putting together a nursing home grievance case in which one of the primary issues is insufficient staffing. Moreover, although the Colorado Grievance Procedure is woefully underused, attorneys should be aware of this procedure to assist in challenging facility- and agency-approved plans of correction where residents, families, or resident councils believe such remedies are inadequate.

Conclusion

Elder law attorneys and nursing home tort litigators should be aware that when a particular remedy is inadequate to address underlying nursing home problems that lead to poor quality of care, residents, family members, and resident councils are

The Legal Center Services

The following is a list of The Legal Center programs, with a brief statement as to its priorities. For a more detailed discussion of the programs at The Legal Center, see <http://www.thelegalcenter.org>.

- **Protection and Advocacy for People with Developmental Disabilities ("PADD")**—abuse, neglect, and civil rights investigations involving persons with developmental disabilities; special education cases; access to community inclusion and medical waiver services specific to people with developmental disabilities, as well as rights restriction issues
- **Protection and Advocacy for Individuals with Mental Illness ("PAIMI")**—abuse, neglect, and civil rights investigations involving persons with mental illness in facilities; legal representation of persons with mental illness in fair housing; criminal justice systems issues involving people with mental illness
- **Protection and Advocacy for Individual Rights ("PAIR")**—legal representation of fair housing issues for people with disabilities and The Legal Center's HIV Legal Project (housing, employment, access to government services, access to public accommodations, education, and breach of confidentiality)
- **Protection and Advocacy for Beneficiaries of Social Security ("PABSS")**—work incentive assistance to SSDI and SSI beneficiaries seeking vocational rehabilitation, employment, and other support services to secure, retain, or regain employment
- **Client Assistance Program**—vocational rehabilitation advocacy and appeals
- **Protection and Advocacy for People with Traumatic Brain Injury ("TBI")**—abuse, neglect, and civil rights violations; access to the Medicaid brain injury waiver for persons needing long-term care
- **Protection and Advocacy for Assistive Technology ("PAAT")**—advocacy and legal assistance to people with disabilities in obtaining necessary assistive technology
- **VOTE**—Colorado's Help America Vote Act Program, seeking to ensure that Colorado voting is accessible to people with disabilities and pursuing advocacy on behalf of individuals who have been disenfranchised
- **Colorado Long-term Care Ombudsman Program**—coordination of the state's local Long-term Care Ombudsman programs
- **Colorado Legal Assistance Developer for the Elderly**—technical assistance to the Colorado Long-term Care Ombudsman Program and coordination of the state's local Legal Assistance Programs for the Elderly
- **Long-term Care Law Project**—direct legal representation of nursing home residents in involuntary discharge appeals; quality of care issues in facilities with a history of poor care; least restrictive environment issues

entitled to a legal remedy. Such a remedy should ensure that there is adequate staffing for nursing home residents to reach their highest level of physical, mental, and psychosocial well being.³²

However, knowing that residents are entitled to a legal remedy and having clients who can actually afford such legal representation on these matters are two different things. Elder law attorneys and nursing home tort litigators may encounter situations in which a client is in a nursing home, there are serious and specific quality of care concerns, and the facility has a history of poor care that has seemingly frustrated the best efforts of the Long-term Care Ombudsman Program and the CDPHE. However, there may not be sufficient monetary damages to justify referral of the matter to a nursing home litigator or for the nursing home litigator to agree to take on the case.

One possible course of action in those circumstances may be for elder law attorneys and nursing home tort litigators to refer the matter to The Legal Center (see accompanying sidebar entitled "The Legal Center Services"). The Legal Center can

evaluate whether it may provide legal representation through the Grievance Procedure if the resident or family member desires to pursue the matter further.

NOTES

1. Presentation by Shelly Hitt, Long Term Care Prog. Mgr., Health Facilities and Emergency Servs. Div., Colorado Dept. of Public Health and Environment ("CDPHE"), 2005 Colorado Long-term Care Ombudsmen Conference (June 2, 2005), Colorado Springs, CO, El Pomar Foundation. Among other matters, information was presented stating the average stay of a Colorado Director of Nursing is nine months, and a Colorado Nursing Home Administrator, ten months.

2. CRS § 25-1-120; 6 CCR 1011-1, Ch. 5, Rule 12.4.

3. *CMS State Operations Manual*, App. PP—"Guidance to Surveyors—Long Term Care Facilities" (hereafter, "*CMS State Operations Manual*"), F353, 42 CFR § 483.30, available at <http://www.cms.hhs.gov/medicaid/survey-cert/sc0446.pdf>.

4. See generally 42 U.S.C. § 1395i-3 (nursing home reform amendments relating to Medicare-certified facilities); 42 U.S.C. § 1396r (nursing home reform amendments relating to

Medicaid-certified facilities). Of particular importance to understanding the history of the nursing home reform effort is the nationally significant and long-running 1975 class action lawsuit with Colorado attorneys Kathleen Mullen (Legal Aid Society of Denver) and John Holland, serving on behalf of all Medicaid beneficiaries in Colorado nursing homes. The class action sought to require the U.S. Department of Health and Human Services ("HHS") to meet its statutory duty to provide residents of nursing homes with adequate care. See *Estate of Smith v. O'Halloran*, 557 F.Supp. 289 (D.Colo. 1983), *rev'd sub. nom.*, *Estate of Smith v. Heckler*, 747 F.2d 583 (10th Cir. 1984). In *Estate of Smith*, the Tenth Circuit held: (a) the Secretary of HHS had a duty to establish a system to be adequately informed as to whether the facilities receiving federal money were satisfying the requirements of the Medicaid Act ("Act"), including the provision of high quality patient care; (b) the Secretary failed to follow the focus of the Act by promulgating a "facility-oriented" enforcement system, rather than a "patient-oriented" system, and that failure was arbitrary and capricious; and (c) *mandamus* relief was appropriate. See also "HHS Plan of Compliance with Court Order" in *Smith v. Heckler*, 1985 WL 56558 (D.Colo., June 10, 1985); *Estate of Smith v. Heckler*, 622 F.Supp. 403 (D.Colo. 1985); *Estate of Smith v. Bowen*, 656 F.Supp. 1093 (D.Colo. 1987), *Estate of Smith v. Bowen*, 675 F.Supp. 586 (Dec. 18, 1987); *Smith v. Bowen*, 1988 WL 235574 (D.Colo., Feb. 18, 1988), *appeal after remand*, *Estate of Smith v. O'Halloran*, 930 F.2d 1496 (10th Cir. 1991). See generally *Beverly Health and Rehabilitation Services, Inc. v. Thompson*, 223 F.Supp.2d 73, 76-81 (D.D.C. 2002) (provides a history of the Nursing Home Reform Law, including the importance of the *Estate of Smith* litigation). The *Estate of Smith* 1984 Tenth Circuit decision has been cited in numerous other cases and more than forty secondary sources. This class action lawsuit was a contributing factor to the passage of the federal nursing home reform amendments to the Medicare and Medicaid Acts and represents historically one of most significant cases on behalf of nursing home residents, both within the state of Colorado and nationally.

5. Office of the Inspector General, HHS, *Quality of Care in Nursing Homes: An Overview*, OEI-02-99-00060 (March 1999), available at <http://oig.hhs.gov/oei/reports/oei-02-99-00060.pdf>.

6. *Id.* at 2.

7. Government Accountability Office ("GAO"), *Nursing Homes; More Can Be Done to Protect Residents from Abuse*, GAO-02-312 (March 2002), available at <http://www.gao.gov/new.items/d02312.pdf>.

8. *Id.* at 4.

9. GAO, *Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline*, Highlights of GAO-03-1016T (July 17, 2003) (testimony before the Committee on Finance, U.S. Senate). See also GAO,

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Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight, GAO-03-561 (July 15, 2003), available at <http://www.gao.gov/htext/d03561.html>.

10. *Id.*

11. GAO, *Nursing Home Deaths; Arkansas Coroner Referrals Confirm Weaknesses in State and Federal Oversight of Quality of Care*, GAO-05-78 (Nov. 2004), available at <http://www.gao.gov/new.items/d0578.pdf>.

12. *Id.* at 4-5.

13. *CMS State Operations Manual*, *supra*, note 3. Academic experts have recommended a mandatory minimum of 4.55 direct care hours per resident per day, including nurses and nurse aides. See Harrington *et al.*, "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States," 40 *Gerontologist* 5, 10 (2000).

14. See *Most Recently Cited Deficiencies in Colorado Long Term Care Federal Re-certification Surveys Per Quarter*, available at http://www.cdphs.state.co.us/hf/download/longterm_caredeficiencies.pdf.

15. See also Rudder, Mollet, and Sobel, *Nursing Home Residents at Risk; Failure of the New York State Nursing Home Survey and Complaint Systems* (Long Term Care Community Coalition, May 2005), available at http://www.ltccc.org/documents/LTCCCMay2005Report_D7.pdf. The New York advocacy coalition urges the New York Dept. of Health to focus on the need to cite insufficient staffing. *Id.* at 20.

16. CRS § 25-1-120; 6 CCR 1011-1, Ch. 5, Rule 12.4.

17. *Id.*

18. See *Salas v. Grancare, Inc.*, 22 P.3d 568 (Colo.App. 2001) (nursing home residents who allegedly received inadequate care are not required to exhaust administrative remedies under Medicare or Medicaid Act before bringing

tort action against nursing home where residents sought refund of money paid—not payment of benefits nor reimbursement for denial of coverage; remedy sought not available through administrative processes, so resort to administrative process would have been futile).

19. 6 CCR 1011-1, Ch. 5, Rule 12.4 (subject matter of grievances).

20. 6 CCR 1011-1, Ch. 5, Rule 12.4.3 (fourteen-day time frame to present a nursing home grievance).

21. *Id.*; 42 CFR § 488.406(c)(2) (facility's prior history of non-compliance may be considered in choosing remedy).

22. *CMS State Operations Manual*, *supra*, note 3.

23. *Id.*

24. 42 CFR § 483.13.

25. 42 CFR § 483.15(a).

26. 42 CFR § 483.20.

27. 42 CFR § 483.25.

28. 42 CFR § 483.65.

29. 42 CFR § 483.30(a)(2) requires a licensed nurse to serve as a charge nurse on each tour of duty, except when: (1) the facility can demonstrate that despite diligent efforts, including offering wages at the community prevailing rate for nursing facilities, it has been unable to recruit appropriate personnel; (2) a waiver will not endanger residents' health or safety; and (3) a registered nurse or physician will respond immediately to telephone calls from the facility. 42 CFR § 483.30(c). The Director of Nursing may serve as a charge nurse only when the facility has an average daily occupancy of sixty or fewer residents. 42 CFR 483.30(b)(3).

30. See 42 U.S.C. 1395r-3(b)(4)(C)(ii); 42 CFR § 483.30(d)(1); *CMS State Operations Manual*, *supra*, note 3 at § 7014(A)(1), (3) (providing limited circumstances under which CMS may waive requirements pertaining to licensed nurses and registered nurses for a Medicare

certified facility). See also 42 U.S.C. § 1396r(b)(4)(C)(ii); 42 CFR § 483.30(c); *CMS State Operations Manual*, *supra*, note 3 at § 7014(A) (providing circumstances in which a state may waive requirements of licensed nurses and registered nurses in a Medicaid-certified facility).

31. *CMS State Operations Manual*, *supra*, note 3 at F353 (sufficient nursing staff) and F354 (registered nurse), listed under F354, available at http://www.cms.hhs.gov/manuals/107_som/som107_appendixtoc.asp.

32. See 42 CFR § 483.30: "The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident, as determined by resident assessments and individual plans of care." See also 42 CFR § 483.25: "Quality of Care—Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care." *CMS State Operations Manual*, *supra*, note 3 at F309 provides that the intent of 42 CFR § 483.25 is as follows: "The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process." Also, the *CMS State Operations Manual*, *supra*, note 3, defines "highest practicable" as the "highest level of functioning and well being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental, or psychosocial needs of the individual." *Id.* ■

See Appendix on following page.



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APPENDIX

Colorado Nursing Home Grievance Procedure (Administrative Appeals Process)

Who may file a nursing home grievance?

- Residents or their legal representatives
 - Resident Advisory Council¹
 - Members of the resident's family
- (CRS § 25-1-120(3)(a), (d); 6 CCR 1011-1, Ch. V, Rule 12.4)

What may the grievance be about?

- Conditions
 - Treatment
 - Violations of rights of any resident by the facility or staff
- (CRS § 25-1-120(3)(d); 6 CCR 1011-1, Ch. V, Rule 12.4)

What is the first step in filing or submitting a nursing home grievance?

- Present a grievance to the "staff designee" orally or in writing within fourteen days of the incident giving rise to the grievance
- (CRS § 25-1-120(3)(d); 6 CCR 1011-1, Ch. V, Rule 12.4.3)

What is a "staff designee"?

- A "staff designee" is the full-time staff member the facility must designate to receive all grievances.
- (CRS § 25-1-120(3)(b); 6 CCR 1011-1, Ch. V, Rule 12.4.1)

What is the staff designee supposed to do?

- The staff designee confers with the persons involved in the incident and other relevant persons. Within three days of receiving the grievance, the staff designee must provide a written explanation of findings and proposed remedies to the complainant and the aggrieved party, if other than the complainant, and legal representative, if any.
- (CRS § 25-1-120(3)(b); 6 CCR 1011-1, Ch. V, Rule 12.4.4)

What if I'm not satisfied with the findings or proposed remedies or their implementation?

- Within ten days of receiving the staff designee's response, complainant or aggrieved party may file the grievance orally or in writing, along with any additional information it wishes, to the facility grievance committee.
- (CRS § 25-1-120(3)(e); 6 CCR 1011-1, Ch. V, Rule 12.4.5)

What is the facility grievance committee?

- The facility grievance committee consists of the chief administrator or his or her designee, a resident selected by the facility's residents, and a third person agreed upon by the administration and the resident representative.
- (CRS § 25-1-120(3)(c); 6 CCR 1011-1, Ch. V, Rule 12.4.2)

What is the grievance committee supposed to do?

- The grievance committee must confer with persons involved in the incident and other relevant persons, including the complainant. Within ten days of the date of the appeal, the grievance committee must provide a written explanation of its findings and proposed remedies to the complainant and the aggrieved party, if other than the complainant, and to the legal representative, if any.
- (CRS 25-1-120(3)(e); 6 CCR 1011-1, Ch. V, Rule 12.4.6)

What if I'm not satisfied with the findings and remedies of the grievance committee or their implementation?

- The complainant or aggrieved party may file the grievance in writing to the Executive Director of the Colorado Department of Public Health and Environment ("CDPHE") within ten days of receipt of the written findings of the grievance committee.
- (CRS § 25-1-120(5); 6 CCR 1011-1, Ch. V, Rule 12.4.7)

What is the CDPHE supposed to do?

- The CDPHE must investigate the facts and circumstances of the grievance and make written findings of fact, conclusions, and recommendations and provide them to the complainant, aggrieved party, legal representative, if any, and as well as to the facility administrator.
- (CRS § 25-1-120(5); 6 CCR 1011-1, Ch. V, Rule 12.4.7)

What if I (or the facility administrator) am aggrieved by the CDPHE's findings and recommendations?

- The complainant or facility administrator may request, within thirty days of receipt of the findings and recommendations, a hearing to be conducted by the CDPHE, pursuant to CRS § 24-4-105.
- (CRS § 25-1-120 (5); 6 CCR 1011-1, Ch. V, Rule 12.4.8)

What if I (or the facility administrator) am aggrieved by the administrative hearing?

- Colorado law provides for judicial review of an agency action by filing an action in the State District Court,² District of Colorado, within thirty days after the agency action becomes effective. If an agency action occurs in relation to a hearing, pursuant to CRS § 24-4-105, then the person must also have been a party to the agency hearing.
- (CRS § 24-1-106(2) and (4))

What would constitute error for the State District Court to reverse the findings and recommendations of the CDPHE's administrative hearing officer?

- A finding that the agency action is:
 - 1) arbitrary or capricious;
 - 2) a denial of a statutory right;
 - 3) contrary to a constitutional right, power, privilege, or immunity;
 - 4) in excess of statutory jurisdiction, authority, purposes, or limitations;
 - 5) not in accord with the procedures or procedural limitations of this article [State Administrative Procedure Act, CRS §§ 24-4-101 *et seq.*] or as otherwise required by law;
 - 6) an abuse or clearly unwarranted exercise of discretion;
 - 7) based upon findings of fact that are clearly erroneous on the whole record or unsupported by substantial evidence when the record is considered as a whole; or
 - 8) otherwise contrary to law.
- (CRS § 24-4-106(7))

What can the State District Court do to correct things if it finds the agency action is in error?

- The court "shall":
 - 1) hold unlawful and set aside the agency action and shall restrain the enforcement of the order or rule under review;
 - 2) compel any agency action to be taken that has been unlawfully withheld or unduly delayed;
 - 3) remand the case for further proceedings; and
 - 4) afford such other relief as may be appropriate.
- (CRS § 24-4-106(7); CRS § 25-1-120; 6 CCR 1011-1, Ch. V, 12.4)

NOTES

1. 42 USC §§ 1395i-3(c)(1)(A)(vii) and 1396r(c)(1)(A)(vii); 42 CFR § 483.15(c).

2. Federal law requires that the state provide a "state appeals process" for transfer and discharge, 42 U.S.C. § 1395i-3(e)(3)(Medicare); 42 U.S.C. § 1396r(e)(3) (Medicaid). Colorado law essentially extends that requirement to all nursing home grievances involving conditions, treatment, or violations of rights of any resident by the facility or staff. CRS § 25-1-120(3)(d); 6 CCR 1011-1, Ch. V. 12.4.