BEFORE THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

STATE OF COLORADO

Case No. 2021-002-ALR

ORDER OF SUMMARY SUSPENSION

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
HEALTH FACILITIES AND EMERGENCY MEDICAL SERVICES DIVISION,
Petitioner,

v.

Triangle Cross Ranch ("Facility"),
Triangle Cross Ranch, Inc. dba Triangle Cross Ranch ("Licensee"),
Valerie Trujillo ("Board of Directors President" and "Licensee Contact Person"),
Aaron Grosul ("Board of Directors Vice President"),
Dawn Hamilton ("Board of Directors Secretary" and "Board of Directors Treasurer"),
Susan LaBonde ("Administrator"),
Respondents.

The Colorado Department of Public Health and Environment ("Department" or "Petitioner"), pursuant to § 24-4-104(4) and § 25-27-106(2)(a), Colorado Revised Statutes (C.R.S.), 6 Code of Colorado Regulations (C.C.R.) 1011-1, Chapter 2, §§ 2.11.2 - 2.11.4, and upon information obtained from a full investigation concerning the matter referenced below, hereby finds:

1. Triangle Cross Ranch ("Facility"), Triangle Cross Ranch, Inc. dba Triangle Cross Ranch ("Licensee"), Valerie Trujillo ("Board of Directors President" and "Licensee Contact Person"), Aaron Grosul ("Board of Directors Vice President"), Dawn Hamilton ("Board of Directors Secretary/Treasurer"), and Susan LaBonde ("Administrator") (hereinafter, collectively, "you" or "Respondents") received a health facility license from the Department pursuant to § 25-27-105, C.R.S., to operate the Facility as an assisted living residence ("ALR"). As the Respondents, you are required to operate the Facility at least at minimum standards for ALRs as established in statute at § 25-27-101, *et seq.*, C.R.S., and at 6 C.C.R. 1011-1, Chapters 2, 7, and 24.

2. The Department has jurisdiction over Respondents' Facility license, as well as the persons, Licensee, owners, and the subject matter herein.

3. Section 24-4-104(4)(a), C.R.S., provides that where a state agency "has objective and reasonable grounds to believe and finds, upon a full investigation, that the licensee has been guilty of deliberate and willful violation or that the public health, safety, or welfare imperatively requires emergency action and incorporates the findings in its order, it may summarily suspend the license pending proceedings for suspension or revocation which shall be promptly instituted and determined." *See also* 6 C.C.R. 1011-1, Chapter 2, § 2.11.3.A ("Notwithstanding other remedies available under state law, the Department may summarily suspend a license pending proceedings for revocation . . . in cases of deliberate or willful violation of applicable statutes and regulations or where the public health, safety or welfare imperatively requires emergency action.").

4. Pursuant to 6 C.C.R. 1011-1, Chapter 2, § 2.11.3(B), for purposes of demonstrating that a licensee is guilty of a deliberate and willful violation, the Department may rely upon "intentional conduct" or "a pattern or practice of repeated, identical, or similar violations."

5. Pursuant to 6 C.C.R. 1011-1, Chapter 2, § 2.11.4, a license issued by the Department may be revoked, suspended, annulled, limited, or modified at any time during the license term because of a licensee's failure to comply with any of the applicable statutes or regulations, or to make the reports required by § 25-3-104, C.R.S.

6. Pursuant to 6 C.C.R. 1011-1, Chapter 2, § 2.14.1, a license issued by the Department shall become invalid when the licensee fails to timely renew the license, ceases operation, or there is a final agency action suspending or revoking the license.

7. Pursuant to 6 C.C.R. 1011-1, Chapter 2, § 2.11.2(A), the Department may revoke or suspend an existing license for good cause including, but not limited to, circumstances in which an owner, officer, director, manager, administrator or other employee of the licensee: (1) Fails or refuses to comply with the statutory and/or regulatory requirements applicable to that license type; (2) Makes a false statement of material fact about individuals served by the licensee, its staff, capacity, or in a matter under investigation by the Department or another governmental entity; (3) Prevents, interferes with, or attempts to impede in any way the work of a representative or agent of the Department in investigating or enforcing the applicable statutes or regulations; (4) Falsely advertises or in any way misrepresents the licensee's ability to care for the individuals served based on its license type or status; (5) Fails to provide reports and documents required by regulation or statute in a timely and complete fashion; (6) Fails to comply with or complete a plan of correction in the time or manner specified; or (7) Falsifies records or

documents.

8. Pursuant to 6 C.C.R. 1011-1, Chapter 2, § 2.11.3(D), if the Department summarily suspends a license, the Department shall comply with the requirements of the State Administrative Procedure Act at § 24-4-101, *et seq.*, C.R.S.

9. Respondents operate a twenty-four (24) bed ALR at 36049 Weld County Road 51, Galeton, Colorado 80622, pursuant to the licensing authority granted by the Department under health care facility license number 230343, with a license effective date of April 8, 2020, to April 7, 2021. The Facility serves individuals with developmental disabilities. The Facility operates as a campus with multiple small houses, including one house for men, one house for women, and a common house where residents socialize and eat meals. The Facility is located in a rural community.

10. The Department conducted surveys on or around April 21, 2020, September 23, 2020, and January 26, 2021, which included onsite and offsite interviews and record reviews of Respondents, the Facility, and the residents, wherein the Department discovered deliberate and willful violations of applicable statutes and regulations where the health, safety, or welfare of the Facility's residents required immediate emergency action. Specifically, the Department determined that Respondents engaged in the following acts that violated Department regulations and state laws and endangered the residents' health, safety, and welfare:

I. Respondents Failed or Refused to Comply with Colorado Public Health Orders Enacted to Protect Residents and Staff from COVID-19

11. On November 20, 2020, the Department issued Colorado Public Health Order Requirements for Assisted Living Residences for COVID-19 Prevention and Response (hereinafter, "PHO 5", attached as Exhibit #1) which required Respondents to conduct surveillance and outbreak COVID-19 testing of all residents and staff who have left the Facility.

12. On or around January 26, 2021, the Department completed Event ECLC11, a combined investigation of complaint #CO26568 and COVID-19 Infection Control focused survey to determine both whether Respondents were in compliance with PHO #5 and whether Respondents were in substantial compliance with the ALR regulations and able to demonstrate fitness to operate a licensed health facility.

13. PHO #5 requires Respondents to, in part, implement Facility screening protocols for individuals entering the Facility and submit a COVID-19 Prevention and Response Plan to the Department; complete daily reporting to the Department regarding occupancy rates

and resource availability; train all staff on current infection control preventions, response, and control for COVID-19; conduct weekly surveillance testing and observation for symptoms for residents who have left the Facility in the last 14 days; conduct surveillance testing weekly, at a minimum, for all staff and ensure staff are wearing face masks at all times while in the Facility; and ensure staff wear eye protection, depending on current county infection rates. Respondents are also required to use the polymerase chain reaction ("PCR") test for detecting infection among staff and residents, but Respondents may procure their own testing services that meet or exceed the testing requirements. Staff and residents, or resident guardians and representatives, may decline COVID-19 testing. Respondents are also required to have written infection control policies and procedures in place to address staff and residents who refuse testing which includes written documentation from the resident or the resident's representative of any refusal to test.

14. In addition, pursuant to 6 C.C.R. 1011-1, Chapter 7, § 13.1(D), residents have the right to choice and personal involvement regarding care and services, including the right to be informed and participate in decision making regarding care and services, in coordination with family members who may have different opinions.

15. During the onsite visit on or around January 26, 2021, the Department observed that staff failed to wear masks or eye protection. Respondents failed to test staff or residents for COVID-19, failed to screen visitors entering the Facility, and failed to complete daily occupancy rates or resource availability to the Department. The Department observed that Respondents' COVID-19 supplies had not been used. The Department also observed that Respondents had never logged in or accessed the Department's website to report daily occupancy and resource availability. Respondents' Administrator stated that she was not completing the daily reporting because she stated the staff had talked about doing it, but they found the instructions "vague". She said all staff members had signed a waiver agreeing not to be tested.

16. The Department determined through observation, record reviews, and interviews that Respondents failed to ask residents whether they wanted testing or vaccinations and failed to obtain written confirmation from residents or residents' guardians regarding testing and vaccination discussions and decisions. Respondents' Administrator told the Department that residents did not make their own decisions due to their mental capacity and stated that their guardians made decisions for them. However, Respondents were unable to produce any resident records that indicated residents' rights to make decisions and choices had been restricted.

17. The Department conducted interviews with the residents, three of whom said they would like to get the COVID-19 vaccine, and one who stated she did not want the COVID-19

vaccine. Respondents' Administrator stated that the Facility manager had conversations with resident family members about testing and vaccinating. The Department contacted resident family members and guardians. Family members for two of the residents who stated they wanted a vaccine said they did not want their resident family members to be tested or to receive a vaccine. The family member for the resident who did not want the vaccine stated that the resident was her own decision maker and she could decide whether she wanted the vaccine.

18. The Department interviewed a resident who stated Respondents had made clear to him that if he left the Facility, he would be required to get tested for COVID-19. He said that he did not leave the Facility because he did not want to get tested. Respondents' Administrator told the Department that residents were allowed to visit their families, but were required to quarantine for 14 days once they returned. She added that the family would have to pay for a staff member to sit with them during the quarantine.

19. The Department determined that Respondents failed to ensure Respondents' Administrator complied with all applicable state laws to help prevent the possible development and transmission of COVID-19, affecting seven (7) current residents, with a pattern of potential for harm for one or more residents. In addition, the Department cited Respondents for failure to ensure residents had the right to choice and personal involvement regarding care and services, including the right to be informed and participate in decision-making regarding care and services, affecting seven (7) current residents, with a pattern of potential for harm for one or more residents

20. As of the date of this Order, Respondents have not complied with PHO #5 requirements to participate in COVID-19 surveillance, and have not contacted the Department to schedule vaccinations for residents or staff or notified the Department that they have coordinated testing or vaccinations elsewhere.

<u>Respondents Demonstrate a Pattern or Practice of COVID-19 Noncompliance</u>

21. The Department previously cited Respondents for the same deficient practice four (4) months earlier during Event ID W4ZZ11, a combined investigation of complaints #CO25606 and #CO25719 and COVID-19 Infection Control focused survey completed on September 23, 2020. The Department determined that Respondents' Administrator failed to manage the overall operations of the Facility. Specifically, Respondents' Administrator failed to comply with all applicable state laws and ensure infection control processes were established and maintained to help prevent the possible transmission of COVID-19, affecting all seven (7) current residents. The Department determined through observation, record review, and interviews that staff failed to wear face coverings, failed to conduct visitor infection screenings, failed to conduct resident infection screenings, failed to take infection control measures during medication administration and meal

preparation, and failed to provide adequate hand hygiene supplies, including soap and paper towels, throughout the Facility. The Department cited Respondents at a "B" level for a pattern of potential for harm for one or more residents, affecting seven (7) current residents.

22. In addition, the Department previously cited Respondents for the same deficient practice five (5) months earlier during Event ID YQ0311, a combined investigation of complaints #CO23641 and #CO25039, and COVID-19 Infection Control focused survey completed on April 21, 2020. The Department determined that Respondents' Administrator failed to ensure the Facility compiled with all federal, state, and local laws regarding licensure and certification, affecting all seven (7) current residents. Specifically, Facility staff admitted surveyors and Respondent Board of Directors President ("BDP") without taking temperatures or asking COVID-19 screening questions. The Department observed that there was no liquid soap in three bathrooms, and the Facility only supplied shared bar soap. The Department observed residents not social distancing, and observed that none of the staff or residents wore masks, gloves, or other personal protective equipment. The Department observed Respondents' House Meeting Notes, which included a section regarding COVID-19, stating "Practice social distancing - we must do this for another 6 weeks. If someone pulls in the ranch, no one goes out to see them. Temperatures must be taken. We have to respect and practice all COVID-19 rules to prevent sickness. We are practicing good health techniques in order for us to not have to wear masks."

Respondents Failed to Provide Timely and Complete Plans of Correction

23. After each survey where the Department cited Respondents for failure to follow PHO #5 and failure to implement proper infection control, Respondents are required to submit a proposed plan of correction to the Department describing how Respondents have corrected the deficient practice and how they will prevent the deficient practice in the future. Generally, the Department reviews the proposed plan of correction after submission and accepts the plan or rejects the plan and requires additional corrections. For Event ID YQ0311, Respondents submitted a proposed plan of correction 27 days late. The Department rejected Respondents' insufficient plans of correction four times. In total, the Department sent eight (8) late notices to Respondents, after which Respondents submitted their last plan of correction for the Event ID YQ0311 on February 19, 2021, 231 days late. For Event ID W4ZZ11, Respondents submitted a proposed plan of correction three days late, which the Department rejected. The Department sent three late notices after the initial rejection. Respondents submitted the last plan of correction for Event ID W4ZZ11 on February 19, 2021, 111 days late. For Event ID ECLC11, Respondents' timely submitted the proposed plan of correction on February 28, 2021. At the date of this Order, the Department has conducted an initial review of Respondents' proposed plan of correction and anticipates rejecting it.

II. Respondents Failed to Provide Personal Services and Protective Oversight to Meet the Needs of the Residents

24. On or around January 26, 2021, the Department completed Event ID ECLC11, a combined investigation of complaint #CO25658 and COVID-19 Infection Control focused survey to determine whether Respondents were in substantial compliance with the ALR regulations and able to demonstrate fitness to operate a licensed health facility.

<u>Respondents Failed to Protect Residents from Excessively Hot Water Temperatures</u>

25. Based on the Department's observations, record review, and interviews, the Department determined that a situation of Immediate Jeopardy existed at Respondents' Facility during the survey. The Department determined that Respondents failed to ensure hot water did not measure more than 120 degrees Fahrenheit ("F") at taps that were accessible to residents, affecting seven (7) current residents, which constituted an "E" level deficiency for actual or potential for serious injury or harm for one or more residents.

26. Specifically, Respondents violated 6 C.C.R. 1011-1, Chapter 7, § 22.9, and the Department determined Respondents failed to have supports in place to prevent seven (7) current residents with cognitive impairments from being scalded by hot water at or in excess of 120 degrees F. The Department determined that all three (3) houses containing a total of seven (7) taps accessible to residents had water temperatures exceeding 120 degrees F, with five (5) sinks measuring between 136.5 to 172 degrees F. The Department observed staff directing residents to wash their hands prior to meals as well as rinse their dishes after eating. The Department also observed daily water temperatures posted on the refrigerator; nine dates on the posted list showed water temperatures higher than 120 degrees F. Respondents' Administrator told the Department that residents played with the water temperatures and that one of the residents was responsible for measuring and posting the daily temperatures. Several days later, Respondent's Administrator provided contradictory information and stated that she was not aware that the resident recorded water temperatures and that the residents required supervision.

27. According to the American Burn Association Educator's Guide, skin exposure to water over temperatures of 155 degrees F for one (1) second could result in third-degree burns. Importantly, changes in a person's intellect, perception, memory, judgment, or awareness may hinder the person's ability to recognize a dangerous situation or respond appropriately to remove themselves from danger, such as exposure to scalding water temperatures.

28. The Department notified Respondents that a situation of "Immediate Jeopardy" existed at the Facility and directed Respondents to put a plan in place within two hours to protect

the residents' health, safety, and welfare. Respondents' Administrator stated she would attempt to submit a written plan within two hours, but was unable to do so immediately because she was in a meeting. She stated she would have a staff member turn down the hot water immediately. Approximately one hour later, the Department rechecked the water temperatures and determined the three faucet temperatures were now higher than the initial readings and the temperatures exceeded 171 degrees F. The Department observed the water heater temperature gauges were set between "hot" and "very hot". Respondents' Administrator submitted two written plans to abate the immediate jeopardy; both plans were rejected because Respondents failed to show evidence of how the immediate jeopardy was corrected and failed to show how Respondents ensured resident safety.

29. The Department returned the following day and observed that although the hot water heater gauge in one house was set to "low," two faucets in the same house measured with two separate thermometers indicated that the temperatures exceeded 130 degrees F. In the two other houses, three sinks measured on two separate thermometers exceeded 128 degrees F.

Respondents Demonstrated a Pattern or Practice of Failure to Protect Residents from Scalding Water Temperatures

30. The Department previously cited Respondents for similar or identical deficiencies during Event ID DRDW11 on or around August 20, 2010, Event ID L96S11 on or around February 27, 2008, and Event ID EIWK11, or around May 15, 1997, for failure to ensure hot water temperatures at faucets accessible to residents did not exceed 120 degrees F.

Respondents Failed to Provide a Complete Plan of Correction

31. For Event ID ECLC11, Respondents' timely submitted a proposed plan of correction on February 28, 2021. At the date of this Order, the Department has conducted an initial review of Respondents' proposed plan of correction and anticipates rejecting it for vagueness and nonspecificity and failure to address the causes, symptoms, and corrective measures needed to resolve the cited deficiency and prevent similar recurrence of the deficient practice in the future.

III. Respondents Failed to Observe Residents' Rights in Resident Care, Treatment, and Oversight

32. Based on the Department's observations, record review, and interviews, the Department determined during Event ID ECLC11 on or around January 26, 2021, that Respondents violated a resident's civil and/or religious liberties wherein Respondents failed to respect the residents' right to be treated with dignity and respect and to be free from humiliation, affecting one (1) sample resident. The Department determined Respondent's failure was a

"C" level violation for isolated actual harm affecting one or more residents.

33. The Department cited Respondents for a violation of 6 C.C.R. 1011-1, Chapter 7, § 13.1(B)(2) - (7), which requires Respondents' to adopt, and place in a publicly visible location, a statement regarding the rights and responsibilities of its residents. Respondents' and staff must observe these rights in the care, treatment, and oversight of the residents. The right to civil and religious liberties includes, (1) The right to be treated with dignity and respect; (2) The right to be free from sexual, verbal, physical, or emotional abuse, humiliation, intimidation, or punishment; (3) The right to be free from neglect; (4) The right to live free from financial exploitation, restraint as defined in this chapter, and involuntary confinement except as allowed by the secure environment requirements of Chapter 7; (5) The right to vote; (6) The right to exercise choice in attending and participating in religious activities; (7) The right to wear clothing of choice unless otherwise indicated in the care plan; and (8) The right to care and services that are not conditioned or limited because of a resident's disability, sexual orientation, ethnicity, and/or personal preferences.

34. Specifically, the Department observed a staff member humiliating a resident, who was diagnosed with developmental delay and moderate intellectual deficit, in the presence of six (6) residents and a Department surveyor. Respondents' staff member failed to treat the resident with respect and dignity, which resulted in the resident crying in the common area living room. The Department observed the resident talking about a video game. She was interrupted by the staff member who told the resident that she needed to stop lying in order to get attention and that the resident was not allowed to play video games. The resident began to cry to which the staff member responded, "We do not lie to get attention - you know better than that." Respondents' staff member told the resident not to cry and said the Facility did not have video games due to the internet issues at the Facility and the resident knew that. The resident, crying and visibly upset, mouthed "sorry" to the Department surveyor. The resident stated that she missed her family and this had been very hard for her; she did not elaborate further.

35. The Department reviewed the resident's care plan written by Respondents, which stated that the resident "will make pouty expressions if corrected or if not getting her desired outcome and may stomp her feet expressing dissatisfaction." Respondents' care plan did not address approaches or interventions staff were expected to take with the resident if she started to cry. However, the care plan stated that if she was having behaviors such as a "severe sensory meltdown", the resident could take herself to her bedroom. The care plan also stated that a female staff member could hold the resident in a tight hug if the previously mentioned method was not successful. The Department interviewed Respondents' Administrator who stated it was not appropriate for staff to upset the

residents to the point where they were crying.

36. The Department observed that Respondents' staff member's actions contradicted Respondents' own "Ranchers Rights" policy, which stated that the "Ranchers are entitled to: a) The right to be treated with dignity and respect; b) The right to be free from sexual, verbal, physical or emotional abuse, humiliation, intimidation, or punishment".

<u>Respondents Failed to Provide a Complete Plan of Correction</u>

37. For Event ID ECLC11, Respondents' timely submitted the proposed plan of correction on February 28, 2021. At the date of this Order, the Department has conducted an initial review of Respondents' proposed plan of correction and anticipates rejecting it for vagueness and nonspecificity and failure to address the causes, symptoms, and corrective measures needed to resolve the cited deficiency and prevent similar reoccurrence of deficient practice in the future.

38. In addition to citing the C-level deficiency for actual harm for Event ECLC11, the Department cited Respondents with another resident rights deficiency at a "B" level, for a pattern of potential harm for one or more residents during the survey.

39. Respondents failed to ensure the right to choice and personal involvement regarding care and services, including the right to be informed and to participate in decision making regarding care and services, in coordination with family members who may have different opinions, affecting seven (7) current residents. *See* 6 C.C.R. 1011-1, § 13.1(D)(1).

40. The Department observed Respondents' "Ranchers' Rights" policy, which stated, "Ranchers are entitled to 'The right to choice and personal involvement regarding care and services including a) The right to be informed and participate in decision making regarding care and services, in coordination with family members who may have different opinions."

41. On January 20, 2021, the Department interviewed Resident #4, who stated that it was made clear to him by management that if he left the ALR, he would be required to get tested for COVID-19. He stated that he does not leave the ALR because he does not want to get tested.

42. On January 20, 2021, Respondents' Administrator stated residents were allowed to leave the ALR to visit their family but were required to quarantine for 14 days once they returned. She stated that family members would have to pay for a staff member to sit with them when they quarantine. She added that the residents did not make their own medical decisions due to their mental capacity and stated their guardians made those decisions for

them. She said family members, not residents, were approached about resident COVID-19 testing. In a later conversation, Respondents' Administrator stated that the residents were not approached about the COVID-19 vaccine. She added that the residents were not able to make those decisions. Respondents' Administrator stated that residents were part of the conversation about the COVID-19 vaccine, but were not aware of what decision was made.

43. The Department interviewed Resident #2's family member who stated that she spoke to Respondents' manager and she declined to have Resident #2 tested for COVID-19. Additionally, she wanted more information about the vaccine before she decided if Resident #2 should be vaccinated.

44. The Department spoke to Resident #1's family member who stated when she spoke to Respondents' manager, she declined to have Resident #1 tested for COVID-19 and did not want her to receive the vaccination yet. The family member stated that she was Resident #1's guardian and she was "covered under the disability act and made decisions for Resident #1."

45. On January 26, 2021, Respondents' Administrator told the Department that family members were verbally informed that for those residents who wished to leave the Facility to visit their families, this would require additional payment for Respondents' to have a staff member sit with the resident during a two-week period of quarantine. She stated that she had conversations with residents' family members but that she failed to confirm the family members' understandings or desires in writing.

IV. Respondents Demonstrated a Pattern of Deficient Practice Deficiencies Disregarding Resident Rights

46. On or around September 23, 2020, the Department previously cited Respondents for two deficiencies at "A" and "B" levels for violating resident rights during Event ID W4ZZ11, a combined investigation of complaints #CO25606 and #CO25719, and COVID-19 Infection Control focused survey.

<u>Respondents Prohibit Residents from Having Private Conversations</u>

47. Based on observation, interview and record review, Respondents failed to ensure staff observed residents' right to private, unrestricted communication with any person of choice, affecting two (2) of seven (7) current residents.

48. Respondents' Facility rights policy stated, in part, that residents are entitled to: the right to have private and unrestricted communications with any person of choice."

49. On or around September 21, 2020, the Department surveyor asked Resident #1 if he would like to talk privately with a surveyor. He agreed and indicated he would be willing to talk in his room. A staff member followed the resident and the surveyor into the Facility and then leaned toward Resident #1 and whispered to him, "Remember your momma." The surveyor asked the staff member what she meant by the comment and she said, "His mother doesn't want him to talk to people he doesn't know."

50. The Department surveyor and Resident #1 went into the resident's room and a staff member remained in the area until the surveyor asked her to leave. The staff member returned in approximately two minutes and the surveyor asked the staff member to close the door so they could speak privately. Resident #1 nodded his head, indicating that yes, the door could be closed. After approximately 30 seconds, the staff member opened the door without knocking. She said Resident #1 could not have conversations in his room without someone present. She then said, "You can't take a boy in his room and close the door. These people are like five year olds."

51. The Department surveyor informed the staff member that she was violating Resident #1's right to have private conversations. The staff member disagreed with the surveyor, and with a raised voice, she insisted the resident could not be interviewed alone. Contrary to the surveyor's observations, the staff member stated that Resident #1 had not consented to talk privately and added that the resident said no "two times".

52. The Department informed Respondents' Director that a staff member was interfering with resident interviews. Respondent's Director stated she was aware of what had occurred and had spoken to the staff member. She added that the staff member would not interfere further with resident interviews. Respondents' Director then stated Resident #1 had a guardian, but she did not know what was included in the scope of that guardianship. Respondents' Director stated an external agency representative had told her in the past she could restrict resident visitation, and therefore, private communications. The staff member subsequently told the Department she has received resident rights training through a handbook provided to her in a staff meeting. The Department asked Respondents' Director to provide evidence of two (2) staff members' training regarding resident rights; however, Respondents' Director was unable to provide any documentation.

53. The Department surveyor asked Resident #4 if he would like to talk privately. Resident #4 said, "Ask the supervisor" indicating that it was Respondents' staff's decision if he was allowed to have a private conversation with the surveyor. The surveyor told the resident that the decision to speak to her was his decision. The resident again stated the

surveyor should ask staff if he was permitted to talk to the surveyor.

54. The Department interviewed Respondents' staff member if she knew some of the residents' rights. The staff member said, "Not off the top of my head." She said she believed resident rights meant a resident could not be forced to do anything. She added, "If guardians have a say, you can't make them (residents) do what they do not want to do."

55. Respondents' Director provided the Department with Resident #1's guardianship document. The Department observed that the document did not indicate Resident #1 could not have private communications, if desired by the Resident #1.

<u>Respondents Failed to Allows State Ombudsman Access to Residents</u>

56. Based on observation and review, Respondents failed to permit the state ombudsman access to the Facility during regular business hours, affecting all seven (7) current residents.

57. Pursuant to §§ 26-11.5-108 and 25-27-104(2)(d), C.R.S., 6 C.C.R. 1011-1, Chapter 7, § 13.2, and in accordance with the Older Americans Act Reauthorization Act of 2016 (P.L. 114-144), an assisted living residence shall permit access to the premises and residents by the state ombudsman and the designated local long-term care ombudsman at any time during the ALR's regular business hours or regular visiting hours, and at any other time when access may be required by the circumstances to be investigated.

58. On or around September 21, 2020, Respondents' Director told the Department that on August 26, 2020, the state ombudsman came to visit the residents. Respondents' Director said she was in the Facility office. She stated the ombudsman did not call the Facility to inform her she was there so that Respondents' Director could unlock the front gate and provide access. Respondents' Director stated she found out the ombudsman was present when a staff member told her four (4) cars were at the Facility's gate, waiting for admission. Respondents' Director stated that, when she looked, there were no cars at the gate. The Director stated she called Respondent's lawyer, who said, "You have to let them in to see" the residents. She then said she returned to the gate several minutes later, and local law enforcement was present and asked to be allowed onto the property, which Respondents' Director allowed. Respondents' Director told the law enforcement officer that the ombudsman would not be allowed to access the Facility until "my lawyer is here."

59. On or around September 21, 2020, the state ombudsman confirmed to the Department that on August 26, 2020, she and others from the state ombudsman office tried to visit the Facility. She added that the gate at the entrance of the Facility was locked. The

ombudsman stated she called the main number and was unable to leave a message because the mailbox was full. The ombudsman stated she then called law enforcement to conduct a wellness check. The ombudsman said a law enforcement officer arrived at the Facility, jumped over the locked gate, and spoke with Respondents' Director inside the Facility. The ombudsman stated the law enforcement officer told her Respondents' Director would not allow her to enter the Facility without their attorney present and added the attorney would arrive in 15 minutes. However, the ombudsman said she waited 25 minutes, and then she left the Facility without having been allowed access to the Facility or contact with the residents.

60. The Department has cited Respondents for violations of resident rights nine (9) times in the last two years, including violations of residents' civil liberties, residents' right to be involved in decision-making of their own care and services, residents right to manage their personal affairs and property, residents' right to privacy and to use the telephone, and the right to access advocates to render them assistance.

<u>Respondents Failed to Treat Residents with Dignity and Respect</u>

61. On or around April 21, 2020, the Department determined that Respondents failed to uphold residents' rights to be free from neglect, treated with dignity and respect, free from intimidation and punishment, and exercise choice in participating in religious activities, affecting all seven (7) current residents.

62. Specifically, the Department determined that Respondents imposed restrictive diets on the residents, which limited their food consumption, and resulted in significant weight loss. Five (5) residents experienced weight lost between 22 and 51 pounds over the course of a year. The Department observed records that showed residents resorted to extreme measures to access additional food, such as stealing, licking dirty dishes, and eating from chicken scraps. An external agency representative told the Department that residents were hungry and losing weight as a result of food restrictions.

63. According to 6 C.C.R. 1011-1, Chapter 7, §§ 17.1 - 17.3, the Facility shall provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, and plans of care. Nourishing meal substitutes and between-meal snacks shall be provided, in accordance with plans of care, to residents who want to eat at non-traditional times or outside of scheduled meal service times. Meals shall include a variety of foods, be nutritionally balanced and sufficient in amount to satisfy resident appetites. The Facility shall offer drinks, including water and other liquids to residents with every meal and in between meals throughout the day. The Facility shall also ensure that residents have independent

access to drinks at all times.

64. The Department observed that Respondents utilized behavioral modification techniques, including punishments and withholding rewards to control residents' behaviors. Punishments were issued when residents did not listen to staff's direction or displayed behaviors deemed inappropriate. Punishments included isolation and confinement to their bedrooms, withholding mail, prohibiting telephone calls, taking residents' personal property away from them, additional mandatory chores, restricting the opportunity to participate in community outings, and being reprimanded by staff. Respondents' punishments distressed the residents. In particular, Resident #1 reported she cried when she was punished. Furthermore, Resident #1's record revealed she became agitated when punished, including yelling, and self-harming behaviors such as hitting and scratching herself. Over a two-week period in April 2020, Respondents' progress notes read that Resident #1 was punished on seven occasions.

65. On or around April 21, 2020, Respondents were directed to submit a plan to mitigate the harm caused by food restrictions and punishments. The plan was accepted and stated, in part, "If a rancher refuses do to any task that is asked of them or happens to have an incident in which their behavior is negative, we as staff will help in any way we can understand that it is the rancher's right to refuse and/or have bad days without the worry of having items removed from their property, having to isolate or go to their bedrooms, not being able to make phone calls, and not having any community events taken away from them." The plan went on to outline additional steps Respondents would take to restore residents' safety and wellbeing, including: reporting all residents' weight loss to primary care practitioner immediately; terminating Facility food restrictions, including removal of locks on storage cabinets; offering snacks in between meals; notification to residents' family members that Respondents could no longer restrict residents' food or institute punishments; retraining of staff; holding a resident meeting to inform residents of the changes to food access and rights; and modifying care plans to update any food restrictions and behavior modification techniques, specifically punishments.

<u>Respondents Neglected Residents</u>

66. 6 C.C.R. 1011, Chapter 7 regulations governing assisted living residences defines "Caretaker neglect" as "neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision or any other service necessary for the health or safety of an at-risk person is not secured for that person or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise."

67. Upon entering the Facility, the Department observed a chain and padlock sitting on the kitchen counter while staff prepared breakfast. A staff member told the Department that

Respondents' restricted residents' access to food by locking the food storage areas. She explained that the locks were necessary to prevent residents from stealing food from the kitchen and overeating. She further stated that Respondents carefully monitored the residents' meals to ensure healthy diets and proper nutrition. She said the residents required controlled diets to ensure proper bodyweight and health. She went on to discuss the "autism diet", which did not allow for dairy, corn, sugars, caffeine, or artificial sweeteners. She also said monitoring caloric intake and serving sizes were important not only for the resident health, but also to ration the Facility's food supplies, which Respondents procured from the local food bank. Respondents did not comment on why they procured food at a food bank.

68. The Department interviewed several residents who reported Respondents restricted their food intake, limiting what kinds of foods they were allowed to eat and their portion sizes, and prohibited access to food in between meals.

69. Respondents' Administrative Care Coordinator (ACC) stated some residents were food "hoarders and gorgers". The ACC provided documentation of the decline in weights of multiple residents to the Department including:
    a. Resident #1: 3/2/2019 159.2 lbs.; 4/16/2020 119.7 lbs. (40 lb weight loss)
    b. Resident #3: 3/2/2019 133 lbs.; 4/16/2020 107.6 lbs. (25 lb weight loss)
    c. Resident #4: 3/2/2019 157.6 lbs.; 4/16/2020 106.5 lbs. (51 lb weight loss)
    d. Resident #5: 3/2/2019 197.4 lbs.; 4/10/2020 168 lbs. (29 lb weight loss)
    e. Resident #7: 3/2/2019 200 lbs.; 4/10/2020 178.4 lbs. (22 lb weight loss)

70. The Department reviewed five resident care plans that documented that Respondents' restricted residents' diets. Respondents' justifications for diet restrictions included residents' history of overeating and statements indicated their cognitive impairment interfered with their ability to make proper decisions about food choices.

71. The Department observed documentation regarding Resident #4 with diagnoses including Asperger syndrome, clinical depression, and hypertension. The Department observed a document titled "Saturday Weight," which revealed that Resident #4 had lost approximately 51 pounds in eleven months. The Department noted that Resident #4's Body Mass Index classified her as underweight. Respondents' House Meeting notes stated the following, "When Resident #4 looks in the mirror, feels too skinny, but is happy she is gaining weight. Doesn't want to be too skinny." The Department observed an external psychiatric provider's note for Resident #4 that stated in part "demonstrates impaired insight and judgement and does not demonstrate capacity for making rational decisions in her own best interest in regard to the type and quality of food she consumes." The notes also stated that Resident #4 was to establish care with a primary care

practitioner to discuss her weight loss so that it can be investigated and monitored.

72. Despite Resident #4's consistent weight loss, her care plan dated August 2019 failed to include interventions to address her weight loss, and in fact documented diet restrictions, "Will steal/sneak food and gorge it quickly" and "Group activities- direct oversight if food is present. She will become obsessed on the food and not the activity." The Department observed Respondents' progress note for Resident #4's progress note, which stated, in part, "(Staff) observed Resident #4 staring at (other residents') plates at breakfast time. Resident #4 wanted to know why some got 2 slices of toast and some only got 1."

73. The Department observed documentation regarding Resident #1, with diagnoses including moderate developmental delay, and intellectual disability. The Department observed a document titled "Saturday Weight," which revealed that Resident #1 had lost approximately 40 pounds in 13 months.

74. Respondents' care plan for Resident #1 stated, in part, "Diet. Controlled: Rancher needs coaching on healthy portion sizes with limited to no second helpings." A section titled Goals read in part "Lose weight." The care plan further read that the resident had been caught stealing food to supplement her meals, including a block of cheese, an onion, and cat food. It read that when she was found hoarding cat food, she admitted eating the cat food but said it did not taste good.

75. The Department reviewed Respondents' records regarding Resident #7, who had diagnoses including developmental delay. The Department reviewed Respondents' document titled "Saturday Weight," which revealed Resident #7 had lost approximately 22 pounds in 13 months.

76. Respondents' care plan for Resident #7 stated, "This rancher will steal/sneak food and gorge it or hide it in his bedroom. He is aware of the no food in his bedroom policy. This rancher will eat out of the trash, compost bucket, and lick dirty spoons/dishes in the sink"; "Areas that need support: hoarding, not licking dirty dishes or taking food from trash/chicken bucket/compost pail."

77. The Department reviewed Respondents' documents for Resident #7, admitted with diagnoses including autism and developmental delay. The Department reviewed Respondents' document titled "Saturday Weight," which revealed he had lost approximately 29 pounds in 13 months.

78. Respondents care plan for Resident #5, stated, in part, "Diet: modified diet; low caffeine. Low gluten, low sugar, no corn, low dairy, no artificial sweeteners to keep the Autism brain as defogged as possible."

79. The Department reviewed Respondents' documents for Resident #2, admitted with diagnoses including fetal alcohol syndrome, learning disorders, and anxiety disorder. The Department reviewed Respondents' document titled "Saturday Weight," which revealed Resident #2's weight remained consistent at 106 pounds for one month.

80. The Department observed a practitioner's order for Resident #2 which stated, in part, "Recommended caloric intake: 1500 - 2000 calories per day"; "Daily incentive calories allowed based on adherence to the attached exercise program: 500 calories; "The ideal weight for this individual: 110 pounds".

81. Despite information indicating Resident #2's weight was below her recommended bodyweight, the Department reviewed Resident #2's care plan which failed to include interventions to address her low body weight, and in fact documented calorie restrictions that were below general guidelines for her age, gender and lifestyle.

82. The Department interviewed Resident #2's family, who said the resident's food intake needed to be managed because her appetite was erratic and she had a tendency to overeat. "She is just eating everything," therefore, "the staff and doctor are holding her food."

83. The Department reviewed Respondents' documentation for Resident #3 who was admitted with a diagnosis of mild developmental delay. The Department reviewed Respondents' document titled "Saturday Weight," which revealed Resident #3 had lost approximately 25 pounds in 13 months. Respondent BDP identified to the Department that Resident #3 was underweight. Despite Resident 3's consistent weight loss, and the fact that Respondent identified that the resident was underweight, Respondents' care plan failed to include interventions to address her weight loss. The Department observed Respondents' care plan for Resident #3 which stated in part "No therapeutic diet ordered. This rancher eats small meals." The Department reviewed the Facility's House Meeting Notes, which stated "Brought to admin's attention that Staff #2 is not feeding enough according to the ranchers" and "Boredom does not mean you are hungry. Drink water, a full glass of water to help hunger."

84. The Department interviewed external agency representatives who expressed concerns about residents' weight loss and lack of access to food. Specifically, they shared the following information: Respondents wanted the residents to lose weight; Residents routinely expressed they were hungry; Respondents locked up food and residents were

only provided food at mealtimes; Residents' restricted access to food had been ongoing for about a year; Respondents did not allow residents to have sweets; Respondents keep a scale next to the kitchen table; Respondents' staff members reported the diets were necessary because residents lacked self-control around eating.

85. Respondent BDP told the Department that the external psychiatric provider who had written orders to restrict the residents' diets had only been working with the residents for two (2) months. When asked why Respondents restrict resident diets, Respondent BDP stated, "We cannot let them eat a dozen donuts."

86. Furthermore, Respondent BDP and Respondents' Administrator told the Department they were not previously aware that Respondents' obligation to uphold resident rights could not be negated by family/guardian/power of attorneys' direction, court order, practitioner order, house rules, or care plan modification. Respondents said it was their routine practice to follow families' direction and adhere to families' preferences. They said they did not know families were unable to direct Respondents to violate resident rights. Specifically, they thought restrictive diets could be implemented upon families' request. Furthermore, they thought a practitioner's order to follow a specific diet could supersede resident rights.

Respondents Punished Residents

87. The Department interviewed residents which revealed Respondents implemented punishments, such as isolating residents in their rooms, confiscating their personal belongings, assigning them additional chores, and withholding their mail. The Department reviewed records, which further documented that Respondents punished residents when residents did not follow Respondents' directions or displayed behaviors that Respondents deemed to be negative.

88. The Department spoke with external agency representatives who reported that Respondents had many mandatory and rigid rules. They said when residents did not do what they were supposed to, Respondents were punitive. For example, Respondents would take their things away, send them to their rooms, or prohibit them from attending community activities. The external agency representatives said there were occasions when they were hesitant to advocate for residents for fear that the residents would be punished when they left.

89. In a subsequent interview, Respondent BDP and Respondents' Administrator said they were not previously aware that their obligation to uphold resident rights or that a resident's rights could not be negated by family/guardian/power of attorneys' direction, court order, practitioner order, house rule, or care plan modification. Respondents said it was their routine practice to follow families' direction and adhere to families' preferences.

They said they did not know families were unable to direct Respondents to violate resident rights. Specifically, they thought behavior modification techniques, including punishments could be implemented upon families' request.

90. According to 6 C.C.R. 1011-1, Chapter 7, Section 13.1(D)(6), residents have the right to refuse to perform tasks requested by Respondents in exchange for room, board, other goods or services.

Resident #1

91. The Department interviewed a resident who stated that Resident #1 had recently gotten "in trouble" and lost her privilege to use the Facility's phone for approximately one month. Resident #1 told the Department that she was often "grounded" for not listening to Respondents' directions. She said being grounded meant she was sent to her bedroom, where she was required to stay alone for approximately three or four hours. She said she was grounded approximately three times per week. Resident #1 also stated that staff would sometimes punish her by telling her to sit on the couch in the common area without talking to anyone for approximately three to four hours. In addition, Resident #1 said Respondents' would take away her unicorn stuffed animal or teddy bear if Resident #1 "says no," when Respondents direct her to do something, such as gardening tasks, like watering plants and pulling weeds. Furthermore, Resident #1 said Respondents withheld her mail from her as punishment. Specifically, Resident #1 said her family mailed her an Easter gift, however she could not have it for 14 days because Respondents told her she didn't behave.

92. When Resident #1 discussed a variety of topics about her life at the Facility, she routinely used the phrase "get in trouble" and referred to things she was not allowed to do or behaviors that would upset Respondents, such as eating a snack after 7:00 p.m., or answering the phone. Resident #1 told the Department that she was regretful whenever she did the wrong thing and would cry when punished by Respondents.

93. The Department reviewed Respondents' progress notes for Resident #1 which stated in the first two (2) weeks of April 2020, she was punished on seven (7) occasions.

94. Respondents required Resident #1 to do dishes for two days because she refolded dirty socks and put them in her dresser. When Resident #1 refused to participate in removing clothes from her dresser, Respondents noted that Resident #1 "stood in the corner and displayed behaviors such as scratching face, biting hands, hitting herself." The notes stated that when the weather became warmer, Resident #1 would be required to complete the scavenger hunt that she refused to do at the beginning of the month.

95. Respondents' notes stated that Resident #1 drank bacon grease when cleaning up the kitchen, and was punished and not allowed to have a special treat that Respondents brought the other residents.

96. Respondents' notes documented several occasion where Respondents required Resident #1 to pick up Alpaca feces as punishment for refusing to play corn hole, and refusing to write a letter to her parents.

97. Respondents' notes indicated that when Resident #1 did not adequately clean dishes or kitchen counters, and Respondents scolded her, Resident #1 was told to face the onsite camera to record her behaviors, which included scratching her face and her biting fingers. Respondents also filmed Resident #1's behaviors when she refused to plant a seed in the garden. Later, Respondents forced Resident #1 to sit and watch other residents and did not allow her to participate in activities.

<u>Resident #3</u>

98. The Department interviewed Resident #3 who stated Respondents punished her by taking away her treasure box and clothing. She said the treasure box contained photos that were important to her. Respondents confirmed that if Resident #3 was caught stealing, they would take her treasure box away. Respondents stated residents were punished for watching too much television.

99. The Department reviewed Respondents' progress notes for Resident #3, which describes an incident after the Department had conducted an onsite survey. Respondents noted that the Department asked to speak to Resident #3 privately. Respondents asked Resident #3 how the interview went, and Respondents disagreed and scolded Resident #3 for telling the Department that Respondents took her belongings.

<u>Resident #6</u>

100. The Department reviewed Respondents' and Resident #6's "Behavioral Contract" which stated, in part, "Any caffeine or cigarettes will only be given as outlined in the schedule. Any outburst or demands will not be tolerated as these two items are a privilege that you are given at this time. Caffeine and cigarettes are an extra expense provided by the family. [Respondents have] no opinion or control as to whether the family continues to support this privilege." Respondents stated they would withhold items from Resident #6 if he exhibits negative behaviors. The Department reviewed Respondents' document stating that Resident #6's cell phone and keyboard had been taken away and that Resident #6 has the opportunity to earn them back in 30 days. In a separate interview, Respondents said that Respondents took away Resident #6's phone and keyboard because he would

break them intentionally. Respondents denied they ever took his personal property away from him as punishment.

Respondents Intimidated Residents

101. During a multiple day onsite investigation, the Department observed in the initial visit that residents were friendly, and spoke openly and willingly with surveyors. The residents presented in good spirits and verbalized that they enjoy the conversations with the Department. Resident #1 asked the surveyor multiple times if she could be interviewed again. She also thanked the surveyor repeatedly. Upon leaving the residence, goodbyes were said and the residents were jovial and said excited and happy goodbyes to the Department.

102. The Department returned to the Facility several days later and observed that the residents' mood and mannerisms were greatly changed. Residents would not make eye contact, appeared fearful, uncomfortable, and upset. Residents said Respondents told them they were not allowed to speak with the Department. The residents then quickly left the house to avoid surveyors and three (3) of them went to Respondent BDP's office.

103. The Department reviewed progress notes that portrayed the Department negatively and misrepresented the Department's interactions with residents, as well as the residents' response to the Department's interviews. In addition, Respondents' progress notes documented that staff questioned residents about their conversations with the Department. The progress notes documented that the Respondent BDP contacted the residents' family members and shared inaccurate information with the families, which alarmed and upset the families. The Department reviewed Respondents' progress notes for Resident #2, which stated, in part, that the Department was onsite at the Facility, and staff members observed Department surveyors pulling residents aside and closing doors so that staff members could not hear conversations.

VI. Respondents Failed to Pay their Intermediate Condition Fines

104. On or around June 23, 2020, the Department issued an intermediate condition fine to Respondents by mail as a result of Event ID YQO311, a combined investigation of complaints #CO23641 and #CO25039, and COVID-19 Infection Control focused survey completed on April 21, 2020, which resulted in eight (8) deficiencies including two "E" level deficiencies due to the Immediate Jeopardy risk to Facility residents. Respondents failed to ensure resident rights, including civil and religious liberties and choice of personal involvement in their care and services provided, were not violated. According to 6 C.C.R. 1011-1, Chapter 7, § 3.16 requires the Department to impose a civil fine for all "E" level deficiencies.

105. The Department issued a fine in the amount of $750.00 to Respondents, payable by July 23, 2020. Respondents did not request informal dispute resolution review or an appeal of the intermediate condition fine. The Department attempted to contact Respondents regarding payment of the fine four times by telephone and once via email. As of the date of this Order, Respondents are 263 days late paying the fine.

106. On or around October 21, 2020, The Department issued an intermediate condition fine to Respondents by mail as a result of Event ID W4ZZ11, a combined investigation of complaints #CO25606 and #CO25719, and COVID-19 Infection Control focused survey completed on September 23, 2020, which resulted in nine deficiencies, including citations for Respondents' failure to provide residents with the right to private communication and ombudsman access. The Department conducted a compliance review and determined that Respondents had been cited previously for infection control deficiencies and resident rights violations.

107. The Department issued a fine in the amount of $750.00 for the repeated violations, payable by November 21, 2020. The Department attempted to contact Respondents regarding payment of the fine twice by telephone and once via email. Respondents did not request informal dispute resolution or an appeal of the intermediate condition fine. As of the date of this Order, Respondents are 123 days late.

108. On or around February 18, 2021, the Department issued an intermediate condition fine to Respondents by mail as a result of Event ID ECLC11, a combined investigation of complaint #CO25658 and COVID-19 Infection Control focused survey completed on January 26, 2021. The complaint investigation and infection control focused survey resulted in eight deficiencies, one at harm level due to Respondent's failure to ensure a resident was treated with dignity and respect and was free from humiliation, an "E" level citation due to the Immediate Jeopardy risk of scalding from exceedingly hot water temperatures, and five other deficiencies that had been previously cited by the Department.

109. The Department issued a fine in the amount of $2,000.00, payable by March 20, 2021. Respondents have not requested informal dispute resolution or an appeal of the intermediate condition fine. As of the date of this Order, Respondents are 24 days late.

110. Pursuant to 6 C.C.R. 1011-1, Chapter 2, § 2.11.3, Respondents' intentional and repeated failure to pay the intermediate condition fines after the Department's numerous contacts with Respondents, including discussions with Respondent Director, demonstrate a deliberate and willful violation of applicable statutes and regulations.

VII. Respondents Have Prevented, Interfered with, and Attempted to Impede the Work of the Department in Investigating or Enforcing the Applicable Statutes and Regulations.

111. On or around January 26, 2021, the Department attempted to conduct an onsite investigation at Respondents' Facility. The Department determined that Respondents failed to ensure the Department could enter the premises to determine compliance with the regulations governing assisted living residences, affecting seven (7) current residents.

112. Pursuant to 6 C.C.R. 1011-1, Chapter 2, § 2.10.1, the Department and any duly authorized representatives thereof shall have the right to enter upon and into the premises of any licensee or applicant in order to determine the state of compliance with the statues and regulations.

113. The Department observed that a gate at the Facility's main, east driveway was locked and the Department could not access the Facility. The Department observed multiple cars near the houses inside the gated area of the Facility. A sign was posted on the gate which had the telephone number of the Facility. The Department called the Facility number twice, but the telephone calls failed due to lack of service coverage. The Department tried the number a third time and a voice message stated that the Facility mailbox was full. The Department called Respondents' manager; however the call was sent straight to voicemail. The Department called the main number again and the voice mail stated it was full. The Department then drove around and entered the Facility property at an open gate on the west side of the property.

114. The Department interviewed Respondents' manager, who stated the phone number listed on the front gate was for the landline in the office. The Department interviewed Respondents' Administrator, who stated that the gate was not required to be open, but should have been unlocked. She added that she would look into why the voicemail was full.

115. Several days later, the Department attempted to access the Facility again to complete the investigation. Again the Department was unable to access the Facility because the gate was closed; the mailbox for the telephone number posted on the gate sign was still full. This time, however, the gate the Department previously used to access the Facility was also closed. The Department again contacted the Respondent Manager, whose number went straight to voicemail. The Department left a message on Respondents' Administrator's voicemail. Eventually, a staff member opened the Facility gate and granted the Department access.

116. Previously, on or around September 23, 2020, the Department attempted to conduct the onsite investigation for Event ID W4ZZ11. The Department could not access the Facility

because the Facility's main gate was locked. The Department called the main number, but Respondents did not answer. The Department called Respondents' Administrator and requested access. Respondent Administrator stated someone would come from a nearby location (not the Facility) to unlock the gate. Thirty minutes later, Respondents' Director arrived to unlock the gate. The Department interviewed the onsite staff about why the Department was not given access. Respondent staff members stated that they were busy with their tasks and did not know the Department was waiting at the gate. The Department cited Respondents for failure to ensure the Department could enter the premises to determine compliance with the regulations governing assisted living residences.

117. As mentioned previously in this Order, the Department determined that during Event ID W4ZZ11, Respondents attempted to interfere with private interviews with residents. Respondents attempted numerous times to interrupt interviews and informed the Department the residents were not allowed to have private conversations. Further, Respondents stated they were allowed to restrict residents' right to have private conversations based on their families' wishes or guardianship agreements. However, Respondents were unable to produce any guardianship agreements that restricted residents' rights to have private conversations.

118. As mentioned previously in this Order, the Department determined that Respondents attempted to interfere with the Departments' investigations by intimidating residents. During Event ID W4ZZ11, the Department attempted to conduct private interviews with residents. Respondents' staff member followed the Department surveyor and the resident into the resident's room and whispered "Remember your momma." When the Department surveyor asked what Respondent staff member meant by that comment, the staff member stated, "His mother doesn't want him to talk to people he doesn't know." Further, during Event ID YQ0311, the Department noted the vast difference between resident behaviors during the days when the Department was first onsite. Specifically, the first date of the onsite visit, residents were friendly, and spoke openly and willingly with Department surveyors. One resident asked the Department several times to be interviewed. When the Department left, residents appeared jovial and said happy and excited goodbyes to the Department. When the Department came back eight days later, the Department observed that residents avoided eye contact, appeared fearful, uncomfortable, and upset. The residents told the Department they were not allowed to speak with the Department, and left the Facility to avoid Department surveyors. The Department reviewed Respondents' records which demonstrated that Respondents negatively portrayed and misrepresented the Departments' interactions with residents. Respondents' progress notes indicated that Respondents questioned residents about their conversations with the Department, and Respondent BDP contacted residents' family

members and shared inaccurate information with resident families, which upset and alarmed the families.

119. Respondents demonstrate good cause for the Department to suspend and revoke their license for violating 6 C.C.R. 1011-1, Chapter 2, § 2.11.2(A)(3). Respondents attempted to prevent the Department from conducting an onsite investigation and attempted to prevent the Department from interviewing residents, and when the Department successfully interviewed residents, Respondent attempted to interfere with those interviews before, during, and after the interviews, impeding the Department's duty to protect the health, welfare, and safety of the residents. Respondents also prevented the state ombudsman from entering the Facility to ensure the residents were safe. Respondents also caused residents to fear consequences from speaking to the Department or the ombudsman.

Conclusion

120. Based upon onsite investigations of Respondents' Facility and interviews with Respondents' staff, residents, and resident family members, the Department has objective and reasonable ground to believe and finds, upon full investigation, that Respondents are guilty of deliberate and willful violations of Colorado laws and regulations and that Respondents pose a threat to the public health, safety and welfare that imperatively requires emergency action. The Department therefore, incorporates these findings in its order to summarily suspend Respondents' ALR Facility license pending proceedings for suspension or revocation, which shall be promptly instituted and determined.

THEREFORE, IT IS HEREBY ORDERED:

1. Facility license number 230343 issued to Triangle Cross Ranch, Inc. dba Triangle Cross Ranch to operate the ALR, Triangle Cross Ranch, located at 36049 Weld County Road 5, Galeton, Colorado 80622 is hereby suspended effective immediately.
2. Respondents shall cease, desist, and refrain from any further act authorized under health facility license number 230343 issued to Licensee Triangle Cross Ranch, Inc. dba Triangle Cross Ranch.
3. A Notice of Charges shall be promptly prepared and sent to Respondents.
4. Administrative proceedings shall be promptly instituted and determined.
5. Respondents shall immediately surrender ALR license number 230343 in the event of the Department's favor at the conclusion of the administrative proceeding.

Done this 12th day of April, 2021.

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Randy Kuykendall Digitally signed by Randy Kuykendall Date: 2021.04.07 13:51:18 -06'00'

D. Randy Kuykendall, Director
Health Facilities and Emergency Medical Services Division
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, Colorado 80246-1530

CERTIFICATE OF SERVICE

This is to certify that I have duly served a copy of this ORDER OF SUMMARY SUSPENSION to Susan LaBonde, Valerie Trujillo, and the Triangle Cross Ranch, Inc. Board of Directors and Triangle Cross Ranch, located at 36049 Weld County Road 5, Galeton, Colorado 80622, in person, via electronic mail, and via First Class U.S. Mail on this 12th day of April, 2021, addressed as follows:

Susan LaBonde, Administrator
Valerie Trujillo, Licensing Contact Person
Triangle Cross Ranch Inc. dba Triangle Cross Ranch
36049 Weld County Road 5
Galeton, Colorado 80622

Valerie Trujillo, President, Board of Directors
Triangle Cross Ranch Inc. dba Triangle Cross Ranch
P.O. Box 727
Galeton, Colorado 80622

West Ridge Accounting and Bookkeeping Service, LLC, Registered Agent
5626 West 19th Street, Suite B
Greeley, Colorado 80634

By: Shelley Sanderman Digitally signed by Shelley Sanderman Date: 2021.04.08 13:38:25 -06'00'

Blumberg No. 5136
PETITIONER'S
EXHIBIT
1

COLORADO
Department of Public
Health & Environment

FIFTH AMENDED PUBLIC HEALTH ORDER 20-20
REQUIREMENTS FOR COLORADO SKILLED NURSING FACILITIES, ASSISTED LIVING RESIDENCES, INTERMEDIATE CARE FACILITIES, AND GROUP HOMES FOR COVID-19 PREVENTION AND RESPONSE
November 20, 2020

PURPOSE OF THE ORDER

The Colorado Department of Public Health and Environment (CDPHE or "state health department") is working to stop the spread of novel coronavirus 2019 (COVID-19). At this time, I find it necessary to implement emergency measures to restrict visitors to skilled nursing facilities, assisted living residences, intermediate care facilities and group homes in Colorado to protect the health of the residents of these facilities. This Order is amended to ensure all skilled nursing facilities, assisted living residences, intermediate care facilities, and group homes conduct surveillance and outbreak COVID-19 testing of all residents and staff who have left the building for the purposes of mitigating the spread of COVID-19.

FINDINGS

1. COVID-19 was first detected in Wuhan, China in late 2019, and since then has spread to over 60 countries including the United States. As of November 19, 2020, there are 182,901 known cases of COVID-19 in Colorado, 11,980 Coloradans have been hospitalized and 2,350 Coloradans have died from COVID-19.

2. COVID-19 spreads from person to person and is thought to be transmitted mainly through respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory viruses spread. It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads. Persons infected with COVID-19 may become symptomatic anywhere from two to fourteen days after exposure. Symptoms include fever, cough, body aches, fatigue, chest tightness, headache, new loss of taste or smell,sore throat, congestion or runny nose, nausea or vomiting, diarrhea, or shortness of breath or difficulty breathing.

3. Individuals with serious chronic health conditions and older adults are most at risk for becoming very ill with this disease, and nursing facilities, assisted living residences, intermediate care facilities and group homes serve residents who are at this level of risk.

4. Pursuant to the authority in section 25-1.5-102(1), C.R.S., I am ordering that Colorado licensed or certified skilled nursing facilities, intermediate care facilities, assisted living residences, and group homes (**Facilities**) implement visitor requirements and daily **Facility** screening protocols for those entering the **Facility**, in order to reduce the likelihood of possible introduction of COVID-19 into these facilities.

5. I am also ordering these **Facilities** to provide regular reporting to CDPHE regarding occupancy rates and certain resource availability to better understand the statewide resource capacity and needs for these facilities to respond to this pandemic. **Facilities** are also required to conduct surveillance and outbreak testing in accordance with the terms of this Order.

ORDER

In order to protect the public's health and to prevent further spread of the disease, all Colorado licensed or certified skilled nursing facilities, intermediate care facilities, assisted living residences, and group homes are required to implement the restrictions and requirements below pertaining to the implementation of COVID-19 ongoing surveillance testing, outbreak testing when needed, and the allowance of visitors to these facilities.

I. TESTING REQUIREMENTS

A. Effective November 20, 2020, or at a later date as determined by CDPHE, all **Facilities** must implement COVID-19 ongoing surveillance testing, and outbreak testing as needed, for all staff and residents. As the most effective test for detecting infection with COVID-19 at this time is polymerase chain reaction (PCR) tests, **Facilities** are required to utilize PCR testing for all testing requirements in this Order. **Facilities** may use additional testing modalities at their discretion for more frequent or expanded testing.

   1. CDPHE will provide PCR testing services for all **Facilities** to implement surveillance and outbreak testing, or **Facilities** may choose to procure their own resource for PCR testing that meets or improves upon the testing timeframes for the testing services provided by CDPHE. **Facilities** shall provide the PCR testing service with all information required by the testing service to

allow for processing of the tests, and shall follow all CDPHE reporting requirements and guidance.

a. Ongoing surveillance testing, and outbreak testing when needed, shall be conducted utilizing a PCR test; however, as needed, other types of tests may be approved by CDPHE.

2. For the purposes of **Facility** testing, **Facility** staff are defined as employees, consultants, contractors, volunteers, students, caregivers, and others who provide medical or ancillary non-medical care and services to residents. Providers of medical care or ancillary non-medical services for residents of the **Facility** must either participate in the **Facility's** surveillance testing, or bring to the **Facility** evidence of negative PCR test results within the preceding week or within the last three days if the Facility is required to conduct twice weekly testing. Ancillary non-medical services include services such as hairstylists, barbers, cosmetologists, estheticians, nail technicians, and massage therapists.

3. Staff and residents, or resident guardians or representatives, may decline COVID-19 testing. **Facilities** must have written infection control policies and procedures in place to address staff and residents who refuse COVID-19 testing, which include written documentation from the resident or the resident's representative of any refusal to test. If an outbreak occurs within the **Facility,** any staff member that refuses testing must be excluded from the **Facility** for 14 days or until the outbreak is resolved, whichever is longer. If a resident refuses testing during an outbreak they shall be quarantined until the outbreak is resolved, and staff shall care for the individual using full personal protective equipment (PPE) effective against COVID-19.

4. **Facilities** must follow the testing requirements, including testing frequency, as outlined in CDPHE testing guidance for **Facilities.**

B. Surveillance Testing Requirements. All **Facilities** must at a minimum implement weekly surveillance testing for all staff. Additionally, **Facilities** shall implement weekly surveillance testing for all residents who have left the **Facility** premises to interact with individuals outside of the **Facility** in the last 14 days. **Facilities** may choose to expand testing beyond these minimum requirements, such as testing all residents on a weekly basis.

1. If at any time the county the **Facility** is located in reaches a two-week test positivity rate of 10% or greater, using the Colorado COVID-19 dashboard, the **Facility** must increase testing to twice weekly, and continue at the higher testing frequency until the two-week positivity rate returns to a rate of less than 10% for two consecutive weeks.

C. Outbreak Testing Requirements. Upon notification of a single positive COVID-19 case among residents or staff, the **Facility** must initiate outbreak testing of all residents and staff, regardless of the presence or absence of COVID-19 related symptoms.

II. VISITATION REQUIREMENTS

A. **Facilities** shall implement indoor visitation for their residents no later than November 25, 2020 if they meet the following requirements:

1. The **Facility** must be located in a county that has less than 10% average two-week positivity rate utilizing the COVID-19 Colorado Dial Dashboard, and
2. The Facility meets all surveillance testing and outbreak requirements in Section I of this Order on an ongoing basis.
3. The **Facility** must not be experiencing a current COVID-19 outbreak as determined by state or local public health, as well as no other ongoing infectious disease outbreaks of other types, such as flu or norovirus;
4. The **Facility** maintains an ongoing 14 day supply of all necessary PPE that would be necessary to respond to an outbreak as documented by the **Facility** in the daily reporting required by Section VI.A of this Order, without dependence on State or local public health stockpiles;
5. The **Facility** has and maintains adequate staffing without the need for or use of contingency arrangements for staffing, as documented by the **Facility** in the daily reporting required by Section VI.A of this Order. The levels of staffing must be sufficient to assure continued responsiveness to residents' needs while simultaneously accommodating the terms of indoor visitation and adequate monitoring for adherence to required infection control measures, such as screening of all residents and staff, handwashing, masks and social distancing.
6. The **Facility** ensures that staff are trained and routinely updated on the most current infection control principles and protocols for the prevention, response and control of COVID-19 in accordance with the training guidance recommendations issued by CDPHE.

B. The following services must be allowed within all **Facilities**, regardless of whether they meet the criteria for indoor visitation; however, individual service providers, other than emergency medical service providers, must be screened for symptoms and excluded if positive:

1. Essential health care service providers, who must also be tested in accordance with the testing frequency described in this order before allowing for entry into the **Facility**
2. Religious exercise

3. Adult Protective Services
4. Long Term Care Ombudsman
5. Designated Support Persons as defined in this Order
6. Compassionate Care Visitation
7. Emergency medical and service personnel.

C. Residential care providers must follow the CDPHE published Mandatory Visitation Requirements for Residential Facilities and review the county positivity rate every Friday for the preceding two weeks to determine whether indoor visitation will occur the following week, and update their visitation procedures accordingly.

D. All new or readmitted residents whose COVID-19 status is unknown must be housed in a private room or separate observation area so the resident can be monitored for COVID-19 symptoms. The resident can be transferred out of the observation area to the main **Facility** if they remain free from fever and without symptoms for 14 days after admission. Residents who are recovering from COVID-19 and have been discharged from the hospital and have not yet met criteria to discontinue transmission-based precautions should continue to be in a separate COVID-19 wing or unit of the **Facility** with staff who are assigned to only work on the COVID-19 wing or unit when it is in use. Only residents with a confirmed COVID-19 test should be located in an isolation area.
   1. Residents who require observation or isolation should not participate in indoor or outdoor visitation until they meet the criteria to be removed from such precautions.

E. If a resident residing at a **Facility** greater than 14 days develops one or more symptoms of COVID-19 and/or tests positive for COVID-19, the **Facility** must:
   1. Consult with the local public health agency;
   2. Isolate the resident from others and stop indoor visitation;
   3. Identify the visitors who interacted with the resident and resident's environment, and provide the information to public health to assist in notifying the individuals of the potential exposure and recommend quarantine and testing;
   4. Perform outbreak testing for all staff and residents in accordance with the CDPHE testing guidance; and
   5. Restrict staff members who refuse to be tested from the building until the procedures for outbreak testing have been completed. If outbreak testing identifies any cases among residents or staff, the staff member refusing testing should complete a 14 day quarantine period and continue to be excluded from

the **Facility** until the outbreak is resolved. If no new cases are identified after testing all residents and staff members the staff member can return to work if they meet the CDC return to work criteria and have completed the 14 day quarantine.

The **Facility** may re-institute indoor visitation once public health determines that the **Facility** is not experiencing an outbreak.

F. **Facilities** may allow for outdoor visitation in accordance with the Outdoor Visitation Guidance published by CDPHE. Facilities must also allow indoor visitation in accordance with this Order and with the Mandatory Visitation Requirements for Residential Facilities published by CDPHE.

G. **Facility** residents with disabilities, which may include, but not be limited to, altered mental status, physical, intellectual or cognitive disability, communication barriers or behavioral concerns, who need assistance due to the specifics of their disability, may designate up to two support people to be with them to support their disability related needs. Only one designated support person may be present to provide services for the resident with disabilities at a time.[1] In accordance with Section II.B of this Order, support personnel shall be screened in accordance with the current criteria for performing a temperature check and symptom screening, offered testing by the **Facility** in accordance with the staff testing requirements in Section I of this Order, and must follow the CDPHE Mandatory Visitation Requirements for Residential Facilities as well as other relevant **Facility** policies for visitation. Facilities may not restrict visitation of support personnel without a reasonable clinical or safety cause.

III. ALTERNATIVE COMMUNICATIONS

A. **Facilities** that restrict or limit visitor access for any of the foregoing reasons must:

1. Offer alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.);
2. Assign staff as primary contact to families for inbound calls, and conduct regular outbound calls to keep families up to date; or
3. Offer a phone line with a voice recording updated at set times (e.g., daily) with the **Facility's** general operating status, such as when it is safe to resume visits.

[1]Guidance on civil rights requirements for places of public accommodation can be found here: https://docs.google.com/document/d/14DNDIBBr8guROAjywtfplxio24qbexF6xatv2t7bpRU/edit

IV. RESTRICTIONS REGARDING THIRD PARTIES. **Facilities** shall review how they interact with volunteers, vendors and receiving supplies, agency staff, EMS personnel and equipment, and transportation providers (e.g., when taking residents to offsite appointments, etc.), and revise policies, practices and procedures to implement necessary actions and best practices to prevent potential disease transmission.

V. PREVENTION AND RESPONSE FOR COVID-19

A. **COVID-19 Prevention and Response Plans.** Each **Facility** shall create and submit to CDPHE, through the Health Facilities and Emergency Medical Services Division at covid-19facilityisolationplan@state.co.us, a COVID-19 prevention and response plan that details the steps the **Facility** will take to implement COVID-19 prevention strategies, in addition to how the **Facility** will identify and isolate residents who test positive or have symptoms compatible with COVID-19. These plans should include the concepts contained in the COVID-19 Preparation and Rapid Response: Checklist for Long Term Care Facilities found on the CDPHE webpage, which cover both prevention and response activities, including strategies for PPE use and preservation and other administrative controls for staff working with residents in isolation, ensuring isolation of residents with illness from susceptible residents, frequency of symptoms monitoring for ill residents and plans for seeking additional medical care as needed, identifying and monitoring residents who are contacts of symptomatic residents during the quarantine period, and process for notification of family member or legal guardian of the isolation requirement. A template plan for completion is available on the CDPHE webpage. These plans should also include a description of the COVID-19 prevention staff training, the frequency of training and the method by which competency in prevention activities is determined, and should be updated as guidance changes or the **Facility** changes their prevention and response activities.

B. Individuals who test positive or have mild symptoms compatible with COVID-19 who are placed in isolation must remain isolated until fever has been gone for at least 24 hours (without the use of medicine that reduces fevers, other symptoms are improving (for example, when cough or shortness of breath have improved), and at least 10 days have passed since symptoms first appeared. For those who experienced severe or critical illness or immunocompromised must remain isolated an additional 10 days (a total of 20 days). If an individual tests positive but has no symptoms, they should remain isolated for 10 days following the collection of their positive test.

C. **Facilities** shall ensure that all residents have access to necessary medical care, including all treatment ordered by a physician, which may include services that are

not readily available in the **Facility** and must be provided by nonemployee, external health care providers. **Facilities** shall perform a temperature check and symptom screening for such providers and perform testing in accordance with the staff testing requirements described in this Order. Health care providers entering the **Facility** to provide this essential care to residents shall utilize appropriate PPE. All **Facility** employees shall wear face coverings in accord with **Executive Order D 2020 039**, as amended and extended by **Executive Orders D 2020 067, D 2020 092, D 2020 110, D 2020 138, D 2020 164, D 2020 190, D 2020 219 and D 2020 245.**

D. **Facilities** should require that when residents or employees of the **Facility** leave the **Facility** to go out in public for necessary activities, as defined in Public Health Order 20-36 COVID-19 Dial, they wear a mask or other face covering to reduce the possibility of disease spread.

VI. REPORTING REQUIREMENTS

A. All **Facilities** in Colorado shall report to CDPHE information pertaining to their available resources to respond to the COVID-19 pandemic. Items that may be reported include, but are not limited to, **Facility** bed capacity, supply of PPE, and available staffing for the facilities. CDPHE will provide the reporting platforms and the form and format for submission of the required information, which may be modified as the response to this pandemic evolves. Daily reporting of this resource information to CDPHE is required.

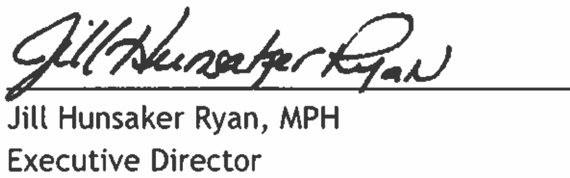
B. Reporting of resource information to CDPHE is required by each **Facility** type in the form and format as determined by CDPHE.

VII. ENFORCEMENT

CDPHE is tasked with protecting the health and welfare of the citizens of Colorado by investigating and controlling the causes of epidemic and communicable disease. This Public Health Order is necessary to control any potential transmission of disease to others. Section 25-1.5-102(1), C.R.S. This Order will be enforced by all appropriate legal means. Local authorities are encouraged to determine the best course of action to encourage maximum compliance. Failure to comply with this order could result in penalties, including jail time, and fines, and may also be subject to discipline on a professional license based upon the applicable practice act.

VIII. SEVERABILITY

If any provision of this Order or the application thereof to any person or circumstance is held to be invalid, the remainder of the Order, including the application of such part or provision to other persons or circumstances, shall not be affected and shall continue in full force and effect. To this end, the provisions of this Order are severable.



Jill Hunsaker Ryan, MPH
Executive Director

November 20, 2020
Date