Health Facilities and Emergency Medical Services Division (HFEMSD) Occurrence Reporting Manual

Revised May 2018 (contact information updated Sept.2020)

Provider Reporting Portal:

https://www.cohfi.colorado.gov/COHFI/Account/Login

Portal Technical Support:

cdphe.hfemsportalsupport@state.co.us
(303) 692-2836

General Occurrence Questions/Information:

cdphe.hfoccur@state.co.us
(303) 692-2826 Occurrence Intake Coordinator
(303) 692-2900 Occurrence Hotline
(303) 692-2801 Occurrence Section Manager
(303) 753-0139 Fax

For all Department contact, please provide your licensed entity name, contact information and a brief description of the issue.

Table of Contents

Introduction 3
Occurrence Reporting Process 4
Federal Reporting Requirement for Nursing Facilities 5
General Questions and Answers 6

Occurrence Category Statutes and General Questions
Abuse, Physical 8
Abuse, Sexual 10
Abuse, Verbal 12
Brain Injuries 14
Burns 16
Death 20
Diverted Drugs 23
Life-Threatening Complication of Anesthesia 26
Life-Threatening Transfusion Errors or Reactions 27
Malfunction or Misuse of Equipment 28
Misappropriation of Resident/Patient Property 30
Missing Persons 33
Neglect 35
Spinal Cord Injuries 39

Occurrence Reporting Statutes and Resource Information
Occurrence Reporting Statute 41
Suspicious Death Statutes (C.R.S. § 30-10-606) 43
Duty to Report Statutes 47
Abuse and Exploitation of At-Risk Elders Reporting 49

Introduction

This manual is intended to follow the format of the previous version as closely as possible and provide guidance to licensed entities on the process to report occurrences to the Health Facilities and Emergency Medical Services Division (the Division). It contains information on how to report occurrences, what type of events are reportable and timelines for the reports.

The Division recognizes that occurrence reporting can be difficult and that it may be unclear on when to report an occurrence. This manual is intended to be used as a reference for those situations. Upon first review of the manual, please review the introduction, as well as the general questions and answers. These sections provide an important overview of occurrence reporting for new licensed entities, staff members who have not previously reported, as well as foundational information for more experienced reporters.

The occurrence category statutes and general questions sections direct licensed entities on the more specific details to report occurrences and answers general questions that provide reporting guidance. This updated version of the manual does not contain specific examples, as specific situations and examples have limitations on the guidance they can provide. Instead, this manual poses more general questions and interpretative guidelines in hopes of directing licensed entities to understand how the Division applies the occurrence reporting statute.

As always, there may be situations where it is unclear if the situation is reportable as an occurrence. Please contact the Division for those situations and speak with the Occurrence Intake Coordinator. The Division contact information can be found on the cover of the manual. Thank you for your timely and accurate reporting.

<u>Occurrence Reporting Process</u>

<u>Determining Reportability</u> - After an event, the licensed entity must determine if the event meets occurrence reporting criteria and report to the Division within the required timeframe. The Division recommends that all staff receive training on occurrence reporting to avoid late reports. The Division will determine timeliness on all reports that are submitted. The licensed entity can use this Occurrence Manual to determine under which category the event may be reportable, and if that event meets the reporting elements. If the licensed entity is unclear, contact the Division.

<u>Initial Report</u> - Initial occurrence reports are due to the Division no later than the end of the <u>next Division business day</u>. (For exceptions, please view federal reporting for nursing facilities on the next page).

When submitting initial reports, provide as much information about the event as possible. In the initial report, provide a description of the occurrence and the victim support that was put in place as a result of the event. Appropriate notifications to other entities are also expected at this time. <u>It is the expectation of the Division that the licensed entity demonstrate how it intends to keep its population safe during the course of the investigation. If this information is not included in the initial report, the Division will contact the licensed entity for more information prior to the submission of the final report.</u>

<u>Final Report</u> - The final occurrence report is due 5 calendar days after the submission of the initial report. When submitting a final report, it is important to provide as much information as possible. Although there may be times the licensed entity is unable to completely fill out the final report because of other involvement, such as law enforcement, the final report should still be submitted in a timely manner.

<u>Division Investigation</u> - Once a final report has been submitted, Division occurrence investigators will perform an off-site investigation and may request further information. Once that investigation is complete, a summary of the occurrence will be prepared and sent to the licensed entity.

<u>Facility Comments</u> - When the licensed entity receives the occurrence summary, it has 7 calendar days to review the summary and provide comments to the Division prior to the summary becoming public information. The comment portion of the process is designed to allow licensed entities the opportunity to add pertinent information to the occurrence summary. It is not designed for personal notes directed towards occurrence investigators. After 7 calendar days, the occurrence summary will be made publicly available via the Division website, www.healthfacilities.info. After the summary has been made publicly available, it will not be altered.

Federal Reporting Requirement for Nursing Facilities

Nursing facilities have a federal requirement to report allegations of mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property. The time frames of these reports differ from occurrence reporting and are determined on the injury of the victim. For serious bodily injury, the time limit is 2 hours. All other reports must be submitted within 24 hours through the occurrence provider portal.

Serious Bodily Injury – 2 Hour Limit: If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion.

<u>When an event meets both occurrence and federal reporting criteria, the licensed entity must report according to the more stringent timeline.</u>

General Questions and Answers

1. How will confidentiality of the reports be maintained?

The occurrence statute mandates confidentiality of the reports. C.R.S. §25-1-124(4) states, "The information in such reports shall not be made public upon subpoena, search warrant, discovery proceedings or otherwise." The Division may share investigatory information with other divisions or regulatory agencies with appropriate jurisdiction. The summary is publicly available, but does not give specific identifying information about the individuals involved.

2. Many licensed entities have multiple reporting requirements. Do these requirements relieve licensed entities of their obligation to report to the Division?

No, licensed entities are obligated to report events that meet the occurrence reporting criteria to the Division, regardless of if other entities are notified.

3. Can the Division remove a reported occurrence if subsequent information reveals it is not reportable?

The Division has the capability to deactivate an occurrence report. The licensed entity will be notified of the decision to deactivate the occurrence report and reason for the deactivation. Deactivated occurrence reports are not available to the public.

4. Will the Division file complaints against individuals involved in occurrence reports to the Department of Regulatory Agencies (DORA)?

Individuals involved in occurrence reports may have complaints filed against them to DORA. If necessary, the licensed entity is expected to file this complaint as a part of the occurrence report. The Division may file a complaint at the conclusion of the investigation, if a complaint has not already been filed.

5. Will events reported as occurrences prompt an onsite investigation?

Events reported as occurrences may prompt an onsite investigation. Examples of occurrences that may prompt onsite investigation are: potential immediate jeopardy, potential communicable diseases, a pattern of similar events, or the lack of an appropriate investigation by the licensed entity.

6. Does occurrence reporting require the licensed entity to report to any other governmental agency?

Abuse reporting requirements are taken from the felony statutes. If an abuse allegation meets the occurrence reporting elements, it meets the definition of felony abuse and **must** be reported to law enforcement, with the exception of child perpetrators under the age of 10.

7. How can I find out if a staff person has been excluded from working in a facility that receives Medicaid funding?

The Office of the Inspector General (Health and Human Services) has a website that contains this information: http://exclusions.oig.hhs.gov

8. What should be done for events that meet more than one reporting criteria?

The licensed entity should determine which elements are best met by the event and then report under that category. The Division will review the occurrence report and determine if the event was reported under the correct category. If it is not, the Division may ask the licensed entity to submit the event under the correct category. Occurrence reports submitted under the incorrect category cannot be moved, but must be resubmitted. For questions about events that may meet more than one reporting criteria, please contact the Occurrence Intake Coordinator.

9. If an event begins as one type of occurrence and then escalates to another type of occurrence, how does a facility report this issue?

For issues of this nature, the Division recommends the facility report the final result of the occurrence. For example, if verbal abuse escalates into physical abuse, the licensed entity would report one physical abuse occurrence and include the details of the verbal abuse that preceded the physical abuse. Similarly, events that begin as one type of occurrence, but result in death, should be reported under the death category. This report should contain the events leading up to the death, even if those events are reportable under a different category. For provider questions about these situations, please contact the Occurrence Intake Coordinator.

10. If a licensed entity has multiple locations, how should it report an occurrence?

Licensed entities that have multiple locations or branches should report the occurrence under the ID where the occurrence took place. In cases where occurrence reports are submitted under the incorrect ID, please contact the Division.

11. How should Department of Corrections facilities report occurrences?

The Division regulates the clinic or infirmary services of correctional facilities. For the purposes of occurrence reporting, events that meet the occurrence reporting criteria are reportable to the Division if they take place either 1) in the clinic or infirmary or 2) within the boundaries of a Department of Corrections facility when a healthcare professional is acting in his or her official capacity outside the clinic or infirmary. For provider questions about these situations, please contact the Occurrence Intake Coordinator.5 - Add mandatory reporting information.

Abuse, Physical - Statute and General Questions

"Any occurrence involving physical...abuse of a patient or resident, as described in Section 18-3-202, 18-3-203, and 18-3-204...C.R.S., by another patient or resident, an employee of the facility, or a visitor to the facility." Section 25-1-124(2)(d), C.R.S.

Two elements needed:

- Intent OR Knowingly OR Recklessly

  AND

- Bodily injury and/or serious bodily injury
  AND/OR
  Unreasonable confinement or restraint

Intentionally – Action taken by an individual with conscious objective to cause the specific result, proscribed by the statute defining the offense. It is immaterial to the issue of specific intent whether or not the result actually occurred. See generally: §18-1-501(5) C.R.S.

Knowingly – Action taken willfully, consciously or with understanding the conduct is prohibited by or will result in the violation of a criminal statute. A person acts knowingly with respect to a result of his or her conduct, when aware that the conduct is practically certain to cause the prohibited result. See generally: §18-1-501(5), (6), and (8) C.R.S.

Recklessly – Action taken in conscious disregard of a substantial and unjustifiable risk that a result will occur or that a circumstance exists. See generally: §18-1-501(5), (6), and (8) C.R.S.

Bodily injury – This means physical pain, illness, or any impairment of physical or mental condition. See: §18-1-901(3)(c) C.R.S.

Serious bodily injury – Bodily injury which, either at the time of the actual injury or at a later time, involves a substantial risk of death, a substantial risk of serious permanent disfigurement, or a substantial risk of protracted loss or impairment of the function of any part or organ of the body, or breaks, fractures, or burns of the second or third degree. See generally: §18-1-901 (3)(p) C.R.S.

General Questions

If an allegation is investigated and not substantiated, is it still reportable as an occurrence?

Yes, it is the allegation of the event, not the outcome of the provider's investigation, which makes it reportable.

Is it necessary for a person to act with intent to perform physical abuse?

No, it is not necessary to be able to form intent to also perform physical abuse. It is possible for the abuser to act knowingly or recklessly without being able to form intent.

After an assessment is done, there is no visible injury found. If the consumer was involved in a physical altercation and indicates by action or interview that he or she experiences pain without any noticeable marks, is this injury?

Yes. Pain is considered injury. Even if a consumer with dementia cannot express pain, any action that would normally be considered painful by a reasonable person should be considered an injury. For example, a slap that leaves no mark would normally be painful and should be considered reportable as an injury even if the consumer cannot express the pain.

Are abuse allegations directed towards staff or visitors by consumers reportable?

No, only allegations of physical abuse directed towards consumers are reportable.

Acute Care Facilities

Who can commit physical abuse?

Anyone can commit physical abuse, as long as it is directed to the patient. Staff, visitors and other patients can all commit physical abuse. It is the facility's responsibility to protect patients from physical abuse, no matter the source.

Home Care Agencies

Who can commit physical abuse?

Staff, and potentially visitors can commit physical abuse. If a client has a visitor while a staff member is working, and the visitor commits physical abuse, it is reportable. If the staff member is not working during a physical abuse, but is informed later, it is not reportable as a physical abuse occurrence.

Residential Facilities

Who can commit physical abuse?

Anyone can commit physical abuse, as long as it is directed to the consumer. Staff, visitors and other consumers can all commit physical abuse. It is the licensed entity's responsibility to protect consumers from physical abuse, no matter the source.

<u>Abuse, Sexual - Statute and General Questions</u>

"Any occurrence involving sexual...abuse of a patient or resident, as described in section...18-3-402, 18-3-403, 18-3-404, or 18-3-405 C.R.S., by another patient or resident, an employee of the facility, or a visitor to the facility." Section 25-1-124 (2)(d) C.R.S.

<u>Three elements needed:</u>

- Knowingly AND
- Consent not given AND
- Sexual intrusion or penetration or, touching intimate parts or the clothing covering the intimate parts or, examiners or treats resident/patient for other than bona fide medical purposes or, observes or photographs another person's intimate parts or, physical force/threat

Knowingly – Action taken willfully, consciously or with understanding it is certain to cause a result. See generally: §18-1-501(5), (6), and (8) C.R.S.

Consent – Cooperation in act or attitude pursuant to an exercise of free will and with knowledge of the nature of the act. A current or previous relationship shall not be sufficient to constitute consent under the provisions of this part 4. Submission under the influence of fear shall not constitute consent. See §18-3-401(1.5), C.R.S. Assent does not constitute consent if given by a person who is legally incompetent, or who, by reason of immaturity, mental disease or mental defect or intoxication, is manifestly unable to make a reasonable judgment as to the nature or harmfulness of the conduct or is given by a person whose consent is sought to be prevented by the law or is induced by force, duress, or deception." See generally: §18-1-505(3) C.R.S.

Intimate Parts - the external genitalia or the perineum or the anus or the buttocks or the pubes or the breast of any person (C.R.S - Title 18 Criminal Code 18-3-401).

<u>General Questions</u>

If an allegation is investigated and not substantiated, is it still reportable as an occurrence?

<u>Yes, it is the allegation of the event, not the outcome of the provider's investigation, which makes it reportable.</u>

Can consumers with cognitive impairment be victims of sexual abuse?

Yes, they can be victims of sexual abuse. The licensed entity must determine if the consumer was able to give consent due to their diagnosis. The licensed entity must then determine if consent was given for the situation.

Can consumers with cognitive impairment sexually abuse others?

Yes, they may be able to sexually abuse others so long as they act with the required culpable mental state. Therefore a consumer with dementia or mental illness can sexually abuse another

if they are capable of acting “knowingly” as required by the statute. In this circumstance, the licensed entity must determine before reporting an occurrence if the abuser acted with the awareness that he or she was engaging in criminal conduct or that his or her conduct would result in a criminal violation. Such a person acts knowingly with respect to a result of his or her conduct when he or she is aware that his or her conduct is practically certain to cause the result.

Can a consumer be sexually abused during medical treatment?

Yes, a consumer can be sexually abused during medical treatment. If the consumer alleges sexual abuse during medical treatment the licensed entity must determine if the alleged act was for a bona fide medical purpose. If the act was for a medically necessary reason, it is not reportable as a sexual abuse occurrence. If the act was not medically necessary and meets the other two elements, it is reportable as a sexual abuse occurrence.

Is sexual abuse reportable when directed to a visitor or a staff member?

No, sexual abuse is only reportable when directed toward a consumer.

Acute Care Facilities

Who can commit sexual abuse?

Anyone can commit sexual abuse, as long as it is directed to the consumer. Staff, visitors and other consumers can all commit sexual abuse. It is the licensed entity’s responsibility to protect consumers from sexual abuse, no matter the source.

Home Care Agencies

Who can commit sexual abuse?

Staff, and potentially client visitors, can commit sexual abuse. If a consumer has a visitor while a staff member is working, and the visitor commits sexual abuse, it is reportable. If the staff member is not working during a sexual abuse, but is informed later, it is not reportable as a sexual abuse occurrence because the consumer was not receiving home care services at the time of the sexual abuse.

Residential Facilities

Who can commit sexual abuse?

Anyone can commit sexual abuse, as long as it is directed to the consumer. Staff, visitors and other consumers can all commit sexual abuse. It is the licensed entity’s responsibility to protect consumers from sexual abuse, no matter the source.

Abuse, Verbal - Statute and Examples

"Any occurrence involving...verbal abuse of a patient or resident, as described in section...18-3-206.C.R.S., by another patient or resident, an employee of the facility, or a visitor to the facility." Section 25-1-124 (2)(d), C.R.S.

"A person commits the crime of menacing if, by any threat or physical action, he knowingly places or attempts to place another person in fear of imminent, serious bodily injury." Section 18-3-206, C.R.S.

Three elements needed:

- Knowingly AND
- Threat OR Physical action (includes threatening gesture) AND
- Fear of imminent, serious bodily injury

Knowingly – Action taken willfully, consciously or with understanding it is certain to cause a result. See generally: §18-1-501(5), (6), and (8) C.R.S.

Serious bodily injury – Bodily injury which, either at the time of the actual injury or at a later time, involves a substantial risk of death, a substantial risk of serious permanent disfigurement, or a substantial risk of protracted loss or impairment of the function of any part or organ of the body, or breaks, fractures, or burns of the second or third degree. See generally: §18-1-901 (3)(p) C.R.S.

General Questions

If an allegation is investigated and not substantiated, is it still reportable as an occurrence?

Yes, it is the allegation of the event, not the outcome of the provider's investigation, which makes it reportable.

Can consumers with cognitive impairments verbally abuse others?

Yes, those consumers are able to verbally abuse others. The definition of knowingly states that the action must be taken "willfully, consciously or with understanding it is certain to cause a result." A consumer with dementia or mental illness can still willfully direct a threat or physical action to another. The licensed entity must determine if the abuser is able to willfully, consciously or with understanding threaten another prior to reporting as an occurrence. To be reportable, there must also be fear on the part of the victim.

How is it determined if the victim of verbal abuse is fearful?

Victims of verbal abuse can demonstrate fear multiple ways. The victims can verbally state they are fearful, or their behavior can indicate fear. During the verbal abuse, if a witness identifies that the victim appears fearful, either through reactions or body language, the event is

reportable as an occurrence as long as the other two elements are met. Similarly, if the victim is interviewed after the verbal abuse and verbally denies fear while exhibiting fearful body language it is also reportable. This is also the case for the victim's behavior for any future interactions with the abuser. Staff should observe the victim carefully for any signs of fear after a potential verbal abuse situation.

Can an identical situation be verbal abuse in one case but not in another?

Yes, an identical situation can be verbal abuse in one instance, but not in another. The reaction of the victim is the key component. If one victim has fear of imminent, serious bodily injury and another victim does not, then one event would be reportable and the other would not. The licensed entity must listen and observe to how the victim reacts to the threat when determining whether or not to report as a verbal abuse.

Acute Care Facilities

Who can commit verbal abuse?

Anyone can commit verbal abuse, as long as it is directed to the consumer. Staff, visitors and other consumers can all commit verbal abuse. It is the licensed entity's responsibility to protect consumers from verbal abuse, no matter the source. Threats directed at staff members or visitors are not reportable as verbal abuse occurrences.

Home Care Agencies

Who can commit verbal abuse?

Staff, and potentially visitors can commit verbal abuse. If a consumer has a visitor while a staff member is working, and the visitor commits verbal abuse, it is reportable. If the staff member is not working during a verbal abuse, but is informed later, it is not reportable as a verbal abuse occurrence because the consumer was not receiving home care services at the time of the verbal abuse. Threats directed at staff members or visitors are not reportable as verbal abuse occurrences.

Residential Facilities

Who can commit verbal abuse?

Anyone can commit verbal abuse, as long as it is directed to the consumer. Staff, visitors and other consumers can all commit verbal abuse. It is the licensed entity's responsibility to protect consumers from verbal abuse, no matter the source. Threats directed at staff members or visitors are not reportable as verbal abuse occurrences.

Brain Injury - Statute and General Questions

"Any occurrence that results in any of the following serious injuries to a patient or resident: (I) Brain...Injuries…" Section 25-1-124 (2)(b)(I) C.R.S.

Two elements needed:

- Result of occurrence (event)

  AND

- Change in level of consciousness and/or loss of bodily function

  OR

- Diagnostic test which shows brain injury

Event – Unexpected, unplanned action or avoidable action that results in serious injuries to patient or resident. Unexpected, unplanned or avoidable action that is defined by community or professional standards of practice.

General Questions

If a consumer experiences an event that may result in a brain injury, but initial tests do not show a change in level of consciousness and/or bodily function is it reportable if the consumer later experiences a change in level of consciousness and/or bodily function?

Yes, it may be reportable. It is not necessary for the consumer to exhibit the change in level of consciousness and/or bodily function immediately. If the licensed entity determines the changes were a result of a previous event, it would still be reportable, despite the delay in the onset of change.

Is a concussion considered a brain injury?

Yes, a concussion is a brain injury.

Acute Care Facilities

No additional questions.

Home Care Agencies

If the consumer suffers a brain injury while not receiving services from the licensed entity, is it reportable?

No, it is not reportable. The licensed entity must only report occurrences while staff is providing services for the client.

Residential Facilities

If the consumer suffers a brain injury while outside of the facility, is it reportable?

Yes, it is reportable.

Burns - Statute, General Questions and Burn Charts

"Any occurrence that results in any of the following serious injuries to a patient or resident: ..Second- or third-degree burns involving twenty percent or more of the body surface area of an adult patient/resident, or fifteen percent or more of the body surface area of a child patient/resident." Section 25-1-124-(2)(b)(III). C.R.S.

Two Elements Needed:

- Second or third degree burns AND
- 20% or more of body surface in an adult or 15% or more of body surface in a child

General Questions

If an adult consumer receives second or third degree burns, but they are on less than 20% of the person's body, is this reportable as a burn occurrence?

This is not reportable as a burn occurrence. While the consumer has second or third degree burns, the second element is not met. Both elements must be met to report a burn. Please note that while this may not be reportable as a burn occurrence, it may meet elements of other reporting categories. Please consider the source of the burn to determine if the incident is reportable under a different category.

If the licensed entity is unsure whether the burn meets the body surface area in an adult or child and can't decide, what should be done?

The licensed entity can use the burn charts provided in this occurrence manual for a reference point. If after consulting the burn charts a decision still cannot be made, please contact the Occurrence Intake Coordinator to further discuss the burn and whether it should be reported.

Are chemical burns reportable?

Yes, chemical burns are reportable if they meet the criteria for burn reporting.

Acute Care Facilities

If an adult consumer presents to the emergency department with second or third degree burns over 20% of their body (or a child over 15%), is this reportable?

No, this is not reportable. Acute care facilities are obligated to report occurrences that occur while on the grounds of the facility.

Home Care Agencies

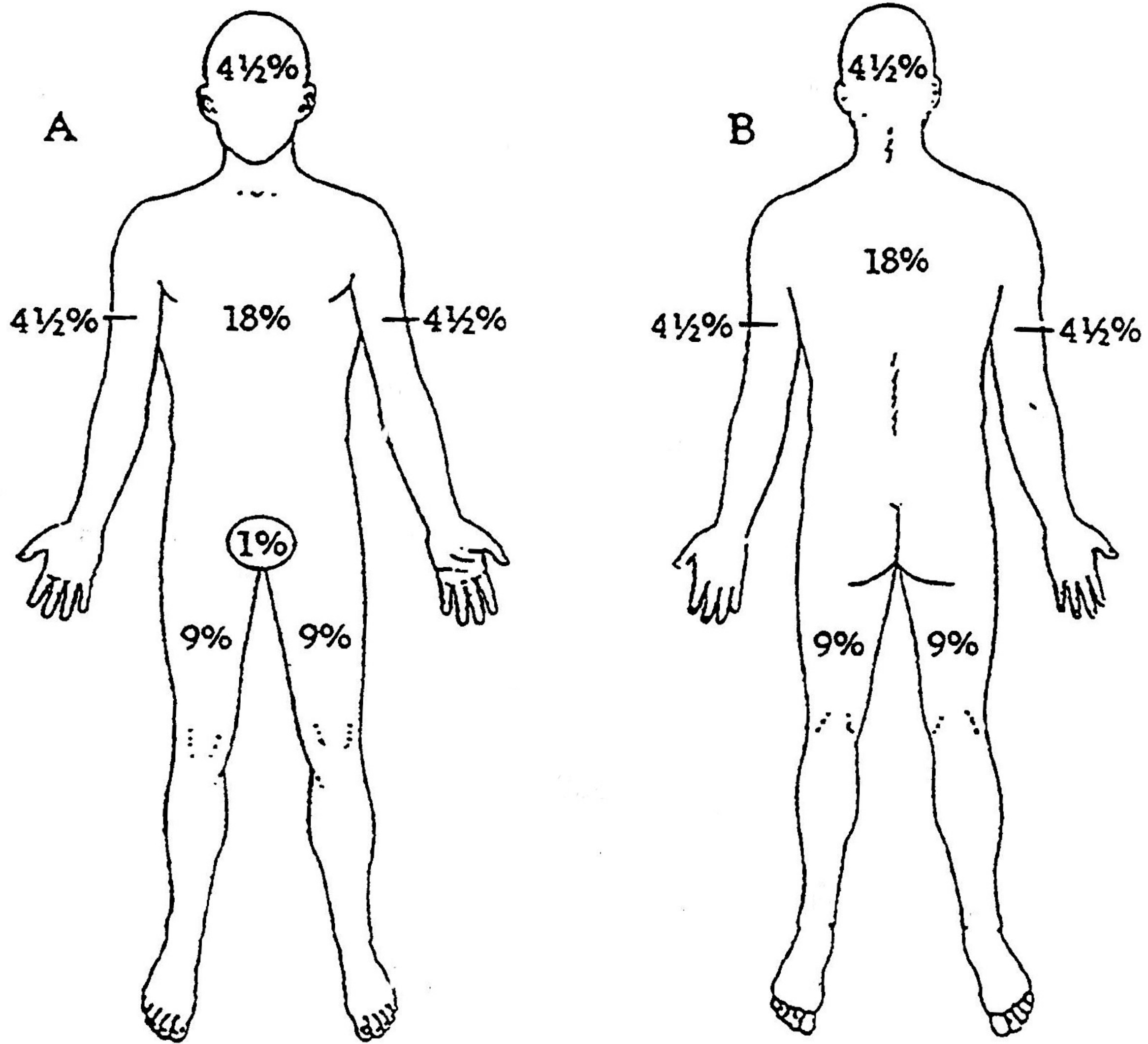
No additional questions for this facility type.

Residential Facilities

If an adult consumer receives a burn while not in the facility, is this reportable?

Yes, this is reportable if the burns are second or third degree and over 20% of the consumer's body. It does not matter that the consumer was not in the licensed entity.

Adult Burn Chart

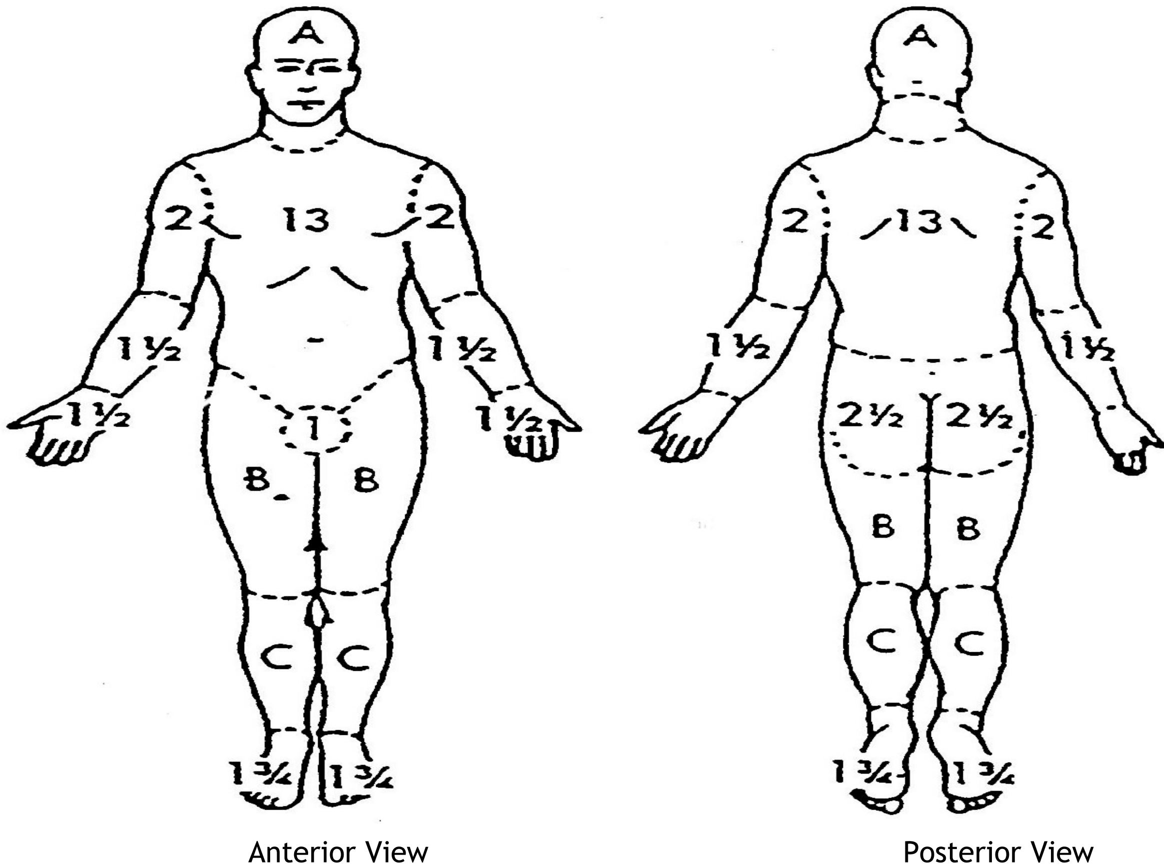


Anterior View

Posterior View

Estimation of adult burn injury: Rule of Nines.

Child Burn Chart



Lund-Browder Chart

Estimation of burn injury: Areas designated by letters (A, B, and C) represent percentages of body surface area that vary according to age. The accompanying table indicates the relative percentage of these areas at various stages in life.

Relative percentages of areas affected by growth (in years)

AGE IN YEARS	0	1	5	10	15	Adult
A: Head (back or front)	9.5	8.5	6.5	5.5	4.5	3.5
B: 1 thigh (back or front)	2.75	3.25	4.0	4.25	4.5	4.75
C: 1 leg (back or front)	2.5	2.5	2.75	3.0	3.25	3.5

Death - Statute and General Questions

"Any occurrence that results in the death of a patient or resident of the facility and is required to be reported to the coroner pursuant to Section 30-10-606, C.R.S., as arising from an unexplained cause or under suspicious circumstances." Section 25-1-124 (2)(a), C.R.S.

Two Elements Needed:

- Occurrence (event) resulting in death AND
- Reportable to the coroner as unexplained or suspicious

Event – Unexpected, unplanned action or avoidable action that results in serious injuries. Unexpected, unplanned or avoidable action is defined by community or professional standards of practice.

General Questions

Coroners vary in what they require licensed entities to report. What criteria are used in reporting death occurrences?

The occurrence reporting requirement is defined by Colorado Revised Statute section 30-10-60. Licensed entities are required to report under those standards.

If the physician lists the cause of death but the next of kin request an autopsy, is this reportable?

Deaths are only reportable if the occurrence reporting criteria are met. In this case if the death is not reportable to the coroner as unexplained or suspicious, it would not be reportable. An autopsy request would not make a death reportable.

Are physician assisted suicides reportable?

No, physician assisted suicides are not reportable. The Colorado End of Life Options Act specifically exempts deaths under the Act from being a reportable death to the coroner. Section 25-48-109(2), C.R.S. Therefore, these deaths do not meet the second element.

Acute Care Facilities

Are dead on arrival (DOA) cases in an emergency department reportable?

No, only the deaths that happen in the licensed entity that meet the two elements are reportable. The emergency department is not responsible for care of the patient when they are in the community.

A consumer is transported from a licensed entity and subsequently dies. Is this reportable?

If the death is the result of an event that happened while under the supervision of the licensed entity and meets the occurrence reporting elements, the death is reportable. The licensed entity is not responsible for reporting death occurrences where the event that resulted in death happened prior to the patient's arrival.

Home Care Agencies

If a death occurs outside of the consumer's home is it reportable?

If the death occurred while the consumer is receiving services and in the presence of staff, it is reportable regardless of where the death occurred.

A consumer is transported to the hospital and subsequently dies in the hospital. Is this reportable?

If the death is the result of an event that happened while the consumer was receiving services from the licensed entity and meets the occurrence reporting elements, the death is reportable. The licensed entity is obligated to report an occurrence by the end of the next business day when the agency is informed of the death.

If a consumer is on hospice and dies, is it reportable?

Hospice deaths may be reportable. The agency must determine if the death was suspicious or unexplained.

Residential Facilities

If a death occurs off the premises is it reportable?

If the death occurred while the consumer is receiving services from the facility, it is reportable regardless of where the death occurred, with the exception of deaths that occur under the Colorado End of Life Options Act

A consumer is transported to the hospital and subsequently dies in the hospital. Is this reportable?

If the death is the result of an event that happened while under the supervision of the licensed entity and meets the occurrence reporting elements, the death is reportable. The licensed entity is obligated to report an occurrence by the end of the next business day when informed of the death.

If a consumer receives both hospice and residential facility services and dies, is it reportable?

Hospice deaths may be reportable. If there is any evidence the consumer did not receive necessary services, or received too many services that led to the patient's death, it could be reportable. The two licensed entities must determine if the death was suspicious or unexplained. The two licensed entities must also determine which entity should report the occurrence. If there are questions, please contact the Occurrence Intake Coordinator for guidance.

Diverted Drugs - Statute and General Questions

"Any occurrence in which drugs intended for use by patients or residents are diverted to use by other persons" Section 25-1-124 (2)(g) C.R.S.

One Element Needed:

- Deliberate

General Questions

Additional information is required for diverted drugs occurrences. When submitting a final report for this category, please provide the following information. If this information is not provided, the Division will contact the facility to obtain the information.

- Full name(s) of possible suspect(s)
- Professional license number(s) (if applicable)
- Name and form of drug(s) diverted
- Location where the diversion occurred
- Quantity of drug(s) diverted
- Police case number (if police notified)

What classification of drugs needs to be reported as an occurrence?

The statute does not exclude any classification of drugs. The element specifies a deliberate diversion, not a particular classification of drugs.

Should drug diversion occurrence reports be made upon discovery of the diversion or at the conclusion of the facility's investigation?

Drug diversion occurrence reports should be made when the licensed entity has enough information to believe that medication has been diverted deliberately.

How broadly/narrowly will the Division define when medication errors are reportable?

Medication errors are not reportable as diverted drugs. They may be reportable as another occurrence category, depending on the reason and outcome of the medication error.

If staff gives medication to person A that belongs to person B because the medication for person A is not available, is this reportable?

Yes, this is reportable. The staff member deliberately gave medication to a person for whom it was not ordered.

If a consumer alleged that their medical marijuana was diverted, is this reportable?

Diverted medical marijuana may be reportable. If the marijuana has been prescribed for consumer use, is diverted and the facility maintains responsibility for administering the medical marijuana, that instance is reportable as diverted drugs. If the marijuana is being used by the consumer for recreational use, it should not be reported as diverted drugs, but as misappropriation of property.

If a consumer alleges illicit drugs are stolen, is it reportable as diverted drugs?

This is not reportable as diverted drugs, but is reportable as misappropriation of property.

Are staff members allowed to borrow medication from consumers?

No, staff members are not allowed to borrow medication from consumers. If a medication is deliberately taken by anyone other than for whom it was intended, it should be reported as a diverted drug occurrence.

<u>Acute Care Facilities</u>

If a properly secured medication goes missing, is it reportable?

This may be reportable. The licensed entity must conduct an investigation to determine if the deliberate element is met.

<u>Home Care Agencies</u>

If a consumer self-medicates and their medication goes missing is it reportable?

This may be reportable. The statute does not specify whether the licensed entity is administering the medication, only that the drug is diverted deliberately. Missing medication from consumers who self-medicate may be a reportable occurrence to the Division if it was taken deliberately.

If a consumer accuses a family member of diverting drugs, is it reportable?

This situation is only reportable if the family member is an employee of the licensed entity.

<u>Residential Facilities</u>

If a consumer self-medicates and his or her medication goes missing is it reportable?

This can be reportable. The statute does not specify whether the health facility is administering the medication, only that the drug is diverted deliberately. Missing medication from consumers who self-medicate can be a reportable occurrence to the Division if it was taken deliberately.

If a staff member leaves medication accessible to consumers and consumer A takes medication prescribed for consumer B, is this reportable?

This may be reportable as a drug diversion. If consumer A is alert and oriented and deliberately took the medication it is reportable. If the consumer A is not alert or oriented the act is not deliberate and is not reportable as diverted drugs. This incident may be reportable as neglect due to the nurse leaving the medication accessible to consumers.

If a properly secured medication goes missing, is it reportable?

This may be reportable. The licensed entity must conduct an investigation to determine if the deliberate element is met.

Life-Threatening Complications of Anesthesia - Statutes and Common Questions

"Any occurrence that results in any of the following serious injuries to a patient or resident: Life-threatening complications of anesthesia…" Section 25-1-124-(2)(b)(II), C.R.S.

Two Elements Needed:

- Occurrence (event) as a result of anesthesia AND
- Life threatening complication/reaction

Event – Unexpected, unplanned action or avoidable action that results in serious injuries to patient or resident. Unexpected, unplanned or avoidable action is defined by community or professional standards of practice.

General Questions:

How does a licensed entity determine if a complication is life-threatening?

Licensed entity staff must make the decision based on complication or reaction. When in question, please contact the Occurrence Intake Coordinator.

Acute Care Facilities

No questions for this category.

Home Care Agencies

Can home care agencies report life-threatening complications of anesthesia?

Yes, home care agencies can report this type of occurrence. If a consumer has an event that is life threatening as a result of anesthesia while receiving services from the home care agency, it is reportable.

Residential Facilities

Can residential facilities report life-threatening complications of anesthesia?

Yes, residential facilities can report this type of occurrence. If a consumer has an event that is life threatening as a result of anesthesia while receiving services from the residential facility, it is reportable. If a consumer had a procedure performed at another facility and reacted to the anesthesia while under the supervision of the licensed entity, it would be reportable.

Life-Threatening Transfusion Errors or Reaction - Statute and General Questions

"Any occurrence that results in any of the following serious injuries to a patient or resident: ...life-threatening transfusion errors or reactions" Section 25-1-124 (2)(b)(II), C.R.S.

Two Elements Needed:

- Errors or reaction from transfusion of blood or blood products AND
- Life-threatening

General Questions

No general questions for this category.

Acute Care Facilities

How does a facility determine if an error or reaction is life-threatening?

Facility personnel must make the decision based on the outcome of the error or reaction. When in question, please contact the Occurrence Intake Coordinator.

Home Care Agencies

Can home care agencies report occurrences in this category?

Home care agencies can only report transfusion error occurrences if that event occurred by home care staff during working hours.

Residential Facilities

Can residential facilities report occurrences in this category?

Residential facilities can only report transfusion error occurrences if that event occurred in the residential facility. For many other occurrence types, the residential facility is responsible for the resident's care even if the resident is out of the facility. In this case, a transfusion would be in another licensed entity, most likely an acute care facility. The transfusion would then be the acute care facility's obligation to report.

Malfunction or Misuse of Equipment - Statute and General Questions

"Any occurrence involving the malfunction or intentional or accidental misuse of patient or resident care equipment that occurs during treatment or diagnosis of a patient or resident and that significantly adversely affects or if not averted would have significantly adversely affected a patient or resident of the facility." Section 25-1-124 (2)(h), C.R.S.

Three elements needed:

- Malfunction or intentional or unintentional misuse AND
- Significant adverse effects or potentially significant adverse effects AND
- Occurring during treatment or diagnosis

Malfunction – Failure to operate normally or as designed.

General Questions

Is the malfunction or misuse of one-time disposable equipment reportable?

Yes, this is reportable. The elements do not differentiate between reusable or one-time use types of equipment.

If equipment malfunctions, but a secondary piece of equipment is in place and functions appropriately, is this reportable?

No, this is not reportable. If the secondary piece of equipment functions appropriately then the potential for an adverse effect does not exist. All three elements must be present to report in this category.

Acute Care Facilities

If a piece of equipment is not used according to manufacturer's recommendations is this reportable?

Yes, this can be reportable. Equipment not used according to manufacturer's recommendation is considered misuse. If the other two elements are met then this is reportable.

Is using equipment past the expiration date reportable?

Yes, using expired equipment is reportable. Equipment is intended to be used prior to the expiration date, and using it after that date would be considered misuse.

Home Care Agencies

If a client is using a piece of equipment independently without staff presence and the equipment malfunctions or is misused, is this reportable.

This may be reportable. If the client is using personal equipment and it malfunctions or is misused, this is not reportable. However, if the client is using the agency's equipment and it malfunctions or is misused, it is reportable.

Residential Facilities

If a resident is using a piece of equipment independently without staff assistance and the equipment malfunctions or is misused, is this reportable?

Yes, this is reportable. The facility is responsible for the equipment in its facility, and is also responsible for determining if the resident is capable of using the equipment independently.

Misappropriation of Resident/Patient Property Statute and General Questions

"Any occurrence involving misappropriation of a patient's or resident's property. For purposes of this paragraph (f), 'Misappropriation of a patient's or resident's property' means a pattern of or deliberately misplacing, exploiting, or wrongfully using, either temporarily or permanently, a patient's or resident's belongings or money without the patient's or resident's consent." Section 25-1-124 (2)(f), C.R.S.

Two elements needed:

- Deliberate misplacing, exploiting or wrongful use of a patient's or resident's property

  OR

- A pattern of misplacing, exploiting or wrongful use of a patient's or resident's property

  AND

- Patient/resident consent not given

Consent – Permission for something to happen or to be done. Assent does not constitute consent if given by a person who is legally incompetent, or who, by reason of immaturity, mental disease or mental defect or intoxication, is manifestly unable to make a reasonable judgment as to the nature or harmfulness of the conduct or is given by a person whose consent is sought to be prevented by the law or is induced by force, duress, or deception." See generally: §18-1-505 C.R.S.

General Questions

Is there a minimum monetary value for items that have been misappropriated?

The occurrence statute does not specify a minimum monetary value for items that need to be reported as misappropriation; therefore all events of misappropriation are reportable.

If a staff member uses a consumer's property without permission and there is no financial loss, is it reportable?

Yes, this is reportable. Financial loss to the resident/patient is not necessary to make it reportable.

If a person alleges illicit drugs are stolen, is it reportable as misappropriation of property?

This may be reportable as misappropriation of property, not as diverted drugs. The licensed entity must decide if the illicit drugs were stolen or confiscated. If the facility confiscates the drugs as a safety issue, it may not be reportable.

If a consumer alleges misappropriation and accuses an employee that is no longer employed by the licensed provider, is this reportable?

This may be reportable. If the employee was employed by the licensed provider when the alleged theft occurred, it is reportable. If the alleged theft happened after the employee was no longer employed by the licensed provider, it is not reportable.

If a consumer alleges a staff member stole from him or her, but during the course of the investigation the item is found and the consumer recalls that he or she misplaced the item, is it reportable?

This may be reportable.

If the consumer finds the item or recants the allegation prior to the submission of the initial report, this event is not reportable. This situation would no longer meet the reporting elements.

If the consumer finds the item or recants the allegations after the submission of the initial report, this event is reportable and the licensed provider is responsible for submitting a final report. The Division would review the final report and determine reportability at that time.

Acute Care Facilities

No further questions for this facility type.

Home Care Agencies

If the consumer agrees to lend something to an employee and the employee does not return the property according to the original agreement, is this reportable?

Yes, this is reportable. While the client originally gave consent, that consent came with conditions of an arrangement. Once the employee failed to honor the arrangement, that consent is removed and makes the situation reportable as misappropriation.

If money is taken from the client's bank account by a family member, is it reportable?

No, this is not reportable through the occurrence program. The agency is not responsible for the client's family or their banking institution. The licenses entity should still report this issue to the police department.

Residential Facilities

If a resident borrows another resident's equipment, but that equipment is the property of the facility, is this reportable?

No, this is not reportable. The property is owned by the facility and is not the resident's property.

If money is taken from the resident's bank account by a family member, is it reportable?

Yes, this is reportable. Although the facility is not responsible for the banking institution or the family member, this misappropriation has the ability to affect the resident's care at the facility and is reportable.

Missing Persons - Statute and General Questions

"Any time that a resident or patient of the facility cannot be located following a search of the facility, the facility grounds, and the area surrounding the facility and there are circumstances that place the resident's health, safety or welfare at risk or, regardless of whether such circumstances exist, the patient or resident has been missing for eight hours." Section 25-1-124 (2)(c), C.R.S.

Element (only 1 needed):

- At risk and missing after search conducted

OR

- Missing more than eight hours, regardless of risk

At risk – A patient or resident of a facility who is susceptible to mistreatment, self-neglect, or exploitation because s/he is unable to perform or obtain services necessary for his or her health, safety, or welfare, or lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his or her person or affairs.

General Questions

If the licensed entity is not aware the consumer was missing, but is then notified of the consumer's absence, is this reportable?

Yes, this may be reportable. The fact that the licensed provider was not aware does not exclude the licensed provider from reporting, even if a search was not conducted. If the consumer is at risk this situation is reportable, even without a search. If the consumer is not at risk and the licensed provider is notified of the absence after more than 8 hours, this would be reportable.

Acute Care Facilities

If a patient leaves the hospital against medical advice (AMA) is this a reportable occurrence?

No, this is not reportable. The patient has announced an intention to leave and is therefore not a missing person.

Are all patients who leave a hospital emergency department reportable as missing persons?

No, not all people who leave the hospital emergency department are reportable as missing persons. For the purposes of occurrence reporting, a patient will only be considered a missing person if the patient has received a medical or psychiatric evaluation and a decision to admit has been made. If the patient leaves prior to the completion of the medical or psychiatric

evaluation, once it has begun, it is reportable. Patients who leave the emergency department prior to being seen by a physician are not reportable as missing persons.

If a patient presents to a facility on an involuntary commitment and leaves the facility, is that reportable?

Yes, that is reportable. If the patient is admitted to the facility and leaves prior to the commitment being released, that is reportable. If the hold has been lifted and the patient does not require any further medical treatment, it is not reportable at that time.

If an inpatient is scheduled to be discharged and leaves prior to completing the discharge, is it reportable?

Yes, this is reportable. For patients that have been admitted to an acute care facility, the discharge process must be completed. The intent to discharge a patient is not sufficient. If the patient expresses a desire to leave prior to discharge from the licensed provider, the patient must participate in the AMA process, otherwise it is reportable as a missing persons occurrence.

Home Care Agencies

No further information for this facility type.

Residential Facilities

If a resident expresses interest in leaving the facility, but does not sign out and cannot be found after a search, is it reportable?

Yes, this is reportable. Although the resident has expressed a desire to leave the facility, if their whereabouts cannot be verified, they are classified as a missing person at the end of the search.

Neglect - Statute and General Questions

"Any occurrence involving neglect of a patient or resident as described in Section 26-3.1-101 (2.3), C.R.S." Section 25-1-124(e) C.R.S.

One Element Needed:

- Failure to provide any care or services as provided above resulting in actual harm

  OR
- Staff member has a history in the past 12 months of similar neglect and had been counseled and/or re-educated

  OR
- Staff member intentionally failed to follow standard of practice and/or facility policy with significant potential for harm

Neglect Occurrence Reporting Guidance

C.R.S. Section 25-1-124(2)(e) states "Any occurrence involving caretaker neglect of a patient or resident, as described in section 26-3.1-101(2.3), C.R.S." is a reportable occurrence.

C.R.S Section 26-3.1-101(2.3)(a) describes neglect as follows: "'Caretaker neglect' means neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, or supervision is not secured for the **at-risk adult is not secured for an at-risk adult** 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, or a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for an at-risk adult.

Subsections (2.3)(b) and (c) specifically exempt actions undertaken or withheld pursuant to valid medical directives or orders or palliative plans of care from the definition of "caretaker neglect:"

(b) Notwithstanding the provisions of paragraph (a) of this subsection (2.3), the withholding, withdrawing, or refusing of any medication, any medical procedure or device, or any treatment, including but not limited to resuscitation, cardiac pacing, mechanical ventilation, dialysis, artificial nutrition and hydration, any medication or medical procedure or device, in accordance with any valid medical directive or order, or as described in a palliative plan of care, is not deemed caretaker neglect.

(c) As used in this subsection (2.3), "medical directive or order" includes a medical durable power of attorney, a declaration as to medical treatment executed pursuant to section 15-18-104, C.R.S., a medical order for scope of treatment form executed pursuant to article 18.7 of title 15, C.R.S., and a CPR directive executed pursuant to article 18.6 of title 15, C.R.S.

The statute further defines an "**at-risk adult**" as "an individual eighteen years of age or older who is susceptible to mistreatment or self-neglect because the individual is unable to perform or obtain services necessary for his or her health, safety, or welfare, or lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his or her person or affairs." (26-3.1-101(1.5), C.R.S)

In order for an incident to meet the requirement for reporting neglect, it must meet both the definition of neglect and the person involved must be an “at-risk adult” as defined in 26-3.1-101(1), C.R.S.

Adults who might meet the definition of an “at-risk adult” include:

- Adults with a developmental disability, traumatic brain injury, Alzheimer's, dementia, or other neurological or cognitive deficit
- Adults with a debilitating mental illness
- Frail or elderly persons who are no longer able to understand or make appropriate choices to manage their affairs
- Adults with a physically disability that limits their ability to perform activities of daily living

Adults who would not meet the definition of “at-risk adult” are those who normally are able to perform life tasks with little assistance and are normally able to make decisions about their own life choices. For example, a young working adult with no physical or cognitive disabilities undergoes surgery and an incident meeting the definition of neglect occurs while the person is under anesthesia. The incident would not be reportable as neglect because the patient did not meet the definition of an “at-risk adult.”

General Questions

If an allegation is investigated and not substantiated, is it still reportable as an occurrence?

Yes, it is the allegation of the event, not the outcome of the provider’s investigation, which makes it reportable.

If a staff member fails to provide care but it does not result in harm to the consumer, is it reportable as neglect?

If there is no harm to the consumer, most cases are not reportable. The only instances that are reportable without actual or significant potential for harm are cases where the staff member has a history of the action and has been counseled in the past.

If a staff member abandons or does not show up for a shift and it results in the neglect elements being met, is this reportable as neglect?

Yes, this is reportable.

Acute Care Facilities

If a medication is administered to the incorrect resident/patient, is it reportable as neglect?

This may be reportable as neglect. The licensed provider must make the determination if the medication error had a significant potential for harm to the patient and if the patient is an at-risk adult. For the purposes of neglect occurrence reporting, it is assumed that the staff member failed to follow standard of practice and/or facility policies when administering medications. If the staff member had a history of similar medication errors, this would be reportable regardless of the potential for harm to the resident/patient.

If a staff member unplugs a patient's call light and the patient is not injured when the unplugged call light is discovered, is this reportable as neglect?

This may be reportable as neglect. If the patient is an at-risk adult and unplugging the call light causes the potential for significant harm to the patient, it would be reportable. For example, if the patient has a history of falls, unplugging the call light would pose a significant potential for harm and be reportable. Also, if the staff member had a history of this behavior in the last 12 months, it would be reportable.

If a staff member falls asleep during a shift, is this reportable as neglect?

Yes, this is reportable. By falling asleep, the staff member failed to follow the standard of practice with significant potential for harm to the patients.

Home Care Agencies

If a staff member fails to secure a client during transportation, is this reportable as neglect?

Yes, this is reportable as neglect if the client is an at-risk adult. The staff member failed to follow standard of practice with significant potential for harm.

If a staff member falls asleep during a shift, is this reportable as neglect?

This may be reportable. If the staff member was instructed to stay awake during their shift, it is reportable as neglect. If the client's care plan designated that it was not mandatory for the staff member to stay awake, it may not be reportable as neglect. This situation would then depend on the staff member's history, as well as the potential for harm to the client.

Residential Facilities

If a medication is administered to the incorrect consumer, is it reportable as neglect?

This may be reportable as neglect. The licensed entity must make the determination if the medication error had a significant potential for harm to the resident and if the resident is an at-risk adult. Although the medication error may have been inadvertent by the staff member, it is assumed that the staff member intentionally committed this act by failing to use facility

safeguards when administering medications. If the staff member had a history of similar medication errors, this would be reportable regardless of the potential for harm to the resident.

If a staff member fails to secure a consumer during transportation, is this reportable as neglect?

Yes, this is reportable as neglect if the consumer is an at-risk adult. The staff member failed to follow standard of practice with significant potential for harm.

If a staff member unplugs a consumer's call light and the consumer is not injured when the unplugged call light is discovered, is this reportable as neglect?

This may be reportable as neglect. If the consumer is an at-risk adult and unplugging the call light causes the potential for significant harm to the consumer, it would be reportable. For example, if the consumer has a history of falls, unplugging the call light would pose a significant potential for harm and be reportable. Also, if the staff member had a history of this behavior in the last 12 months, it would be reportable.

If a staff member falls asleep during a shift, is this reportable as neglect?

Yes, this is reportable. By falling asleep the staff member failed to follow the standard of practice with significant potential for harm to the consumers.

Spinal Cord Injury - Statutes and Common Questions

"Any occurrence that results in any of the following serious injuries to a patient or resident: (I) ...or Spinal Cord Injuries.." Section 25-1-124 (2)(b)(I) C.R.S.

Any trauma to the central nervous system within the spinal column, including the cervical spine, thoracic spine, lumbar spine, and sacral nerves which causes: motor or sensory loss which may be permanent or temporary. (Division guideline)

3 Elements Needed:

- Result of occurrence (event) AND
- Functional loss consistent with spinal cord injury AND
- Permanent or temporary

Event – Unexpected, unplanned action or avoidable action that results in serious injuries to patient or resident. Unexpected, unplanned or avoidable action is defined by community or professional standards of practice.

General Questions

If a consumer has an injury as the result of an occurrence and tests show the consumer has an injury to the vertebrae, is this reportable?

No, this is not reportable. If the injury is to a vertebrae and not to the spinal cord, the incident is not reportable.

Acute Care Facilities

If a patient presents to the hospital with a spinal cord injury, is it reportable?

No, this is not reportable by the acute care facility. Only events that take place in the acute care facility are reportable. If the patient presents from the community, that spinal cord injury is not reportable. If the patient presents from another licensed care provider, it is the responsibility of the other licensed care provider to report the spinal cord injury occurrence.

Home Care Agencies

If a home care consumer sustains a spinal cord injury while the agency is not in the home, is it reportable.

No, it is not reportable by the home care agency. As with all types of occurrences, events that take place while the agency is not in the home are not reportable.

Residential Facilities

If a consumer sustains a spinal cord injury outside of the facility, is it reportable?

Yes, it is reportable. As with other types of occurrences, events that take place outside of the facility are reportable by the facility, even if the facility does not bear direct responsibility.

Occurrence Reporting Statute

25-1-124. Health care facilities - consumer information - reporting - release. (1) The general assembly hereby finds that an increasing number of people are faced with the difficult task of choosing a health care facility for themselves and their family members. This task may be made less difficult by improved access to reliable, helpful, and unbiased information concerning the quality of care and the safety of the environment offered by each healthcare facility. The general assembly further finds that it is appropriate that the department, in keeping with its role of protecting and improving the public health, solicit this information from health care facilities and disseminate it to the public in a form that will assist people in making informed choices among health care facilities.

(2) Each health care facility licensed pursuant to section 25-3-101 or certified pursuant to section 25-1.5-103 (1) (a) (II) shall report to the department all of the following occurrences:

(a) Any occurrence that results in the death of a patient or resident of the facility and is required to be reported to the coroner pursuant to section 30-10-606, C.R.S., as arising from an unexplained cause or under suspicious circumstances;

(b) Any occurrence that results in any of the following serious injuries to a patient or resident:

(I) Brain or spinal cord injuries;

(II) Life-threatening complications of anesthesia or life-threatening transfusion errors or reactions;

(III) Second- or third-degree burns involving twenty percent or more of the body surface area of an adult patient or resident or fifteen percent or more of the body surface area of a child patient or resident;

(c) Any time that a resident or patient of the facility cannot be located following a search of the facility, the facility grounds, and the area surrounding the facility and there are circumstances that place the resident's health, safety, or welfare at risk or, regardless of whether such circumstances exist, the patient or resident has been missing for eight hours;

(d) Any occurrence involving physical, sexual, or verbal abuse of a patient or resident, as described in section 18-3-202, 18-3-203, 18-3-204, 18-3-206, 18-3-402, 18-3-403, as it existed prior to July 1, 2000, 18-3-404, or 18-3-405, C.R.S., by another patient or resident, an employee of the facility, or a visitor to the facility;

(e) Any occurrence involving caretaker neglect of a patient or resident, as described in section 26-3.1-101 (2.3), C.R.S.;

(f) Any occurrence involving misappropriation of a patient's or resident's property. For purposes of this paragraph (f), "misappropriation of a patient's or resident's property" means a pattern of or deliberately misplacing, exploiting, or wrongfully using, either temporarily or permanently, a patient's or resident's belongings or money without the patient's or resident's consent.

(g) Any occurrence in which drugs intended for use by patients or residents are diverted to use by other persons. If the diverted drugs are injectable, the health care facility shall also report the full name and date of birth of any individual who diverted the injectable drugs, if known.

(h) Any occurrence involving the malfunction or intentional or accidental misuse of patient or resident care equipment that occurs during treatment or diagnosis of a patient or resident and that significantly adversely affects or if not averted would have significantly adversely affected a patient or resident of the facility.

(2.5) (a) In addition to the reports required by subsection (2) of this section, if the Colorado attorney general, the division for developmental disabilities in the department of human services, a community centered board, an adult protection service, or a law enforcement agency makes a report of an occurrence as described in subsection (2) of this section involving a licensed long-term care facility, that report shall be provided to the department and shall be made available for

inspection consistent with the provisions of subsection (6) of this section. Any reports concerning an adult protection service shall be in compliance with the confidentiality requirements of section 26-3.1-102 (7), C.R.S.

(b) For purposes of this subsection (2.5), a "licensed long-term care facility" means a licensed community residential or group home, a licensed intermediate care facility for individuals with intellectual disabilities, and a licensed facility for persons with developmental disabilities.

(3) The board by rule shall specify the manner, time period, and form in which the reports required pursuant to subsection (2) of this section shall be made.

(4) Any report submitted pursuant to subsection (2) of this section shall be strictly confidential; except that information in any such report may be transmitted to an appropriate regulatory agency having jurisdiction for disciplinary or license sanctions. The information in such reports shall not be made public upon subpoena, search warrant, discovery proceedings, or otherwise, except as provided in subsection (6) of this section.

(5) The department shall investigate each report submitted pursuant to subsection (2) of this section that it determines was appropriately submitted. For each report investigated, the department shall prepare a summary of its findings, including the department's conclusions and whether there was a violation of licensing standards or a deficiency or whether the facility acted appropriately in response to the occurrence. If the investigation is not conducted on site, the department shall specify in the summary how the investigation was conducted. Any investigation conducted pursuant to this subsection (5) shall be in addition to and not in lieu of any inspection required to be conducted pursuant to section 25-1.5-103 (1) (a) with regard to licensing.

(6) (a) The department shall make the following information available to the public:

(I) Any investigation summaries prepared pursuant to subsection (5) of this section;

(II) Any complaints against a health care facility that have been filed with the department and that the department has investigated, including the conclusions reached by the department and whether there was a violation of licensing standards or a deficiency or whether the facility acted appropriately in response to the subject of the complaint; and

(III) A listing of any deficiency citations issued against each healthcare facility.

(b) The information released pursuant to this subsection (6) shall not identify the patient or resident or the health care professional involved in the report.

(7) Prior to the completion of an investigation pursuant to this section, the department may respond to any inquiry regarding a report received pursuant to subsection (2) of this section by confirming that it has received such report and that an investigation is pending.

(8) In addition to the report to the department for an occurrence described in paragraph (d) of subsection (2) of this section, the occurrence shall be reported to a law enforcement agency.

Colorado Revised Statute Section 30-10-606

30-10-606. Coroner - inquiry - grounds - postmortem - jury - certificate of death.

(1) The responding law enforcement agency shall notify the coroner when a death is discovered or confirmed as soon as practicable after the scene is safe and secure. The coroner shall immediately notify the district attorney or his or her designee if by prior agreement, and then at his or her discretion proceed to the scene to view the body. Upon arrival of the coroner, law enforcement shall make all reasonable accommodations to allow the coroner to collect time-sensitive information such as body and scene temperature, lividity, and rigor. The coroner, in cooperation with law enforcement, shall make all proper inquiry in order to determine the cause and manner of death of any person in his or her jurisdiction who has died under any of the following circumstances:

(a) If the death is or may be unnatural as a result of external influences, violence, or injury;

(a.3) Due to the influence of or the result of intoxication by alcohol, drugs, or poison;

(a.5) As a result of an accident, including at the workplace;

(a.7) When the death of an infant or child is unexpected or unexplained;

(b) When no physician is in attendance or when, though in attendance, the physician is unable to certify the cause of death;

(c) From a death that occurs within twenty-four hours of admission to a hospital;

(d) Repealed.

(e) From a disease which may be hazardous or contagious or which may constitute a threat to the health of the general public;

(f) If the death occurs from the action of a peace officer or while in the custody of law enforcement officials or while incarcerated in a public institution;

(g) When the death was sudden and happened to a person who was in apparent good health;

(h) When a body is unidentifiable, decomposed, charred, or skeletonized; or

(i) Circumstances that the coroner otherwise determines may warrant further inquiry to determine cause and manner of death or further law enforcement investigation.

(1.1) The coroner shall request that jurisdiction of a death be transferred to the coroner of the county in which the event which resulted in the death of the person occurred, with the jurisdiction effective upon the acceptance by the receiving coroner. The transfer shall be in writing, and a copy thereof shall be maintained in the offices of the transferring and receiving coroners. The district attorney from each county involved in the transfer shall be contacted prior to the transfer unless prior agreements have been established.

(1.2) (a) When a person dies as a result of circumstances specified in subsection (1) of this section or is found dead and the cause of death is unknown, the person who discovers the death shall report it immediately to law enforcement officials or the coroner, and the coroner shall take legal custody of the body.

(b) The body of any person who dies as a result of circumstances specified in subsection (1) of this section shall not be removed from the place of death prior to the arrival of the coroner or his or her designee or without the authority of the coroner or his or her designee unless it is necessary to identify the victim, to protect the property from damage or destruction, or to preserve and protect evidence, or protect life, health, or safety. The coroner, in consultation with the district attorney or local law enforcement agency, shall facilitate the timely removal of the body to preserve and protect evidence. The coroner may order the removal of the body for further investigation or release the body to the next of kin if no further investigation is required by law enforcement.

(c) If a suicide note related to the death is found at the place of death, the coroner or law enforcement agency according to a prior agreement shall take custody of the note as well as any other documentation related to the cause or manner of death as is appropriate. If there is no prior agreement, law enforcement shall have the authority to take custody of the suicide note and shall provide a copy of the suicide note to the coroner. The coroner shall have the authority to view the suicide note prior to receiving a copy.

(d) In the case of a noncriminal investigation, the coroner in collaboration with local law enforcement shall identify the deceased, determine the deceased's next of kin, and notify the appropriate next of kin or other persons of the death.

(e) In the case of a noncriminal investigation, in order to assist with the identification of the deceased, location and identity of next of kin, and determination of the cause and manner of death, the coroner, in cooperation with law enforcement, has the authority to collect, examine, and store, or request law enforcement to collect, examine, and store, any documents, evidence, or information, including information available in electronic devices such as phones or computers subject to the limitations in the fourth amendment to the United States constitution and section 7 of article II of the Colorado constitution.

(f) When in the course of a coroner investigation, a death becomes suspicious or the possibility of criminal activity arises, the coroner shall immediately consult with the district attorney and law enforcement in the jurisdiction where the events that caused the death occurred.

(g) In the case of a noncriminal investigation, the coroner may take custody of prescription medications dispensed to the deceased to assist in determining the cause and manner of death subject to the limitations in the fourth amendment to the United States constitution and section 7 of article II of the Colorado constitution. The coroner shall properly document, store, and dispose of the medications or request law enforcement to document, store, and dispose of the medications.

(2) The coroner or his or her designee shall perform a forensic autopsy or have a forensic autopsy performed as required by section 30-10-606.5 or upon the request of the district attorney. Failure to comply with this section may be prosecuted as a violation of section 18-8-405, C.R.S.

(2.5) In the case of a noncriminal investigation, the coroner, in cooperation with the public administrator if applicable, may take appropriate measures to safeguard the property and its contents. The coroner may charge the costs of securing the premises against the estate of the deceased. A coroner who secures or safeguards the property and its contents is immune from civil liability for damage to or loss of the property or its contents.

(2.7) A coroner shall comply with information requests for statistical or research purposes from the department of public health and environment and the department of transportation.

(3) When the coroner has knowledge that any person has died under any of the circumstances specified in subsection (1) of this section, he may summon forthwith six citizens of the county to appear at a place named to hold an inquest to hear testimony and to make such inquiries as he deems appropriate.

(4) (a) In all cases where the coroner has held an investigation or inquest, the certificate of death shall be issued by the coroner.

(b) Any certificate of death issued by a coroner shall be filed with the registrar and shall state the findings concerning the nature of the disease or the manner of death, and, if from external causes, the certificate shall state the manner of death. In addition, the certificate shall include the information described in section 25-2-103 (3) (b), C.R.S., whenever the subject of the investigation or inquest is under one year of age.

(c) A copy of the certificate of death or affidavit of presumed death, including any related documents and statements of fact, shall be retained indefinitely in the applicable county in a secure location in an appropriate county facility accessible only to the county coroner or the coroner's designee and in a manner that is consistent with the county's record retention policy and federal law.

(5) Nothing in this section shall be construed to require an investigation, autopsy, or inquest in any case where death occurred without medical attendance solely because the deceased was under treatment by prayer or spiritual means alone in accordance with the tenets and practices of a well-recognized church or religious denomination.

(6) (a) Notwithstanding sections 12-43-218 and 13-90-107 (1) (d) or (1) (g), C.R.S., the coroner holding an inquest or investigation pursuant to this section has the authority to request and receive a copy of:

(I) Any autopsy report or medical information from any pathologist, physician, dentist, hospital, or healthcare provider or institution if such report or information is relevant to the inquest or investigation; and

(II) Any information, record, or report related to treatment, consultation, counseling, or therapy services from any licensed psychologist, professional counselor, marriage and family therapist, social worker, or addiction counselor, certified addiction counselor, registered psychotherapist, psychologist candidate registered pursuant to section 12-43-304 (7), C.R.S., marriage and family therapist candidate registered pursuant to section 12-43-504 (5), C.R.S., licensed professional counselor candidate registered pursuant to section 12-43-603 (5), C.R.S., or person described in

section 12-43-215, C.R.S., if the report, record, or information is relevant to the inquest or investigation.

(b) The coroner or his or her designee shall, at the request of the district attorney or attorney general, release to the district attorney or attorney general any autopsy report or medical information described in subparagraph (I) of paragraph (a) of this subsection (6) that the coroner obtains pursuant to paragraph (a) of this subsection (6).

(c) The coroner or his or her designee shall not release to any party any information, record, or report described in subparagraph (II) of paragraph (a) of this subsection (6) that the coroner obtains pursuant to paragraph (a) of this subsection (6).

(d) Any person who complies with a request from a coroner or his or her designee pursuant to paragraph (a) of this subsection (6) shall be immune from any civil or criminal liability that might otherwise be incurred or imposed with respect to the disclosure of confidential patient or client information.

Duty to Report Statutes

18-8-115. Duty to report a crime - liability for disclosure. It is the duty of every corporation or person who has reasonable grounds to believe that a crime has been committed to report promptly the suspected crime to law enforcement authorities. Notwithstanding any other provision of the law to the contrary, a corporation or person may disclose information concerning a suspected crime to other persons or corporations for the purpose of giving notice of the possibility that other such criminal conduct may be attempted which may affect the persons or corporations notified. When acting in good faith, such corporation or person shall be immune from any civil liability for such reporting or disclosure. This duty shall exist notwithstanding any other provision of the law to the contrary; except that this section shall not require disclosure of any communication privileged by law.

This section does not require the degree of certainty on the part of a citizen reporting the commission of a crime as does the probable cause standard that police officers are held to in making warrantless arrests. Lunsford v. Western States Life Ins., 919 P.2d 899 (Colo App. 1996).

12-36-135. Injuries to be reported - penalty for failure to report - immunity from liability. (1) (a) It shall be the duty of every licensee who attends or treats a bullet wound, a gunshot wound, a powder burn, or any other injury arising from the discharge of a firearm, or an injury caused by a knife, an ice pick, or any other sharp or pointed instrument that the licensee believes to have been intentionally inflicted upon a person, or an injury arising from a dog bite that the licensee believes was inflicted upon a person by a dangerous dog, as defined in section 18-9-204.5 (2) (b), C.R.S., or any other injury that the licensee has reason to believe involves a criminal act, including injuries resulting from domestic violence, to report the injury at once to the police of the city, town, or city and county or the sheriff of the county in which the licensee is located. Any licensee who fails to make a report as required by this section commits a class 2 petty offense, as defined by section 18-1.3-503, C.R.S., and, upon conviction thereof, shall be punished by a fine of not more than three hundred dollars, or by imprisonment in the county jail for not more than ninety days, or by both such fine and imprisonment.

(b) When a licensee performs a forensic medical examination that includes the collection of evidence at the request of a victim of sexual assault, not in connection with a referring or requesting law enforcement agency, and the licensee's employing medical facility knows where the crime occurred, the facility shall contact the law enforcement agency in whose jurisdiction the crime occurred regarding preservation of the evidence. If the medical facility does not know where

the crime occurred, the facility shall contact its local law enforcement agency regarding preservation of the evidence.

(1.5) As used in subsection (1) of this section, unless the context otherwise requires:

(a) "Domestic violence" means an act of violence upon a person with whom the actor is or has been involved in an intimate relationship. Domestic violence also includes any other crime against a person or any municipal ordinance violation against a person when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship.

(b) "Intimate relationship" means a relationship between spouses, former spouses, past or present unmarried couples, or persons who are both the parents of the same child regardless of whether the persons have been married or have lived together at any time.

(2) Any licensee who, in good faith, makes a report pursuant to subsection (1) of this section shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed with respect to the making of such report, and shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

(3) Any licensee who makes a report pursuant to subsection (1) of this section shall not be subject to the physician-patient relationship described in section 13-90-107 (1) (d), C.R.S., as to the medical examination and diagnosis. Such licensee may be examined as a witness, but not as to any statements made by the patient that are the subject matter of section 13-90-107 (1) (d), C.R.S.

18-6.5-108 Section 1 Mandatory Reports of Abuse and Exploitation of At-Risk Elders

(1) (a) On and after July 1, 2016, a person specified in paragraph (b) of this subsection (1) who observes the mistreatment of an at-risk elder or an at-risk adult with IDD, or who has reasonable cause to believe that an at-risk elder or an at-risk adult with IDD has been mistreated or is at imminent risk of mistreatment, shall report such fact to a law enforcement agency not more than twenty-four hours after making the observation or discovery.
(b) The following persons, whether paid or unpaid, shall report as required by subsection (1)(a) of this section:
(I) Any person providing health care or healthcare-related services, including general medical, surgical, or nursing services; medical, surgical, or nursing specialty services; dental services; vision services; pharmacy services; chiropractic services; naturopathic medical services; or physical, occupational, musical, or other therapies;
(II) Hospital and long-term care facility personnel engaged in the admission, care, or treatment of patients;
(III) First responders including emergency medical service providers, fire protection personnel, law enforcement officers, and persons employed by, contracting with, or volunteering with any law enforcement agency, including victim advocates;
(IV) Medical examiners and coroners;
(V) Code enforcement officers;
(VI) Veterinarians;
(VII) Psychologists, addiction counselors, professional counselors, marriage and family therapists, and registered psychotherapists, as those persons are defined in article 43 of title 12, C.R.S.;
(VIII) Social workers, as defined in part 4 of article 43 of title 12, C.R.S.;
(IX) Staff of community-centered boards;
(X) Staff, consultants, or independent contractors of service agencies as defined in section 25.5-10-202 (34), C.R.S.;
(XI) Staff or consultants for a licensed or unlicensed, certified or uncertified, care facility, agency, home, or governing board, including but not limited to long-term care facilities, home care agencies, or home health providers;
(XII) Staff of, or consultants for, a home care placement agency, as defined in section 25-27.5-102 (5), C.R.S.;

(XIII) Persons performing case management or assistant services for at-risk elders or at-risk adults with IDD;

(XIV) Staff of county departments of human or social services;

(XV) Staff of the state departments of human services, public health and environment, or health care policy and financing;

(XVI) Staff of senior congregate centers or senior research or outreach organizations;

(XVII) Staff, and staff of contracted providers, of area agencies on aging, except the long-term care ombudsmen;

(XVIII) Employees, contractors, and volunteers operating specialized transportation services for at-risk elders and at-risk adults with IDD;

(XIX) Court-appointed guardians and conservators;

(XX) Personnel at schools serving persons in preschool through twelfth grade;

(XXI) Clergy members; except that the reporting requirement described in paragraph (a) of this subsection (1) does not apply to a person who acquires reasonable cause to believe that an at-risk elder or an at-risk adult with IDD has been mistreated or has been exploited or is at imminent risk of mistreatment or exploitation during a communication about which the person may not be examined as a witness pursuant to section 13-90-107 (1) (c), C.R.S., unless the person also acquires such reasonable cause from a source other than such a communication; and

(XXII) (A) Personnel of banks, savings and loan associations, credit unions, and other lending or financial institutions who directly observe in person the mistreatment of an at-risk elder or who have reasonable cause to believe that an at-risk elder has been mistreated or is at imminent risk of mistreatment; and

(B) Personnel of banks, savings and loan associations, credit unions, and other lending or financial institutions who directly observe in person the mistreatment of an at-risk adult with IDD or who have reasonable cause to believe that an at-risk adult with IDD has been mistreated or is at imminent risk of mistreatment by reason of actual knowledge of facts or circumstances indicating the mistreatment.

(c) A person who willfully violates paragraph (a) of this subsection (1) commits a class 3 misdemeanor and shall be punished in accordance with section 18-1.3-501.

(d) Notwithstanding the provisions of paragraph (a) of this subsection (1), a person described in paragraph (b) of this subsection (1) is not required to report the mistreatment of an at-risk elder or an at-risk adult with IDD if the person knows that another person has already reported to a law enforcement agency the same mistreatment that would have been the basis of the person's own report.

(2) (a) A law enforcement agency that receives a report of mistreatment of an at-risk elder or an at-risk adult with IDD shall acquire, to the extent possible, the following information from the person making the report:

(I) The name, age, address, and contact information of the at-risk elder or at-risk adult with IDD;

(II) The name, age, address, and contact information of the person making the report;

(III) The name, age, address, and contact information of the caretaker of the at-risk elder or at-risk adult with IDD, if any;

(IV) The name of the alleged perpetrator;

(V) The nature and extent of any injury, whether physical or financial, to the at-risk elder or at-risk adult with IDD;

(VI) The nature and extent of the condition that required the report to be made; and

(VII) Any other pertinent information.

(b) Not more than twenty-four hours after receiving a report of mistreatment of an at-risk elder or an at-risk adult with IDD, a law enforcement agency shall provide the report to the county department for the county in which the at-risk elder or at-risk adult with IDD resides and the district attorney's office of the location where the mistreatment occurred.

(c) The law enforcement agency shall complete a criminal investigation when appropriate. The law enforcement agency shall provide a summary report of the investigation to the county department for the county in which the at-risk elder or at-risk adult with IDD resides and to the district attorney's office of the location where the mistreatment occurred.

(3) A person, including but not limited to a person specified in paragraph (b) of subsection (1) of this section, who reports mistreatment of an at-risk elder or an at-risk adult with IDD to a law enforcement agency pursuant to subsection (1) of this section is immune from suit and liability for damages in any civil action or criminal prosecution if the report was made in good faith; except that such a person is not immune if he or she is the alleged perpetrator of the mistreatment.

(4) A person, including but not limited to a person specified in paragraph (b) of subsection (1) of this section, who knowingly makes a false report of mistreatment of an at-risk elder or an at-risk adult with IDD to a law enforcement agency commits a class 3 misdemeanor and must be punished as provided in section 18-1.3-501 and is liable for damages proximately caused thereby.

(5) The reporting duty described in subsection (1) of this section does not create a civil duty of care or establishing a civil standard of care that is owed to an at-risk elder or an at-risk adult with IDD by a person specified in paragraph (b) of subsection (1) of this section.