Chapter HSS 132

NURSING HOMES

Note: Chapter H 32 as it existed on July 31, 1982 was repealed and a new chapter HSS 132 was created effective August 1, 1982.

Subchapter I — General

HSS 132.11 Statutory authority. This chapter is promulgated under the authority of s. 50.02, Stats., to provide conditions of licensure for nursing homes.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82.

HSS 132.12 Scope. All nursing homes licensed under s. 50.03, Stats., are subject to all the provisions of this chapter, except for those provisions that apply only to particular licensure categories, and except for those nursing homes regulated by ch. HSS 134. Nursing homes include those owned and operated by the state, counties, municipalities, or other public bodies.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82.

HSS 132.13 Definitions. In this chapter:

(1) "Abuse" means any single or repeated act of force, violence, harassment, deprivation, neglect or mental pressure which reasonably could cause physical pain or injury, or mental anguish or fear.

(2) "Ambulatory" means able to walk without assistance.

(3) "Department" means the Wisconsin department of health and social services.

(4) "Developmental disability" means mental retardation or a related condition, such as cerebral palsy, epilepsy or autism, but excluding mental illness and infirmities of aging, which is:

(a) Manifested before the individual reaches age 22;

(b) Likely to continue indefinitely; and

(c) Results in substantial functional limitations in 3 or more of the following areas of major life activity:

1. Self-care;

2. Understanding and use of language;

3. Learning;

4. Mobility;

5. Self-direction; and

6. Capacity for independent living.

(5) "Dietitian" means a person who either:

(a) Is eligible for registration as a dietitian by the commission on dietetic registration of the American dietetic association under its requirements in effect on January 17, 1982; or

(b) Has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management, and has one year of supervisory experience in the dietetic service of a health care institution.

(6) "Direct supervision" means supervision of an assistant by a supervisor who is present in the same building as the assistant while the assistant is performing the supervised function.

(7) "Facility" means a nursing home subject to the requirements of this chapter.

(8) "Full-time" means at least 37.5 hours each week devoted to facility business.

(8m) "IMD" or "institution for mental diseases" means a facility that meets the definition of an institution for mental diseases under 42 CFR 435.1009.

(9) "Intermediate care facility" means a nursing home which is licensed by the department as an intermediate care facility to provide intermediate nursing care.

(10) "Intermediate nursing care" means basic care consisting of physical, emotional, social and other rehabilitative services under periodic medical supervision. This nursing care requires the skill of a registered nurse for observation and recording of reactions and symptoms, and for supervision of nursing care. Most of the residents have long-term illnesses or disabilities which may have reached a relatively stable plateau. Other residents whose conditions are stabilized may need medical and

nursing services to maintain stability. Essential supportive consultant services are provided.

(11) "Licensed practical nurse" means a person licensed as a licensed practical nurse under ch. 441, Stats.

(12) "Limited nursing care" means simple nursing care procedures required by residents with long-term illnesses or disabilities in order to maintain stability and which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who works under the direction of a registered nurse. Supervision of the physical, emotional, social and rehabilitative needs of the resident is the responsibility of the appropriate health care provider serving under the direction of a physician.

(13) "Mobile nonambulatory" means unable to walk without assistance, but able to move from place to place with the use of a device such as a walker, crutches, a wheel chair or a wheeled platform.

(14) "Nonambulatory" means unable to walk without assistance.

(15) "Nonmobile" means unable to move from place to place.

(16) "Nurse" means a registered nurse or licensed practical nurse.

(17) "Nurse practitioner" means a registered professional nurse who meets the requirements of s. HSS 105.20 (2) (b).

(18) "Nursing assistant" means a person who is employed primarily to provide direct care services to residents but is not registered or licensed under ch. 441, Stats.

(19) "Personal care" means personal assistance, supervision and a suitable activities program. In addition:

(a) Provision is made for periodic medical supervision and other medical services as needed. These services are for individuals who do not need nursing care but do need the services provided by this type of facility in meeting their needs. Examples of these individuals are those referred from institutions for the developmentally disabled, those disabled from aging, and the chronically ill whose conditions have become stabilized;

(b) The services provided are chiefly characterized by the fact that they can be provided by personnel other than those trained in medical or allied fields. The services are directed toward personal assistance, supervision, and protection;

(c) The medical service emphasizes a preventive approach of periodic medical supervision by the resident's physician as part of a formal medical program that will provide required consultation services and also cover emergencies; and

(d) The dietary needs of residents are met by the provision of an adequate general diet or by therapeutic, medically prescribed diets.

(20) "Pharmacist" means a person registered as a pharmacist under ch. 450, Stats.

(21) "Physical therapist" means a person licensed to practice physical therapy under ch. 448, Stats.

(22) "Physician" means a person licensed to practice medicine or osteopathy under ch. 448, Stats.

(23) "Physician extender" means a person who is a physician's assistant or a nurse practitioner acting under the general supervision and direction of a physician.

(24) "Physician's assistant" means a person certified under ch. 448, Stats., to perform as a physician's assistant.

(25) "Practitioner" means a physician, dentist, podiatrist or other person permitted by Wisconsin law to distribute, dispense and administer a controlled substance in the course of professional practice.

(26) "Recuperative care" means care anticipated to be provided for a period of 90 days or less for a resident whose physician has certified that he or she is convalescing or recuperating from an illness or a medical treatment.

(27) "Registered nurse" means a person who holds a certificate of registration as a registered nurse under ch. 441, Stats.

(28) "Resident" means a person cared for or treated in any facility on a 24-hour basis irrespective of how the person has been admitted to the facility.

(29) "Respite care" means care anticipated to be provided for a period of 28 days or less for the purpose of temporarily relieving a family member or other caregiver from his or her daily caregiving duties.

(30) "Short-term care" means recuperative care or respite care.

(31) "Skilled nursing facility" means a nursing home which is licensed by the department to provide skilled nursing services.

(32) (a) "Skilled nursing services" means those services furnished pursuant to a physician's orders which:

1. Require the skills of professional personnel such as registered or licensed practical nurses; and

2. Are provided either directly by or under the supervision of these personnel.

(b) In determining whether a service is skilled, the following criteria shall be used:

1. The service would constitute a skilled service where the inherent complexity of a service prescribed for a resident is such that it can be safely and effectively performed only by or under the supervision of professional personnel;

2. The restoration potential of a resident is not the deciding factor in determining whether a service is to be considered skilled or unskilled. Even where full recovery or medical improvement is not possible, skilled care may be needed to prevent, to the extent possible, deterioration of the condition or to sustain current capacities; and

3. A service that is generally unskilled would be considered skilled where, because of special medical complications, its performance or su-

pervision or the observation of the resident necessitates the use of skilled nursing personnel.

(33) "Specialized consultation" means the provision of professional or technical advice, such as systems analysis, crisis resolution or inservice training, to assist the facility in maximizing service outcomes.

(34) "Supervision" means at least intermittent face-to-face contact between supervisor and assistant, with the supervisor instructing and overseeing the assistant, but does not require the continuous presence of the supervisor in the same building as the assistant.

(35) "Tour of duty" means a portion of the day during which a shift of resident care personnel are on duty.

(36) "Unit dose drug delivery system" means a system for the distribution of medications in which single doses of medications are individually packaged and sealed for distribution to residents.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; emerg. renum. (3) to (24) to be (4) to (25), cr. (3), eff. 9-15-86; r. and recr. Register, January, 1987, No. 373, eff. 2-1-87; emerg. cr. (8m), eff. 7-1-88; am. (4), Register, February, 1989, No. 398, eff. 3-1-89; cr. (8m), Register, October, 1989, No. 406, eff. 11-1-89.

HSS 132.14 Licensure. (1) CATEGORIES. Nursing homes shall elect one of the following categories of licensure:

(a) Skilled nursing facility; or

(b) Intermediate care facility.

(1m) LICENSURE AS AN INSTITUTION FOR MENTAL DISEASES.

(a) *Requirements.* The department may grant a facility a license to operate as an institution for mental diseases if the following conditions are met:

1. The conversion of all or some of the beds within the facility will result in a physically identifiable unit of the facility, which may be a ward, contiguous wards, a wing, a floor or a building, and which is separately staffed;

2. The IMD shall have a minimum of 16 beds;

3. The conversion of beds to or from an IMD shall not increase the total number of beds within the facility; and

4. The facility has submitted an application under subs. (2) and (3) to convert all or a portion of its beds to an IMD and the department has determined that the facility is in substantial compliance with this chapter. A facility may not submit an application for conversion of beds to or from an IMD more than 2 times a year.

(b) *Exclusion.* An existing facility applying to be licensed in whole or part as an IMD is not subject to prior review under ch. 150, Stats.

(2) APPLICATION. Application for a license shall be made on a form provided by the department.

Note: To obtain a copy of the application form for a license to operate a nursing home, write: Bureau of Quality Compliance, Division of Health, P.O. Box 309, Madison, Wisconsin 53701.

(3) REQUIREMENTS FOR LICENSURE. (a) In every application the license applicant shall provide the following information:

1. The identities of all persons or business entities having the authority, directly or indirectly, to direct or cause the direction of the management or policies of the facility;

2. The identities of all persons or business entities having any ownership interest whatsoever in the facility, whether direct or indirect, and whether the interest is in the profits, land or building, including owners of any business entity which owns any part of the land or building;

3. The identities of all creditors holding a security interest in the premises, whether land or building; and

4. In the case of a change of ownership, disclosure of any relationship or connection between the old licensee and the new licensee, and between any owner or operator of the old licensee and the owner or operator of the new licensee, whether direct or indirect.

(b) The applicant shall provide any additional information requested by the department during its review of the license application.

(c) The applicant shall submit evidence to establish that he or she has sufficient resources to permit operation of the facility for a period of 6 months.

(d) No license may be issued unless and until the applicant has supplied all information requested by the department.

(4) REVIEW OF APPLICATION. (a) *Investigation.* After receiving a complete application, the department shall investigate the applicant to determine if the applicant is fit and qualified to be a licensee and to determine if the applicant is able to comply with this chapter.

(b) *Fit and qualified.* In making its determination of the applicant's fitness, the department shall review the information contained in the application and shall review any other documents that appear to be relevant in making that determination, including survey and complaint investigation findings for each facility with which the applicant is affiliated or was affiliated during the past 5 years. The department shall consider at least the following:

1. Any class A or class B violation, as defined under s. 50.04, Stats., issued by the department relating to the applicant's operation of a residential or health care facility in Wisconsin;

2. Any adverse action against the applicant by the licensing agency of this state or any other state relating to the applicant's operation of a residential or health care facility. In this subdivision, "adverse action" means an action initiated by a state licensing agency which resulted in the denial, suspension or revocation of the license of a residential or health care facility operated by the applicant;

3. Any adverse action against the applicant based upon noncompliance with federal statutes or regulations in the applicant's operation of a residential or health care facility in this or any other state. In this subdivision, "adverse action" means an action by a state or federal agency which resulted in the denial, non-renewal, cancellation or termination of

certification of a residential or health care facility operated by the applicant;

4. The frequency of noncompliance with state licensure and federal certification laws in the applicant's operation of a residential or health care facility in this or any other state;

5. Any denial, suspension, enjoining or revocation of a license the applicant had as a health care provider as defined in s. 146.81 (1), Stats., or any conviction of the applicant for providing health care without a license;

6. Any conviction of the applicant for a crime involving neglect or abuse of patients or of the elderly or involving assaultive behavior or wanton disregard for the health or safety of others;

7. Any conviction of the applicant for a crime related to the delivery of health care services or items;

8. Any conviction of the applicant for a crime involving controlled substances;

9. Any knowing or intentional failure or refusal by the applicant to disclose required ownership information; and

10. Any prior financial failures of the applicant that resulted in bankruptcy or in the closing of an inpatient health care facility or the moving of its residents.

(5) ACTION BY THE DEPARTMENT. Within 60 days after receiving a complete application for a license, the department shall either approve the application and issue a license or deny the application. The department shall deny a license to any applicant who has a history, determined under sub. (4) (b) 1 to 4, of substantial noncompliance with federal or this state's or any state's nursing home requirements, or who fails under sub. (4) (b) 5 to 10, to qualify for a license. If the application for a license is denied, the department shall give the applicant reasons, in writing, for the denial and shall identify the process for appealing the denial.

(6) TYPES OF LICENSE. (a) *Probationary license.* If the applicant has not been previously licensed under this chapter or if the facility is not in operation at the time application is made, the department shall issue a probationary license. A probationary license shall be valid for 12 months from the date of issuance unless sooner suspended or revoked under s. 50.03 (5), Stats. If the applicant is found to be fit and qualified under sub. (4) and in substantial compliance with this chapter, the department shall issue a regular license upon expiration of the probationary license. The regular license shall be valid for a period of one year from the date of issuance unless sooner suspended or revoked.

(b) *Regular license.* If the applicant has been previously licensed, the department shall issue a regular license if the applicant is found to be in substantial compliance with this chapter. A regular license shall be valid for a period of one year from the date of issuance unless sooner suspended or revoked.

(7) SCOPE OF LICENSE. (a) The license is issued only for the permises and the persons named in the license applicaton, and may not be transferred or assigned by the licensee.

(b) The license shall state any applicable restrictions, including maximum bed capacity and the level of care that may be provided, and any other limitations that the department considers appropriate and necessary taking all facts and circumstances into account.

(c) A licensee shall fully comply with all requirements and restrictions of the license.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; cr. (5), Register, November, 1985, No. 359, eff. 12-1-85; r. and recr., Register, January, 1987, No. 373, eff. 2-1-87; emerg. cr. (1m), eff. 7-1-88; am. (3) (c), renum. (4) to (6) to be (5) to (7) and am. (5) and (6) (a), cr. (4), Register, February, 1989, No. 398, eff. 3-1-89; cr. (1m), Register, October, 1989, No. 406, eff. 11-1-89.

HSS 132.15 Certification for medical assistance. For requirements for certification under the medical assistance program, see ch. HSS 105.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82.

Subchapter II — Enforcement

HSS 132.21 Waivers and variances. (1) DEFINITIONS. As used in this section:

(a) "Waiver" means the grant of an exemption from a requirement of this chapter.

(b) "Variance" means the granting of an alternate requirement in place of a requirement of this chapter.

(2) REQUIREMENTS FOR WAIVERS OR VARIANCES. A waiver or variance may be granted if the department finds that the waiver or variance will not adversely affect the health, safety, or welfare of any resident and that:

(a) Strict enforcement of a requirement would result in unreasonable hardship on the facility or on a resident; or

(b) An alternative to a rule, including new concepts, methods, procedures, techniques, equipment, personnel qualifications, or the conducting of pilot projects, is in the interests of better care or management.

(3) PROCEDURES. (a) *Applications.* 1. All applications for waiver or variance from the requirements of this chapter shall be made in writing to the department, specifying the following:

a. The rule from which the waiver or variance is requested;

b. The time period for which the waiver or variance is requested;

c. If the request is for a variance, the specific alternative action which the facility proposes;

d. The reasons for the request; and

e. Justification that sub. (2) would be satisfied.

2. Requests for a waiver or variance may be made at any time.

3. The department may require additional information from the facility prior to acting on the request.

(b) *Grants and denials.* 1. The department shall grant or deny each request for waiver or variance in writing. Notice of denials shall contain

the reasons for denial. If a notice of denial is not issued within 60 days after the receipt of a complete request, the waiver or variance shall be automatically approved.

2. The terms of a requested variance may be modified upon agreement between the department and a facility.

3. The department may impose such conditions on the granting of a waiver or variance which it deems necessary.

4. The department may limit the duration of any waiver or variance.

(c) *Hearings.* 1. Denials of waivers or variances may be contested by requesting a hearing as provided by ch. 227, Stats.

2. The licensee shall sustain the burden of proving that the denial of a waiver or variance was unreasonable.

(d) *Revocation.* The department may revoke a waiver or variance if:

1. It is determined that the waiver or variance is adversely affecting the health, safety or welfare of the residents; or

2. The facility has failed to comply with the variance as granted; or

3. The licensee notifies the department in writing that it wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied; or

4. Required by a change in law.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (3) (a) 1. d., Register, January, 1987, No. 373, eff. 2-1-87.

Subchapter III — Residents' Rights and Protections

HSS 132.31 Rights of residents. (1) RESIDENTS' RIGHTS. Every resident shall, except as provided in sub. (3), have the right to:

(a) *Communications.* Have private and unrestricted communications with the resident's family, physician, attorney and any other person, unless medically contraindicated as documented by the resident's physician in the resident's medical record, except that communications with public officials or with the resident's attorney shall not be restricted in any event. The right to private and unrestricted communications shall include, but is not limited to, the right to:

1. Receive, send, and mail sealed, unopened correspondence. No resident's incoming or outgoing correspondence may be opened, delayed, held, or censored, except that a resident or guardian may direct in writing that specified incoming correspondence be opened, delayed, or held.

2. Use a telephone for private communications.

3. Have private visits, pursuant to a reasonable written visitation policy.

(b) *Grievances.* Present grievances on one's own behalf or through others to the facility's staff or administrator, to public officials or to any other person without justifiable fear of reprisal, and join with other residents or individuals within or outside of the facility to work for improvements in resident care.

(c) *Finances.* Manage one's own financial affairs, including any personal allowances under federal or state programs. No resident funds may be held or spent except in accordance with the following requirements:

1. A facility may not hold or spend a resident's funds unless the resident or another person legally responsible for the resident's funds authorizes this action in writing. The facility shall obtain separate authorizations for holding a resident's funds and for spending a resident's funds. The authorization for spending a resident's funds may include a spending limit. Expenditures that exceed the designated spending limit require a separate authorization for each individual occurrence;

2. Any resident funds held or controlled by the facility, and any earnings from them, shall be credited to the resident and may not be commingled with other funds or property except that of other residents;

3. The facility shall furnish a resident, the resident's guardian, or a representative designated by the resident with at least a quarterly statement of all funds and property held by the facility for the resident and all expenditures made from the resident's account, and a similar statement at the time of the resident's permanent discharge. If the resident has authorized discretionary expenditures by the facility and the facility has accepted responsibility for these expenditures, upon written request of the resident, the resident's guardian or a designated representative of the resident, the facility shall issue this statement monthly; and

4. The facility shall maintain a record of all expenditures, disbursements and deposits made on behalf of the resident.

(d) *Admission information.* Be fully informed in writing, prior to or at the time of admission, of all services and the charges for these services, and be informed in writing, during the resident's stay, of any changes in services available or in charges for services, as follows:

1. No person may be admitted to a facility without that person or that person's guardian or any other responsible person designated in writing by the resident signing an acknowledgement of having received a statement of information before or on the day of admission which contains at least the following information or, in the case of a person to be admitted for short-term care, the information required under s. HSS 132.70 (3):

a. An accurate description of the basic services provided by the facility, the rate charged for those services, and the method of payment for them;

b. Information about all additional services regularly offered but not included in the basic services. The facility shall provide information on where a statement of the fees charged for each of these services can be obtained. These additional services include pharmacy, x-ray, beautician and all other additional services regularly offered to residents or arranged for residents by the facility;

c. The method for notifying residents of a change in rates or fees;

d. Terms for refunding advance payments in case of transfer, death or voluntary or involuntary discharge;

e. Terms of holding and charging for a bed during a resident's temporary absence;

f. Conditions for involuntary discharge or transfer, including transfers within the facility;

g. Information about the availability of storage space for personal effects; and

h. A summary of residents' rights recognized and protected by this section and all facility policies and regulations governing resident conduct and responsibilities.

2. No statement of admission information may be in conflict with any part of this chapter.

(e) *Treatment.* Be treated with courtesy, respect, and full recognition of one's dignity and individuality by all employes of the facility and by all licensed, certified, and registered providers of health care and pharmacists with whom the resident comes in contact.

(f) *Privacy.* Have physical and emotional privacy in treatment, living arrangements, and in caring for personal needs, including, but not limited to:

1. Privacy for visits by spouse. If both spouses are residents of the same facility, they shall be permitted to share a room unless medically contraindicated as documented by the resident's physician in the resident's medical record.

Note: See s. HSS 132.84 (1) (a).

2. Privacy concerning health care. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Persons not directly involved in the resident's care shall require the resident's permission to authorize their presence.

3. Confidentiality of health and personal records, and the right to approve or refuse their release to any individual outside the facility, except in the case of the resident's transfer to another facility or as required by law or third-party payment contracts.

(g) *Work.* Not be required to perform work for the facility, but may work for the facility if:

1. The work is included for therapeutic purposes in the resident's plan of care; and

2. The work is ordered by the resident's physician and does not threaten the health, safety, or welfare of the resident or others.

(h) *Outside activities.* Meet with and participate in activities of social, religious, and community groups at the resident's discretion, unless medically contraindicated as documented by the resident's physician in the resident's medical record.

(i) *Personal possessions.* Retain and use personal clothing and effects and to retain, as space permits, other personal possessions in a reasonably secure manner.

(j) *Transfer or discharge.* Be transferred or discharged, and be given reasonable advance notice of any planned transfer or discharge and an explanation of the need for and alternatives to the transfer or discharge except when there is a medical emergency. The facility, agency, program

or person to which the resident is transferred shall have accepted the resident for transfer in advance of the transfer, except in a medical emergency.

Note: See s. HSS 132.53.

(k) *Abuse and restraints.* Be free from mental and physical abuse, and be free from chemical and physical restraints except as authorized in writing by a physician for a specified and limited period of time and documented in the resident's medical record. Physical restraints may be used in an emergency when necessary to protect the resident or another person from injury or to prevent physical harm to the resident or another person resulting from the destruction of property, provided that written authorization for continued use of the physical restraints is obtained from the physician within 12 hours. Any use of physical restraints shall be noted in the resident's medical record. "Physical restraint" means any article, device or garment used primarily to modify resident behavior by interfering with the free movement of the resident or normal functioning of a portion of the body, and which the resident is unable to remove easily, or confinement in a locked room, but does not include a mechanical support as defined under s. HSS 132.60 (6) (a) 2.

Note: See ss. HSS 132.33, 132.43, and 132.60 (6).

(l) *Care.* Receive adequate and appropriate care within the capacity of the facility.

(m) *Choice of provider.* Use the licensed, certified or registered provider of health care and pharmacist of the resident's choice.

(n) *Care planning.* Be fully informed of one's treatment and care and participate in the planning of that treatment and care.

(o) *Religious activity.* Participate in religious activities and services, and meet privately with clergy.

(p) *Nondiscriminatory treatment.* Be free from discrimination based on the source from which the facility's charges for the resident's care are paid, as follows:

1. No facility may assign a resident to a particular wing or other distinct area of the facility, whether for sleeping, dining or any other purpose, on the basis of the source or amount of payment, except that a facility only part of which is certified for Medicare reimbursement under 42 USC 1395 is not prohibited from assigning a resident to the certified part of the facility because the source of payment for the resident's care is Medicare.

2. Facilities shall offer and provide an identical package of basic services meeting the requirements of this chapter to all individuals regardless of the sources of a resident's payment or amount of payment. Facilities may offer enhancements of basic services, or enhancements of individual components of basic services, provided that these enhanced services are made available at an identical cost to all residents regardless of the source of a resident's payment. A facility which elects to offer enhancements to basic services to its residents must provide all residents with a detailed explanation of enhanced services and the additional charges for these services pursuant to par. (d) 1 b.

3. If a facility offers at extra charge additional services which are not covered by the medical assistance program under ss. 49.43 to 49.497, Stats., and chs. HSS 101 to 108, it shall provide them to any resident willing and able to pay for them, regardless of the source from which the resident pays the facility's charges.

4. No facility may require, offer or provide an identification tag for a resident or any other item which discloses the source from which the facility's charges for that resident's care are paid.

(2) INCOMPETENCE. If the resident is found incompetent by a court under ch. 880, Stats., and not restored to legal capacity, the rights and responsibilities established under this section which the resident is not competent to exercise shall devolve upon the resident's guardian.

(3) CORRECTIONS CLIENTS. Rights established under this section do not, except as determined by the department, apply to residents in a facility who are in the legal custody of the department for correctional purposes.

(4) NOTIFICATION. (a) *Serving notice.* Copies of the resident rights provided under this section and the facility's policies and regulations governing resident conduct and responsibilities shall be made available to each prospective resident and his or her guardian, if any, and to each member of the facility's staff. Facility staff shall verbally explain to each new resident and to that person's guardian, if any, prior to or at the time of the person's admission to the facility, these rights and the facility's policies and regulations governing resident conduct and responsibilities.

(b) *Amendments.* All amendments to the rights provided under this section and all amendments to the facility regulations and policies governing resident conduct and responsibilities require notification of each resident or guardian, if any, or any other responsible person designated in writing by the resident, at the time the amendment is put into effect. The facility shall provide the resident or guardian, if any, or any other responsible person designated in writing by the resident and each member of the facility's staff with a copy of all amendments.

(c) *Posting.* Copies of the residents' rights provided under this chapter and the facility's policies and regulations governing resident conduct and responsibilities shall be posted in a prominent place in the facility.

(5) ENCOURAGEMENT AND ASSISTANCE. Each facility shall encourage and assist residents to exercise their rights as residents and citizens and shall provide appropriate training for staff awareness so that staff are encouraged to respect the rights of residents established under this section.

(6) COMPLAINTS. (a) *Filing complaints.* Any person may file a complaint with a licensee or the department regarding the operation of a facility. Complaints may be made orally or in writing.

(b) *Reviewing complaints.* Each facility shall establish a system of reviewing complaints and allegations of violations of residents' rights established under this section. The facility shall designate a specific individual who, for the purpose of effectuating this section, shall report to the administrator.

(c) *Reporting complaints.* Allegations that residents' rights have been violated by persons licensed, certified or registered under chs. 441, 446 to 450, 455, and 456, Stats., shall be promptly reported by the facility to the appropriate licensing or examining board and to the person against whom the allegation has been made. Any employe of the facility and any person licensed, certified, or registered under chs. 441, 446 to 450, 455 or 456, Stats., may also report such allegations to the board.

(d) *Liability.* No person who files a report as required in par. (c) or who participates, in good faith, in the review system established under par. (b) shall be liable for civil damages for such acts, in accordance with s. 50.09 (6) (c), Stats.

(e) *Summary of complaints.* The facility shall attach a statement which summarizes complaints or allegations of violations of rights established under this section to an application for a new license or a renewal of its license. Such statement shall contain the date of the complaint or allegation, the names of the persons involved, the disposition of the matter, and the date of disposition. The department shall consider the statement in reviewing the application.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; r. and recr. (1) (c), (d), (j), (m), (2) to (4), renum. (5) to (6), cr. (1) (p) and (5), Register, January, 1987, No. 373, eff. 2-1-87; am. (1) (d) 1. intro., (k) and (4) (b), Register, February, 1989, No. 398, eff. 3-1-89.

HSS 132.32 Community organization access. (1) ACCESS. (a) In this section, "access" means the right to:

1. Enter any facility;

2. Seek a resident's agreement to communicate privately and without restriction with the resident;

3. Communicate privately and without restriction with any resident who does not object to communication; and

4. Inspect the health care and other records of a resident under ss. 146.81 through 146.83, Stats. Access does not include the right to examine the business records of the facility without the consent of the administrator or designee.

(b) Any employe, agent, or designated representative of a community legal services program or community service organization who meets the requirements of sub. (2) shall be permitted access to any facility whenever visitors are permitted by the written visitation policy referred to in s. HSS 132.31 (1) (a) 3., but not before 8:00 a.m., nor after 9:00 p.m.

(2) CONDITIONS. (a) The employe, agent, or designated representative shall, upon request of the facility's administrator or administrator's designee, present valid and current identification signed by the principal officer of the agency, program, or organization represented, and evidence of compliance with par. (b).

(b) Access shall be granted for visits which are consistent with an express purpose of an organization which is currently registered with the state board on aging and long term care or purpose of which is to:

1. Visit, talk with, or offer personal, social, and legal services to any resident, or obtain information from the resident about the facility and its operations;

2. Inform residents of their rights and entitlements and their corresponding obligations under federal and state law, by means of educational materials and discussions in groups or with individual residents;

3. Assist any resident in asserting legal rights regarding claims for public assistance, medical assistance and social security benefits, and in all other matters in which a resident may be aggrieved; or

4. Engage in any other method of advising and representing residents so as to assure them full enjoyment of their rights.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82.

HSS 132.33 Housing residents in locked units. (1) DEFINITIONS. As used in this section:

(a) "Locked unit" means a ward, wing or room which is designated as a protective environment and is secured in a manner that prevents a resident from leaving the unit at will. A physical restraint applied to the body is not a locked unit. A facility locked for purposes of security is not a locked unit, provided that residents may exit at will.

(b) "Consent" means a written, signed request given without duress by a resident capable of understanding the nature of the locked unit, the circumstances of one's condition, and the meaning of the consent to be given.

(2) RESTRICTION. Except as otherwise provided by this section, no resident may be housed in a locked unit. Physical or chemical restraints or repeated use of emergency restraint under sub. (5) may not be used to circumvent this restriction. Placement in a locked unit shall be based on the determination that this placement is the least restrictive environment consistent with the needs of the person.

Note: For requirements relating to the use of physical and chemical restraints, including locked rooms, see s. HSS 132.60 (6).

(3) PLACEMENT. (a) A resident may be housed in a locked unit under any one of the following conditions:

1. The resident consents under sub. (4) to being housed on a locked unit;

2. The court that protectively placed the resident under s. 55.06, Stats., made a specific finding of the need for a locked unit;

3. The resident has been transferred to a locked unit pursuant to s. 55.06 (9) (c), Stats., and the medical record contains documentation of the notice provided to the guardian, the court and the agency designated under s. 55.02, Stats; or

4. In an emergency governed by sub. (5).

(b) A facility may transfer a resident from a locked unit to an unlocked unit without court approval pursuant to s. 55.06 (9) (b), Stats., if it determines that the needs of the resident can be met on an unlocked unit. Notice of the transfer shall be provided as required under s. 55.06 (9) (b), Stats., and shall be documented in the resident's medical record.

(4) CONSENT. (a) A resident may give consent to reside in a locked unit.

(b) The consent of par. (a) shall be effective only for 90 days from the date of the consent, unless revoked pursuant to par. (c). Consent may be renewed for 90-day periods pursuant to this subsection.

(c) The consent of par. (a) may be revoked by the resident at any time. The resident shall be transferred to an unlocked unit promptly following revocation.

(5) EMERGENCIES. In an emergency, a resident may be confined in a locked unit if necessary to protect the resident or others from injury or to protect property, provided the facility immediately attempts to notify the physician for instructions. A physician's order for the confinement must be obtained within 12 hours. No resident may be confined for more than an additional 72 hours under order of the physician.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (1)(a) and (2), r. and recr. (3), Register, January, 1987, No. 373, eff. 2-1-87.

Subchapter IV — Management

HSS 132.41 Administrator. (1) STATUTORY REFERENCE. Section 50.04 (2), Stats., requires that a nursing home be supervised by an administrator licensed under ch. 456, Stats. Supervision shall include, but not be limited to, taking all reasonable steps to provide qualified personnel to assure the health, safety, and rights of the residents.

(2) FULL-TIME ADMINISTRATOR. Every nursing home shall be supervised full-time by an administrator licensed under ch. 456, Stats., except:

(a) *Multiple facilities.* If more than one nursing home or other licensed health care facility is located on the same or contiguous property, one full-time administrator may serve all the facilities;

(b) *Small homes.* A facility licensed for 50 beds or less shall employ an administrator for at least 4 hours per day on each of 5 days per week. No such administrator shall be employed in more than 2 nursing homes or other health care facilities.

(3) ABSENCE OF ADMINISTRATOR. A person present in and competent to supervise the facility shall be designated to be in charge whenever there is not an administrator in the facility, and shall be identified to all staff.

(4) CHANGE OF ADMINISTRATOR. (a) *Termination of administrator.* Except as provided in par. (b), no administrator shall be terminated unless recruitment procedures are begun immediately.

(b) *Replacement of administrator.* If it is necessary immediately to terminate an administrator, or if the licensee loses an administrator for other reasons, a replacement shall be employed or designated as soon as possible within 120 days of the vacancy.

(c) *Temporary replacement.* During any vacancy in the position of administrator, the licensee shall employ or designate a person competent to fulfill the functions of an administrator.

(d) *Notice of change of administrator.* When the licensee loses an administrator, the licensee shall notify the department within 2 working days of loss and provide written notification to the department of the name and qualifications of the person in charge of the facility during the va-

cancy and the name and qualifications of the replacement administrator, when known.

Note: See s. 50.04 (2), Stats.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82.

HSS 132.42 Employes. (1) DEFINITION. In this section, "employe" means anyone directly employed by the facility on other than a consulting or contractual basis.

(2) QUALIFICATIONS AND RESTRICTIONS. No person under 16 years of age shall be employed to provide direct care to residents. An employe less than 18 years of age who provides direct care to residents must work under the direct supervision of a nurse.

(3) PHYSICAL HEALTH CERTIFICATIONS. (a) *New employes.* Every employe shall be certified in writing by a physician or physician extender as having been screened for tuberculosis infection and being free from clinically apparent communicable disease within 90 days before beginning work.

(b) *Continuing employes.* Employes shall be retested for tuberculosis infection based on the prevalence of tuberculosis in the community and the likelihood of exposure to tuberculosis in the facility.

(c) *Non-employes.* Persons who reside in the facility but are not residents or employes, such as relatives of the facility's owners, shall obtain physician certifications as required of employes.

(4) DISEASE SURVEILLANCE AND CONTROL. Facilities shall develop and implement written policies for control of communicable diseases which ensure that employes and volunteers with symptoms or signs of communicable disease or infected skin lesions are not permitted to work unless authorized to do so by a physician or physician extender.

(5) VOLUNTEERS. Facilities may use volunteers provided that the volunteers receive the orientation and supervision necessary to assure resident health, safety, and welfare.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (3) (a) and (4), Register, January, 1987, No. 373, eff. 2-1-87.

HSS 132.43 Abuse of residents. (1) CONSIDERATE CARE AND TREATMENT. Residents shall receive considerate care and treatment at all times consistent with s. 50.09 (1) (e), Stats.

(2) RESIDENT ABUSE. No one may abuse a resident.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82.

HSS 132.44 Employe development. (1) NEW EMPLOYES. (a) *Orientation for all employes.* Except in an emergency, before performing any duties, each new employe, including temporary help, shall receive appropriate orientation to the facility and its policies, including, but not limited to, policies relating to fire prevention, accident prevention, and emergency procedures. All employes shall be oriented to residents' rights under s. HSS 132.31 and to their position and duties by the time they have worked 30 days.

(b) *Training.* Except for nurses, all employes who provide direct care to residents shall be trained through:

1. A training program given by a registered nurse;

2. A program offered by a hospital or health agency;

3. A course of study in a vocational school;

4. The American Red Cross course for nursing assistants in nursing homes; or

5. A program approved by the department.

(c) *Assignments.* Employes shall be assigned only to resident care duties consistent with their training.

(2) CONTINUING EDUCATION. (a) *Nursing inservice.* The facility shall require employes who provide direct care to residents to attend educational programs designed to develop and improve the skill and knowledge of the employes with respect to the needs of the facility's residents, including rehabilitative therapy, oral health care, and special programming for developmentally disabled residents if the facility admits developmentally disabled persons. These programs shall be conducted as often as is necessary to enable staff to acquire the skills and techniques necessary to implement the individual program plans for each resident under their care.

(b) *Dietary inservice.* Educational programs shall be held periodically for dietary staff, and shall include instruction in the proper handling of food, personal hygiene and grooming, and nutrition and modified diet patterns served by the facility.

(3) MEDICATION ADMINISTRATION. Before persons, other than nurses and practitioners, are authorized under s. HSS 132.60 (5) (d) 1. to administer medications, they shall be trained in a course approved by the department.

Note: For recordkeeping requirements for all orientation and inservice programs, see s. HSS 132.45 (6) (f).

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; r. and recr. (2) (a) and am. (4), Register, January, 1987, No. 373, eff. 2-1-87.

HSS 132.45 Records. (1) GENERAL. The administrator or administrator's designee shall provide the department with any information required to document compliance with HSS 132 and ch. 50, Stats., and shall provide reasonable means for examining records and gathering the information.

(2) PERSONNEL RECORDS. A separate record of each employe shall be maintained, be kept current, and contain sufficient information to support assignment to the employe's current position and duties.

(3) MEDICAL RECORDS — STAFF. (a) *Timeliness.* Duties relating to medical records shall be completed in a timely manner.

(b) *Skilled care facilities.* 1. Each skilled care facility shall designate a full-time employe of the facility as the person responsible for the medical record service, who:

a. Is a graduate of a school of medical record science that is accredited jointly by the council on medical education of the American medical association and the American medical record association; or

b. Receives regular consultation as appropriate from a person qualified under subd. 1.a. Such consultation shall not be substituted for the routine duties of staff maintaining records.

2. The records consultant under subd. 1.b. shall evaluate the records and records service, identify problem areas, and submit written recommendations for change to the administrator.

(c) *Intermediate care facilities.* In an intermediate care facility, an employe shall be assigned responsibility for maintaining, completing, and preserving medical records.

(4) MEDICAL RECORDS — GENERAL. (a) *Availability of records.* Medical records of current residents shall be stored in the facility and shall be easily accessible, at all times, to persons authorized to provide care and treatment. Medical records of both current and past residents shall be readily available to persons designated by statute or authorized by the resident to obtain the release of the medical records.

(b) *Organization.* The facility shall maintain a systematically organized records system appropriate to the nature and size of the facility for the collection and release of resident information.

(c) *Unit record.* A unit record shall be maintained for each resident and day care client.

(d) *Indexes.* 1. A master resident index shall be maintained.

2. A disease index shall be maintained which indexes medical records at least by final diagnosis.

(e) *Maintenance.* The facility shall safeguard medical records against loss, destruction, or unauthorized use, and shall provide adequate space and equipment to efficiently review, index, file, and promptly retrieve the medical records.

(f) *Retention and destruction.* 1. The medical record shall be completed and stored within 60 days following a resident's discharge or death.

2. An original medical record and legible copy or copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of this resident shall be retained for a period of at least 5 years following a resident's discharge or death. All other records required by this chapter shall be retained for a period of at least 2 years.

3. Medical records no longer required to be retained under subd. 2. may be destroyed, provided:

a. The confidentiality of the information is maintained; and

b. The facility permanently retains at least identification of the resident, final diagnosis, physician, and dates of admission and discharge. This may be achieved by way of the indexes required by par. (d).

4. A facility shall arrange for the storage and safekeeping of records for the periods and under the conditions required by this paragraph in the event the facility closes.

5. If the ownership of a facility changes, the medical records and indexes shall remain with the facility.

(g) *Records documentation.* 1. All entries in medical records shall be legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.

2. A rubber stamp reproduction of a person's signature may be used instead of a handwritten signature, if:

a. The stamp is used only by the person whose signature the stamp replicates; and

b. The facility possesses a statement signed by the person, certifying that only that person shall possess and use the stamp.

3. Symbols and abbreviations may be used in medical records if approved by a written facility policy which defines the symbols and abbreviations and which controls their use.

(5) MEDICAL RECORDS — CONTENT. Except for persons admitted for short-term care, to whom s. HSS 132.70 (7) applies, each resident's medical record shall contain:

(a) *Identification and summary sheet.*

(b) *Physician's documentation.* 1. An admission medical evaluation by a physician or physician extender, including:

a. A summary of prior treatment;

b. Current medical findings;

c. Diagnoses at the time of admission to the facility;

d. The resident's rehabilitation potential;

e. The results of the physical examination required by s. HSS 132.52 (3); and

f. Level of care;

2. All physician's orders including, when applicable, orders concerning:

a. Admission to the facility as required by s. HSS 132.52 (2) (a);

b. Medications and treatments as specified by s. HSS 132.60 (5);

c. Diets as required by s. HSS 132.63 (4);

d. Rehabilitative services as required by s. HSS 132.64 (2);

e. Limitations on activities;

f. Restraint orders as required by s. HSS 132.60 (6); and

g. Discharge or transfer as required by s. HSS 132.53;

3. Physician progress notes following each visit as required by s. HSS 132.61 (2) (b) 6;

4. Annual physical examination, if required; and

5. Alternate visit schedule, and justification for such alternate visits as described in s. HSS 132.61 (2) (b).

(c) *Nursing service documentation.* 1. A history and assessment of the resident's nursing needs as required by s. HSS 132.52 (5);

2. Initial care plan as required by s. HSS 132.52 (4), and the care plan required by s. HSS 132.60 (8);

3. Nursing notes are required as follows:

a. For residents requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least weekly; and

b. For residents not requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least every other week;

4. In addition to subds. 1., 2., and 3., nursing documentation describing:

a. The general physical and mental condition of the resident, including any unusual symptoms or actions;

b. All incidents or accidents including time, place, details of incident or accident, action taken, and follow-up care;

c. The administration of all medications (see s. HSS 132.60 (5) (d)), the need for PRN medications and the resident's response, refusal to take medication, omission of medications, errors in the administration of medications, and drug reactions;

d. Food and fluid intake, when the monitoring of intake is necessary;

e. Any unusual occurrences of appetite or refusal or reluctance to accept diets;

f. Summary of restorative nursing measures which are provided;

g. Summary of the use of physical and chemical restraints as required by s. HSS 132.60 (6) (g);

h. Other non-routine nursing care given;

i. The condition of a resident upon discharge; and

j. The time of death, the physician called, and the person to whom the body was released.

(d) *Social service records.* 1. A social history of the resident as required by s. HSS 132.52 (6); and

2. Notes regarding pertinent social data and action taken.

(e) *Activities records.* Documentation of activities programming, a history and assessment as required by s. HSS 132.52 (6), a summary of attendance, and quarterly progress notes.

(f) *Rehabilitative services.* 1. An evaluation of the rehabilitative needs of the resident; and

2. Progress notes detailing treatment given, evaluation, and progress.

(g) *Dietary assessment.* Record of the dietary assessment required by s. HSS 132.52 (6).

(h) *Dental services.* Records of all dental services.

(i) *Diagnostic services.* Records of all diagnostic tests performed during the resident's stay in the facility.

(j) *Plan of care.* Plan of care required by s. HSS 132.60 (8).

(k) *Authorization or consent.* A photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident and any resident consent form required under this chapter, except that if the authorization or consent form exceeds one page in length an accurate summary may be substituted in the resident record and the complete authorization or consent form shall in this case be maintained as required under sub. (6) (i). The summary shall include:

1. The name and address of the guardian or other person having authority to speak or act on behalf of the resident;

2. The date on which the authorization or consent takes effect and the date on which it expires;

3. The express legal nature of the authorization or consent and any limitations on it; and

4. Any other factors reasonably necessary to clarify the scope and extent of the authorization or consent.

(l) *Discharge or transfer information.* Documents, prepared upon a resident's discharge or transfer from the facility, summarizing, when appropriate:

1. Current medical findings and condition;

2. Final diagnoses;

3. Rehabilitation potential;

4. A summary of the course of treatment;

5. Nursing and dietary information;

6. Ambulation status;

7. Administrative and social information; and

8. Needed continued care and instructions.

(6) OTHER RECORDS. The facility shall retain:

(a) *Dietary records.* All menus and therapeutic diets;

(b) *Staffing records.* Records of staff work schedules and time worked;

(c) *Safety tests.* Records of tests of fire detection, alarm, and extinguishment equipment;

(d) *Resident census.* At least a weekly census of all residents, indicating numbers of residents requiring each level of care;

(e) *Professional consultations.* Documentation of professional consultations by:

1. A dietitian, if required by s. HSS 132.63 (2) (b);

2. A registered nurse, if required by s. HSS 132.62 (2) (d); and

3. Others, as may be used by the facility;

(f) *Inservice and orientation programs.* Subject matter, instructors and attendance records of all inservice and orientation programs;

(g) *Transfer agreements.* Transfer agreements, unless exempt under s. HSS 132.53 (4);

(h) *Funds and property statement.* The statement prepared upon a resident's discharge or transfer from the facility that accounts for all funds and property held by the facility for the resident, as required under s. HSS 132.31 (1) (c) 3; and

(i) *Court orders and consent forms.* Copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of the resident.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (1) (3) (c) (5) (intro.), (b) 1. intro. and e., 2. a. and d., 3., (c) 1. and 2., (d) 1., (e), (f) 1. and (g), (6) (g), renum. (4) (a) to (e), (5) (e) and (6) (h) to be (4) (c) to (g), (5) (l) and (6) (i) and am. (5) (l), cr. (4) (a) and (b), (5) (e) and (6) (h), Register, January, 1987, No. 373, eff. 2-1-87.

Subchapter V — Admissions, Retentions and Removals

HSS 132.51 Limitations on admissions and programs. (1) LICENSE LIMITATIONS. (a) *Bed capacity.* No facility may house more residents than the maximum bed capacity for which it is licensed. Persons participating in a day care program are not residents for purposes of this chapter.

(b) *Care levels.* 1. No person who requires care greater than that which the facility is licensed to provide may be admitted to or retained in the facility.

2. No resident whose condition changes to require care greater than that which the facility is licensed to provide shall be retained.

(c) *Other conditions.* The facility shall comply with all other conditions of the license.

(2) OTHER LIMITATIONS ON ADMISSIONS. (a) *Persons requiring unavailable services.* Persons who require services which the facility does not provide or make available shall not be admitted or retained.

(b) *Communicable diseases.* 1. Restriction. No person suspected of having a disease in a communicable state shall be admitted, unless the facility has the means to manage the condition as provided by subd. 2.

2. Isolation techniques. Persons suspected of having a disease in a communicable state shall be managed substantially according to *Guideline for Isolation Precautions in Hospitals* and *Guideline for Infection Control in Hospital Personnel* and *Universal Precautions for Prevention of Blood borne Pathogens in Health Care Settings*, published by the U.S. department of health and human services, public health services, centers for disease control.

3. Reportable diseases. Suspected diseases reportable by law shall be reported to the local public health agency or the division of health, bureau of community health and prevention, as provided by ch. HSS 145.

Note: For a copy of ch. HSS 145 which includes a list of the communicable diseases which must be reported, write the Bureau of Community Health and Prevention, P.O. Box 309, Madison, WI 53701 (phone 608-267-9003). There is no charge for a copy of ch. HSS 145. The referenced publications, "Guideline for Isolation Precautions in Hospitals and Guideline for Infection Control in Hospital Personnel" (HSS Publication No. (CSC) 83-8314) and "Universal Precautions for Prevention of . . . Bloodborne Pathogens in Health Care Settings", may be purchased from the Superintendant of Documents, Washington D.C. 20402, and is available for review in the office of the Department's Bureau of Quality Compliance, the Office of the Secretary of State, and the Office of the Revisor of Statutes.

(c) *Destructive residents.* Residents who are known to be destructive of property, self-destructive, disturbing or abusive to other residents, or suicidal, shall not be admitted or retained, unless the facility has and uses sufficient resources to appropriately manage and care for them.

(d) *Developmental disabilities.* 1. No person who has a developmental disability may be admitted to a facility unless the facility is certified as an intermediate care facility for the mentally retarded, except that a person who has a developmental disability and who requires skilled nursing care services may be admitted to a skilled nursing facilty.

2. Except in an emergency, no person who has a developmental disability may be admitted to a facility unless the county department under s. 46.23, 51.42 or 51.437 Stats., of the individual's county of residence has recommended the admission.

(e) *Mental illness.* Except in an emergency, no person who is under age 65 and has a mental illness as defined in s. 51.01 (13) may be admitted to a facility unless the county department under s. 46.23, 51.42 or 51.437, Stats., of the individual's county of residence has recommended the admission.

(f) *Minors.* 1. No person under the age of 18 years may be admitted, unless approved for admission by the department.

2. Requests for approval to admit a person under the age of 18 years shall be made in writing and shall include:

a. A statement from the referring physician stating the medical, nursing, rehabilitation, and special services required by the minor;

b. A statement from the administrator certifying that the required services can be provided;

c. A statement from the attending physician certifying that the physician will be providing medical care; and

d. A statement from the persons or agencies assuming financial responsibility.

(g) *Admissions 7 days a week.* No facility may refuse to admit new residents solely because of the day of the week.

(3) DAY CARE SERVICES. A facility may provide day care services to persons not housed by the facility, provided that:

(a) Day care services do not interfere with the services for residents;

(b) Each day care client is served upon the certification by a physician or physician's assistant that the client is free from tuberculosis infection; and

(c) Provision is made to enable day care clients to rest. Beds need not be provided for this purpose, and beds assigned to residents may not be provided for this purpose.

Note: For administration of medications to day care clients, see s. HSS 132.60 (5) (d) 6.; for required records, see s. HSS 132.45 (4) (c).

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; emerg. r. and recr. (2) (d) and (3), eff. 9-15-86; r. and recr. (2) (d) am. (1) (b) 1., (2) (e) 1. and 2. intro., (3) (a) and (b), (4) (c), Register, January, 1987, No. 373, eff. 2-1-87; am. (2) (b) 2. and 3. (d) 2., r. (2) (d) 3. and (3), renum. (2) (e), (f) and (4) to be (2) (f), (g) and (3), cr. (2) (e), Register, February, 1989, No. 398, eff. 3-1-89.

HSS 132.52 Procedures for admission. (1) APPLICABILITY. The procedures in this section apply to all persons admitted to facilities except persons admitted for short-term care. Section HSS 132.70 (2) applies to persons admitted for short-term care.

(2) PHYSICIAN'S ORDERS. No person may be admitted as a resident except upon:

(a) Order of a physician;

(b) Receipt of information from a physician, before or on the day of admission, about the person's current medical condition and diagnosis, and receipt of a physician's initial plan of care and orders from a physician for immediate care of the resident; and

(c) Receipt of certification in writing from a physician that the person is free of communicable tuberculosis and clinically apparent communicable disease, or an order for procedures to treat any disease the person may be found to have.

(3) MEDICAL EXAMINATION AND EVALUATION. (a) *Examination.* Each resident shall have a physical examination by a physician or physician extender within 48 hours following admission unless an examination was performed within 15 days before admission.

(b) *Evaluation.* Within 48 hours after admission the physician or physician extender shall complete the resident's medical history and physical examination record.

Note: For admission of residents with communicable disease, see s. HSS 132.51 (2) (b).

(4) INITIAL CARE PLAN. Upon admission, a plan of care for nursing services shall be prepared and implemented, pending development of the plan of care required by s. HSS 132.60 (8).

(5) RESIDENT HISTORY AND ASSESSMENT. Within 72 hours of a resident's admission, a registered nurse shall supervise the preparation of a written history and assessment summarizing the resident's prior health care, patterns of activities of daily living, needs, capabilities, and disabilities.

(6) SPECIALTY ASSESSMENTS. Within 2 weeks following admission, each service discipline appropriate to the resident's care, but in all cases dietetics, activities, and social services, shall prepare a history and assessment of the resident's prior health and care in the respective discipline.

Note: For care planning requirements, see s. HSS 132.60 (8).

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; renum. (1) to (5) to be (2) to (6) and am. (2) and (3), cr. (1), Register, January, 1987, No. 373, eff. 2-1-87.

HSS 132.53 Transfers and discharges. (1) SCOPE. This section shall apply to all resident transfers and discharges, except that in the event of conflict with s. 49.45 (6c) (c) and (d), 49.498 (4) or 50.03 (5m) or (14), Stats., the relevant statutory requirement shall apply.

(2) CONDITIONS. (a) *Prohibition and exceptions.* No resident may be discharged or transferred from a facility, except:

1. Upon the request or with the informed consent of the resident or guardian;

2. For nonpayment of charges, following reasonable opportunity to pay any deficiency;

3. If the resident requires care other than that which the facility is licensed to provide;

4. If the resident requires care which the facility does not provide and is not required to provide under this chapter;

5. For medical reasons as ordered by a physician;

6. In case of a medical emergency or disaster;

7. If the health, safety or welfare of the resident or other residents is endangered, as documented in the resident's clinical record;

8. If the resident does not need nursing home care;

9. If the short-term care period for which the resident was admitted has expired; or

10. As otherwise permitted by law.

(b) *Alternate placement.* 1. Except for transfers or discharges under par. (a) 2 and 6, no resident may be involuntarily transferred or discharged unless an alternative placement is arranged for the resident pursuant to s. HSS 132.31 (1) (j).

2. No resident may be involuntarily transferred or discharged under par. (a) 2 for nonpayment of charges if the resident meets both of the following conditions:

a. He or she is in need of ongoing care and treatment and has not been accepted for ongoing care and treatment by another facility or through community support services; and

b. The funding of the resident's care in the nursing home under s. 49.45 (6m), Stats., is reduced or terminated because either the resident requires a level or type of care which is not provided by the nursing home or the nursing home is found to be an institution for mental diseases as defined under 42 CFR 435.1009.

(3) PROCEDURES. (a) *Notice.* The facility shall provide a resident, the resident's physician and, if known, an immediate family member or legal counsel, guardian, relative or other responsible person at least 30 days notice of transfer or discharge under sub. (2) (a) 2 to 10, and the reasons for the transfer or discharge, unless the continued presence of the resident endangers the health, safety or welfare of the resident or other residents. The notice shall also contain the name, address and telephone number of the board on aging and long-term care. For a resident with

developmental disability or mental illness, the notice shall contain the mailing address and telephone number of the protection and advocacy agency designated under s. 51.62 (2) (a), Stats.

(b) *Planning conference.* 1. Unless circumstances posing a danger to the health, safety or welfare of a resident require otherwise, at least 7 days before the planning conference required by subd. 2., the resident, guardian, if any, any appropriate county agency, and others designated by the resident, including the resident's physician, shall be given a notice containing the time and place of the conference, a statement informing the resident that any persons of the resident's choice may attend the conference, and the procedure for submitting a complaint to the department.

2. Unless the resident is receiving respite care or unless precluded by circumstances posing a danger to the health, safety, or welfare of a resident, prior to any involuntary transfer or discharge under sub. (2) (a) 2 to 10, a planning conference shall be held at least 14 days before transfer or discharge with the resident, guardian, if any, any appropriate county agency, and others designated by the resident, including the resident's physician, to review the need for relocation, assess the effect of relocation on the resident, discuss alternative placements and develop a relocation plan which includes at least those activities listed in subd. 3.

3. Transfer and discharge activities shall include:

a. Counseling regarding the impending transfer or discharge;

b. The opportunity for the resident to make at least one visit to the potential alternative placement, if any, including a meeting with that facility's admissions staff, unless medically contraindicated or waived by the resident;

c. Assistance in moving the resident and the resident's belongings and funds to the new facility or quarters; and

d. Provisions for needed medications and treatments during relocation.

4. A resident who is transferred or discharged at the resident's request shall be advised of the assistance required by subd. 3. and shall be provided with that assistance upon request.

(c) *Records.* Upon transfer or discharge of a resident, the documents required by s. HSS 132.45 (5) (l) and (6) (h) shall be prepared and provided to the facility admitting the resident, along with any other information about the resident needed by the admitting facility.

(4) TRANSFER AGREEMENTS. (a) *Requirement.* Each facility shall have in effect a transfer agreement with one or more hospitals under which inpatient hospital care or other hospital services are available promptly to the facility's residents when needed. Each intermediate care facility shall also have in effect a transfer agreement with one or more skilled care facilities.

(b) *Transfer of residents.* A hospital and a facility shall be considered to have a transfer agreement in effect if there is a written agreement between them or, when the 2 institutions are under common control, if there is a written statement by the person or body which controls them, which gives reasonable assurance that:

1. Transfer of residents will take place between the hospital and the facility ensuring timely admission, whenever such transfer is medically appropriate as determined by the attending physician; and

2. There shall be interchange of medical and other information necessary for the care and treatment of individuals transferred between the institutions, or for determining whether such individuals can be adequately cared for somewhere other than in either of the institutions.

(c) *Exemption.* A facility which does not have a resident transfer agreement in effect, but which is found by the department to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of residents and the information referred to in par. (b) 2., shall be considered to have such an agreement in effect if and for so long as the department finds that to do so is in the public interest and essential to ensuring skilled nursing facility services in the community.

(d) *Notice requirements.* 1. Before a resident of a facility is transferred to a hospital or for therapeutic leave, the facility shall provide written information to the resident and an immediate family member or legal counsel concerning the provisions of the approved state medicaid plan about the period of time, if any, during which the resident is permitted to return and resume residence in the nursing facility.

2. At the time of a resident's transfer to a hospital or for therapeutic leave, the facility shall provide written notice to the resident and an immediate family member or legal counsel of the duration of the period, if any, specified under subd. 1.

Note: The "approved state medicaid plan" referred to s. 49.498 (4) (d) 1a, Stats., and subd. 1 states that the department shall have a bedhold policy. The bedhold policy is found in s. HSS 107.09 (4) (j).

(5) BEDHOLD. (a) *Bedhold.* A resident who is on leave or temporarily discharged, as to a hospital for surgery or treatment, and has expressed an intention to return to the facility under the terms of the admission statement for bedhold, shall not be denied readmission unless, at the time readmission is requested, a condition of sub. (2) (b) has been satisfied.

(b) *Limitation.* The facility shall hold a resident's bed under par. (a) until the resident returns, until the resident waives his or her right to have the bed held, or up to 15 days following the temporary leave or discharge, whichever is earlier.

Note: See s. HSS 107.09 (4) (j) for medical assistance bedhold rules.

(6) APPEALS ON TRANSFERS AND DISCHARGES. (a) *Right to appeal.* 1. A resident may appeal an involuntary transfer or discharge decision.

2. Every facility shall post in a prominent place a notice that a resident has a right to appeal a transfer or discharge decision. The notice shall explain how to appeal that decision and shall contain the address and telephone number of the nearest bureau of quality compliance regional office. The notice shall also contain the name, address and telephone number of the state board on aging and long-term care or, if the resident is developmentally disabled or has a mental illness, the mailing address and telephone number of the protection and advocacy agency designated under s. 51.62 (2) (a), Stats.

3. A copy of the notice of a resident's right to appeal a transfer or discharge decision shall be placed in each resident's admission folder.

4. Every notice of transfer or discharge under sub. (3) (a) to a resident, relative, guardian or other responsible party shall include a notice of the resident's right to appeal that decision.

(b) *Appeal procedures.* 1. If a resident wishes to appeal a transfer or discharge decision, the resident shall send a letter to the nearest regional office of the department's bureau of quality compliance within 7 days after receiving a notice of transfer or discharge from the facility, with a copy to the facility administrator, asking for a review of the decision.

2. The resident's written appeal shall indicate why the transfer or discharge should not take place.

3. Within 5 days after receiving a copy of the resident's written appeal, the facility shall provide written justification to the department's bureau of quality compliance for the transfer or discharge of the resident from the facility.

4. If the resident files a written appeal within 7 days after receiving notice of transfer or of discharge from the facility, the resident may not be transferred or discharged from the facility until the department's bureau of quality compliance has completed its review of the decision and notified both the resident and the facility of its decision.

5. The department's bureau of quality compliance shall complete its review of the facility's decision and notify both the resident and the facility in writing of its decision within 14 days after receiving written justification for the transfer or discharge of the resident from the facility.

6. A resident or a facility may appeal the decision of the department's bureau of quality compliance in writing to the department's office of administrative hearings within 5 days after receipt of the decision.

Note: The mailing address of the Department's Office of Administrative Hearings is P.O. Box 7875, Madison, Wisconsin 53707.

7. The appeal procedures in this paragraph do not apply if the continued presence of the resident poses a danger to the health, safety or welfare of the resident or other residents.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; cr. (2) (b) 8. and 9., am. (2) (c), (3) (b) 2. and (c), Register, January, 1987, No. 373, eff. 2-1-87; renum. (2) (c) to be (2) (c) 1. and am., cr. (2) (c) 2., Register, February, 1989, No. 398, eff. 3-1-89; am. (2) (c) 2.b., Register, October, 1989, No. 406, eff. 11-1-89; r. and recr. (1) to (3), cr. (4) (d) and (6), Register, June, 1991, No. 426, eff. 7-1-91.

HSS 132.54 Transfer within the facility. Prior to any transfer of a resident between rooms or beds within a facility, the resident or guardian, if any, and any other person designated by the resident shall be given reasonable notice and an explanation of the reasons for transfer. Transfer of a resident between rooms or beds within a facility may be made only for medical reasons or for the resident's welfare or the welfare of other residents or as permitted under s. HSS 132.31 (1) (p) 1.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. Register, January, 1987, No. 373, eff. 2-1-87.

Subchapter VI — Services

HSS 132.60 Resident care. (1) INDIVIDUAL CARE. Unless it is in conflict with the plan of care, each resident shall receive care based upon individual needs.

(a) *Hygiene.* 1. Each resident shall be kept comfortably clean and well-groomed.

2. Beds shall be made daily, with a complete change of linen to be provided as often as necessary, but at least once each week.

3. Residents shall have clean clothing as needed to present a neat appearance and to be free of odors. Residents who are not bedfast shall be dressed each day, in their own clothing if available, as appropriate to their activities, preferences, and comforts.

(b) *Decubiti prevention.* Nursing personnel shall employ appropriate nursing management techniques to promote the maintenance of skin integrity and to prevent development of decubiti (bedsores). These techniques may include periodic position change, massage therapy and regular monitoring of skin integrity.

(c) *Basic nursing care.* 1. Nursing care initiated in the hospital shall be continued immediately upon admission to the nursing home unless ordered otherwise by the admitting physician.

2. Nursing personnel shall provide care designed to maintain current functioning and to improve the resident's ability to carry out activities of daily living, including assistance with maintaining good body alignment and proper positioning to prevent deformities.

3. Each resident shall be encouraged to be up and out of bed as much as possible, unless otherwise ordered by a physician.

4. Any significant changes in the condition of any resident shall be reported to the nurse in charge or on call, who shall take appropriate action including the notice provided for in sub. (3).

(d) *Rehabilitative measures.* Residents shall be assisted in carrying out rehabilitative measures initiated by a rehabilitative therapist or ordered by a physician, including assistance with adjusting to any disabilities and using any prosthetic devices.

(e) *Tuberculosis retesting.* Residents shall be retested for tuberculosis infection based on the prevalence of tuberculosis in the community and the likelihood of exposure to tuberculosis in the facility.

Note: See s. HSS 132.60 (5) (a) 1. for treatments and orders.

(2) NOURISHMENT. (a) *Diets.* Residents shall be served diets as prescribed.

(b) *Adaptive devices.* Adaptive self-help devices, including dentures if available, shall be provided to residents, and residents shall be trained in their use to contribute to independence in eating.

(c) *Assistance.* Residents who require assistance with food or fluid intake shall be helped as necessary.

(d) *Food and fluid intake and diet acceptance.* A resident's food and fluid intake and acceptance of diet shall be observed, and significant deviations from normal eating patterns shall be reported to the nurse and either the resident's physician or dietitian as appropriate.

Note: For other dietary requirements, see s. HSS 132.63.

(3) NOTIFICATION OF CHANGES IN CONDITION OR STATUS OF RESIDENT. (a) *Changes in condition.* A resident's physician, guardian, if any, and any other responsible person designated in writing by the resident or guardian to be notified shall be notified promptly of any significant accident, injury, or adverse change in the resident's condition.

(b) *Changes in status.* A resident's guardian and any other person designated in writing by the resident or guardian shall be notified promptly of any significant non-medical change in the resident's status, including financial situation, any plan to discharge the resident, or any plan to transfer the resident within the facility or to another facility.

Note: For responses to changes in medical condition, see s. HSS 132.60 (1) (c) 4; for records, see s. HSS 132.45 (5) (c) 4.

(4) EMERGENCIES. In case of a medical emergency, the facility shall provide or arrange for appropriate emergency services.

(5) TREATMENT AND ORDERS. (a) *Orders.* 1. Restriction. Medications, treatments and rehabilitative therapies shall be administered as ordered by a physician or dentist subject to the resident's right to refuse them. No medication, treatment or changes in medication or treatment may be administered to a resident without a physician's or dentist's written order which shall be filed in the resident's clinical record, except as provided in subd. 2.

2. Oral orders. Oral orders from physicians or dentists may be accepted by a nurse or pharmacist, or, in the case of oral orders for rehabilitative therapy, by a therapist. Oral orders shall be immediately written, signed and dated by the nurse, pharmacist or therapist on a physician's or dentist's order sheet, and shall be countersigned by the physician or dentist within 72 hours and filed in the resident's clinical record within 10 days of the order.

3. Oral orders without nurses. If the facility does not have nurse coverage, an oral order for medications shall be telephoned to a registered pharmacist by the physician or dentist. The nursing home may not administer the medication until it has received a transcript of the oral order from the pharmacist. The order shall be countersigned and filed as required under subd. 2.

4. Review of medications. Each resident's medication shall be reviewed by a registered nurse at the time of the review of the plan of care.

(b) *Stop orders.* 1. Compliance with stop order policies. Medications not specifically limited as to time or number of doses when ordered shall be automatically stopped in accordance with the stop order policy required by s. HSS 132.65 (3) (a) 3. b.

2. Notice to physicians or dentists. Each resident's attending physician or dentist shall be notified of stop order policies and contacted promptly for renewal of orders which are subject to automatic termination.

(c) *Release of medications to residents.* Medications shall be released to residents who are on leave or have been discharged only on order of the physician or dentist.

(d) *Administration of medications.* 1. Personnel who may administer medications. In a nursing home, medication may be administered only by a nurse, a practitioner, as defined in s. 450.07 (1) (d), Stats., or a person who has completed training in a drug administration course approved by the department.

2. Responsibility for administration. Policies and procedures designed to provide safe and accurate administration of medications shall be developed by the facility and shall be followed by personnel assigned to prepare and administer medications and to record their administration. The same person shall prepare, administer, and immediately record in the resident's clinical record the administration of medications, except when a single unit dose package distribution system is used.

3. Omitted doses in unit dose system. If, for any reason, a medication is not administered as ordered in a unit dose system, an "unadministered dose slip" with an explanation of the omission shall be placed in the resident's medication container and a notation shall be made in the clinical record.

4. Self-administration. Self-administration of medications by residents shall be permitted on order of the resident's physician or dentist or in a predischarge program under the supervision of a registered nurse or designee.

5. Errors and reactions. Medication errors and suspected or apparent drug reactions shall be reported to the nurse in charge or on call as soon as discovered and and an entry made in the resident's clinical record. The nurse shall take appropriate action.

6. Day care. The handling and administration of medications for day care clients shall comply with the requirements of this subsection.

(e) *Reference sources.* Up-to-date medication reference texts and sources of information shall be available to the nurse in charge or on call.

Note: See s. HSS 132.65, pharmaceutical services, for additional requirements.

(6) PHYSICAL AND CHEMICAL RESTRAINTS. (a) *Definitions.* As used in this subsection, the following definitions apply:

1. "Physical restraint" means any article, device or garment used primarily to modify resident behavior by interfering with the free movement of the resident or normal functioning of a portion of the body, and which the resident is unable to remove easily, or confinement in a locked room, but does not include a mechanical support.

Note: For rules governing locked units, see s. HSS 132.33.

2. "Mechanical support" means any article, device, or garment which is used only to achieve the proper position or balance of the resident, which may include but is not limited to a geri chair, posey belt, jacket, or a bedside rail.

3. "Chemical restraint" means a medication used primarily to modify behavior by interfering with the resident's freedom of movement or mental alertness.

(b) *Orders required.* Physical or chemical restraints shall be applied or administered only on the written order of a physician which shall indicate the resident's name, the reason for restraint, and the period during which the restraint is to be applied.

(c) *Emergencies.* A physical restraint may be applied temporarily without an order if necessary to protect the resident or another person from injury or to prevent physical harm to the resident or another person resulting from the destruction of property, provided that the physician is notified immediately and authorization for continued use is obtained from the physician within 12 hours.

(d) *Restriction.* If the mobility of a resident is required to be restrained and can be appropriately restrained either by a physical or chemical restraint or by a locked unit, the provisions of s. HSS 132.33 shall apply.

(e) *Type of restraints.* Physical restraints shall be of a type which can be removed promptly in an emergency, and shall be the least restrictive type appropriate to the resident.

(f) *Periodic care.* Nursing personnel shall check a physically restrained resident as necesary, but at least every 2 hours, to see that the resident's personal needs are met and to change the resident's position.

(g) *Records.* Any use of restraints shall be noted, dated, and signed in the resident's clinical record on each tour of duty during which the restraints are in use.

Note: See s. HSS 132.45 (5) (c) 4. g., records.

(7) USE OF OXYGEN. (a) *Orders for oxygen.* Except in an emergency, oxygen shall be administered only on order of a physician.

(b) *Person administering.* Oxygen shall be administered to residents only by a capable person trained in its administration and use.

(c) *Signs.* "No smoking" signs shall be posted in the room and at the entrance of the room in which oxygen is in use.

(d) *Flammable goods.* Prior to administering oxygen, all matches and other smoking material shall be removed from the room.

(8) RESIDENT CARE PLANNING. (a) *Development and content of care plans.* Except in the case of a person admitted for short-term care, within 4 weeks following admission a written care plan shall be developed, based on the resident's history and assessments from all appropriate disciplines and the physician's evaluation and orders, as required by s. HSS 132.52, which shall include:

1. Realistic goals, with specific time limits for attainment; and

2. The methods for delivering needed care, and indication of which professional disciplines are responsible for delivering the care.

Note: For requirements upon admission, see s. HSS 132.52. For requirements for short-term care residents, see s. HSS 132.70 (2).

(b) *Evaluations and updates.* The care of each resident shall be reviewed by each of the services involved in the resident's care and the care plan evaluated and updated as needed.

Note: For concurrent review of medications, see sub. (5) (a) 4.

(c) *Implementation.* The care plans shall be substantially followed.

(d) *Assessment instrument.* A resident's care plan shall be developed based on the facility's assessment required under s. 49.498 (2) (c), Stats., of the resident. The assessment shall be conducted by the facility using a form approved by the department which is based on a minimum data set specified under 42 USC 1395i-3 (f) (6) (A). The form shall cover resident identifying information; background information about the resident, including current payment sources, responsible party if not the resident, and any advance directives; the resident's diagnosis, condition and body control, cognitive patterns, hearing, vision, dental status, need for help to perform activities of daily living, continence, recent use of appliances, devices or programs, potential for rehabilitation, skin condition, psychological well-being, mood and behavior patterns, activities, medications use, and any special treatment or procedures the person is receiving such as chemotherapy.

Note: For copies of the resident assessment form, write to the Bureau of Quality Compliance, Division of Health, P.O. Box 309, Madison, WI 53701.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; r. and recr. (5) (d) 1., Register, February, 1983, No. 326, eff. 3-1-83; am. (1) (d), (2) (d), (3) (5) (a) 1. to 3., (6) (c) and (8) (a), r. and recr. (1) (b) and (6) (f), Register, January, 1987, No. 373, eff. 2-1-87; am. (6) (a) 1. Register, February, 1989, No. 398, eff. 3-1-89; cr. (8) (d), Register, November, 1990, No. 419, eff. 12-1-90.

HSS 132.61 Medical services. (1) MEDICAL DIRECTION IN SKILLED CARE FACILITIES. (a) *Medical director.* Every skilled care facility shall retain, pursuant to a written agreement, a physician to serve as medical director on a part-time or full-time basis as is appropriate for the needs of the residents and the facility. If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the licensee.

(b) *Coordination of medical care.* Medical direction and coordination of medical care in the facility shall be provided by the medical director. The medical director shall develop written rules and regulations which shall be approved by the licensee and include delineation of the responsibilities of attending physicians. If there is an organized medical staff, by-laws also shall be developed by the medical director and approved by the licensee. Coordination of medical care shall include liaison with attending physicians to provide that physicians' orders are written promptly upon admission of a resident, that periodic evaluations of the adequacy and appropriateness of health professional and supportive staff and services are conducted, and that the medical needs of the residents are met.

(c) *Responsibilities to the facility.* The medical director shall monitor the health status of the facility's employes. Incidents and accidents that occur on the premises shall be reviewed by the medical director to identify hazards to health and safety.

(2) PHYSICIAN SERVICES IN ALL FACILITIES. The facility shall assure that the following services are provided:

(a) *Attending physicians.* Each resident shall be under the supervision of a physician of the resident's or guardian's choice who evaluates and monitors the resident's immediate and long-term needs and prescribes measures necessary for the health, safety, and welfare of the resident. Each attending physician shall make arrangements for the medical care of a physician's residents in the physician's absence.

Note: For medical examinations and assessments required for admission, see s. HSS 132.52.

(b) *Physicians' visits.* 1. Each resident who requires skilled nursing care shall be seen by a physician at least every 30 days, unless the physician specifies and justifies in writing an alternate schedule of visits.

2. Each resident who does not require skilled nursing care shall be seen by a physician at least every 90 days, unless the physician specifies and justifies in writing an alternate schedule of visits.

3. In no case may a physician's alternate schedule specify fewer than one visit annually.

4. The physician shall review the plan of care required under s. HSS 132.52 (1) (b) at the time of each visit.

5. The physician shall review the resident's medications and other orders at least at the time of each visit.

Note: For review by a registered nurse, see s. HSS 132.60 (5) (a) 4.

6. The physician shall write, date and sign a note on the resident's progress at the time of each visit.

7. Physician visits are not required for respite care residents except as provided under s. HSS 132.70 (5).

(c) *Availability of physicians for emergency patient care.* The facility shall have written procedures, available at each nurse's station, for procuring a physician to furnish necessary medical care in emergencies and for providing care pending arrival of a physician. The names and telephone numbers of the physicians or medical service personnel available for emergency calls shall be posted at each nursing station.

Note: For reporting requirements, see s. HSS 132.45 (5) (c) 4; for requirements to notify others, see s. HSS 132.60 (3) (a).

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; r. and recr. (2) (b), Register, January, 1987, No. 373, eff. 2-1-87.

HSS 132.62 Nursing services. (1) DEFINITIONS. (a) "Nursing personnel" means nurses, nurse aides, nursing assistants, and orderlies.

(b) "Ward clerk" means an employe who performs clerical duties of the nursing personnel.

(2) NURSING ADMINISTRATION. (a) *Director of nursing services in skilled care and intermediate care facilities.* 1. Staffing requirement. Every skilled care facility and every intermediate care facility shall employ a full-time director of nursing services who may also serve as a charge nurse in accordance with par. (b). The director of nursing services shall work only on the day shift except as required for the proper supervision of nursing personnel.

2. Qualifications. The director of nursing services shall:

a. Be a registered nurse; and

b. Be trained or experienced in areas such as nursing service administration, restorative nursing, psychiatric nursing, or geriatric nursing.

3. Duties. The director of nursing services shall be responsible for:

a. Supervising the functions, activities and training of the nursing personnel;

b. Developing and maintaining standard nursing practice, nursing policy and procedure manuals, and written job descriptions for each level of nursing personnel;

c. Coordinating nursing services with other resident services;

d. Designating the charge nurses provided for by this section;

e. Being on call at all times, or designating another registered nurse to be on call, when no registered nurse is on duty in the facility; and

f. Ensuring that the duties of nursing personnel shall be clearly defined and assigned to staff members consistent with the level of education, preparation, experience, and licensing of each.

(b) *Charge nurses in skilled care facilities and intermediate care facilities.* 1. Staffing requirement. A skilled nursing facility shall have at least one charge nurse on duty at all times, and:

a. A facility with fewer than 60 residents in need of skilled nursing care shall have at least one registered nurse, who may be the director of nursing services, on duty as charge nurse during every daytime tour of duty;

b. A facility with 60 to 74 residents in need of skilled nursing care shall, in addition to the director of nursing services, have at least one registered nurse on duty as charge nurse during every daytime tour of duty;

c. A facility with 75 to 99 residents in need of skilled nursing care shall have, in addition to the director of nursing services, at least one registered nurse on duty as charge nurse during every daytime tour of duty. In addition, the facility shall have at least one registered nurse on duty as charge nurse every day on at least one other non-daytime tour of duty.

d. A facility with 100 or more residents in need of skilled nursing care shall have, in addition to the director of nursing services, at least one registered nurse on duty as charge nurse at all times.

e. An intermediate care facility shall have a charge nurse during every daytime tour of duty, who may be the director of nursing.

2. Qualifications. Unless otherwise required under this paragraph, the charge nurses shall be registered nurses or licensed practical nurses, and shall have had specialized training, or be acquiring specialized training, or have had experience in areas such as nursing service administration, restorative nursing, psychiatric nursing, or geriatric nursing.

3. Duties. a. The charge nurse, if a registered nurse, shall supervise the nursing care of all assigned residents, and delegate the duty to provide for the direct care of specific residents, including administration of medications, to nursing personnel based upon individual resident needs, the facility's physical arrangement, and the staff capability.

b. The charge nurse, if a licensed practical nurse, shall manage and direct the nursing and other activities of other licensed practical nurses and less skilled assistants and shall arrange for the provision of direct care to specific residents, including administration of medications, by nursing personnel based upon individual resident needs, the facility's physical arrangement, and the staff capability. A licensed practical nurse

who serves as a charge nurse shall be under the supervision and direction of a registered nurse who is either in the facility or on call.

(c) *Nurses in intermediate care facilities.* 1. An intermediate care facility with fewer than 60 residents shall have at least one registered nurse or one licensed practical nurse on duty during every daytime tour of duty. The registered nurse may be the director of nursing services in accordance with par. (a).

2. An intermediate care facility with 60 or more residents shall have at least one registered nurse on duty during every daytime tour of duty. The registered nurse may be the director of nursing services in accordance with par. (a).

(3) NURSE STAFFING. In addition to the requirements of sub. (2), the following conditions shall be met:

(a) *Total staffing.* Every facility shall provide at least the following hours of service by nursing personnel, computed on a daily basis:

1. For each resident in need of skilled nursing care, 2.25 hours per day; for each resident in need of intermediate nursing care, 2.00 hours per day; and for each resident in need of limited nursing care, 1.25 hours per day of nursing personnel; of which a minimum of 20% shall be provided by nurses.

2. For each resident in need of personal care, .50 hours of patient care personnel per day.

(b) *Assignments.* There shall be adequate nursing service personnel assigned to care for the specific needs of each resident on each tour of duty. Those personnel shall be briefed on the condition and appropriate care of each resident.

(c) *Relief personnel.* Facilities shall obtain qualified relief personnel.

(d) *Records; weekly schedules.* Weekly time schedules shall be planned at least one week in advance, shall be posted and dated, shall indicate the names and classifications of nursing personnel and relief personnel assigned on each nursing unit for each tour of duty, and shall be updated as changes occur.

Note: See s. HSS 132.45 (6) (b) for records.

(e) *Staff meetings.* Meetings shall be held at least quarterly for the nursing personnel to brief them on new developments, raise issues relevant to the service, and for such other purposes as are pertinent. These meetings may be held in conjunction with those required by s. HSS 132.44.

(f) *Twenty-four hour coverage.* All facilities shall have at least one nursing staff person on duty at all times.

(g) *Staffing patterns.* The assignment of the nursing personnel required by this subsection to each tour of duty shall be consistent with the needs of the residents in the facility.

(h) *Computing hours.* 1. Only staff time related to the nursing service shall be counted to satisfy the requirements of this section.

2. When determining staff time to count toward satisfaction of the minimum nursing service hours in this section, the following duties of non-nursing personnel, including ward clerks, may be included:

a. Direct resident care, if the personnel have been appropriately trained to perform direct resident care duties;

b. Routine completion of medical records and census reports, including copying, transcribing, and filing;

c. Processing requests for diagnostic and consultative services, and arranging appointments with professional services;

d. Ordering routine diets and nourishments; and

e. Notifying staff and services of pending discharges.

3. No services provided by volunteers may be counted toward satisfaction of this requirement.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (2) (b) 2. and (c), r. (2) (d), Register, January, 1987, No 373, eff. 2-1-87; am. (3) (a), Register, February, 1989, No. 398, eff. 3-1-89.

HSS 132.63 Dietary service. (1) DIETARY SERVICE. The facility shall provide a dietary service or contract for a dietary service which meets the requirements of this section.

(2) STAFF. (a) *Full or part-time supervisor.* The dietary service shall be supervised by a full-time supervisor, except that an intermediate care facility with fewer than 50 residents may employ a person to work as supervisor part-time.

(b) *Qualifications.* The dietary service supervisor shall be either:

1. A dietitian; or

2. Shall receive necessary consultation from a dietitian and shall either:

a. Have completed a course of study in food service supervision at a vocational, technical, and adult education school or equivalent, or presently be enrolled in such a course of study; or

b. Hold an associate degree as a dietetic technician.

Note: See s. HSS 132.45 (6) (e) 1., for records of consultations.

(c) *Staff.* There shall be dietary service personnel on duty at least 12 hours daily who may include the supervisor.

(3) HYGIENE OF STAFF. Dietary staff and other personnel who participate in dietary service shall be in good health and practice hygienic food handling techniques.

Note: For inservice training requirements, see s. HSS 132.44 (2) (b).

(4) MENUS. (a) *General.* 1. Menus shall be planned and written at least 2 weeks in advance of their use, and shall be adjusted for seasonal availability of foods.

2. Menus shall be in accordance with physicians' orders and, to the extent medically possible, in accordance with the "recommended daily dietary allowances," of the food and nutrition board of the national re-

search council, national academy of sciences as contained in Appendix A of this chapter.

3. Food sufficient to meet the needs of each resident shall be planned, prepared and served for each meal. When changes in the menu are necessary, substitutions shall provide equal nutritive value.

4. The facility shall make reasonable adjustments to accomodate each resident's preferences, habits, customs, appetite, and physical condition.

5. A file of tested recipes shall be maintained.

6. A variety of protein foods, fruits, vegetables, dairy products, breads, and cereals shall be provided.

(b) *Therapeutic diets.* 1. Therapeutic diets shall be served only on order of the physician, and shall be consistent with such orders.

2. Therapeutic menus shall be planned as provided in par. (a) 1., with supervision or consultation from a qualified dietitian.

3. Vitamin and mineral supplements shall be given only on order of the physician.

(5) MEAL SERVICE. (a) *Schedule.* At least 3 meals or their equivalent shall be offered to each resident daily, not more than 6 hours apart, with not more than a 15-hour span between a substantial evening meal and the following breakfast.

(b) *Identification of trays.* Trays, if used, shall be identified with the resident's name and type of diet.

(c) *Table service.* The facility shall provide table service in dining rooms for all residents who can and want to eat at a table, including residents in wheelchairs.

(d) *Re-service.* Food served to a resident in an unopened manufacturer's package may not be re-served unless the package remains unopened and maintained at a proper temperature.

(e) *Temperature.* Food shall be served at proper temperatures.

(f) *Snacks.* If not prohibited by the resident's diet or condition, nourishments shall be offered routinely to all residents between the evening meal and bedtime.

(g) *Drinking water.* When a resident is confined to bed, a covered pitcher of drinking water and a glass shall be provided on a bedside stand. The water shall be changed frequently during the day, and pitchers and glasses shall be sanitized daily. Single-service disposable pitchers and glasses may be used. Common drinking utensils shall not be used.

(6) FOOD SUPPLIES AND PREPARATION. (a) *Supplies.* Food shall be purchased or procured from approved sources or sources meeting federal, state, and local standards or laws.

(b) *Preparation.* Food shall be cleaned and prepared by methods that conserve nutritive value, flavor and appearance. Food shall be cut, chopped, or ground as needed for individual residents.

(c) *Milk.* Only pasteurized fluid milk which is certified Grade A shall be used for beverages. Powdered milk may be used for cooking if it meets

Grade A standards or is heated to a temperature of 165° F. (74° C.) during cooking.

(7) SANITATION. (a) *Equipment and utensils.* 1. All equipment, appliances, and utensils used in preparation or serving of food shall be maintained in a functional, sanitary, and safe condition. Replacement equipment shall meet criteria established in "Listing of Food Service Equipment" by the national sanitation foundation.

2. The floors, walls, and ceilings of all rooms in which food or drink is stored or prepared or in which utensils are washed shall be kept clean, smooth, and in good repair.

3. All furnishings, table linens, drapes, and furniture shall be maintained in a clean and sanitary condition.

4. Single-service utensils shall be stored in the original, unopened wrapper until used, may not be made of toxic material and may not be re-used or redistributed if the original wrapper has been opened.

Note: Copies of the National Sanitation Foundation's "Listing of Food Service Equipment" are kept on file and may be consulted in the department and in the offices of the secretary of state and the revisor of statutes.

(b) *Storage and handling of food.* 1. Food shall be stored, prepared, distributed, and served under sanitary conditions which prevent contamination.

2. All readily perishable food and drink, except when being prepared or served, shall be kept in a refrigerator which shall have a temperature maintained at or below 40° F. (4° C.).

Note: See ch. HSS 145 for the requirements for reporting incidents of suspected disease transmitted by food.

(c) *Animals.* Animals shall not be allowed where food is prepared, served or stored, or where utensils are washed or stored.

(8) DISHWASHING. Whether washed by hand or mechanical means, all dishes, plates, cups, glasses, pots, pans, and utensils shall be cleaned in accordance with accepted procedures which shall include separate steps for pre-washing, washing, rinsing, and sanitizing by means of hot water or chemicals or a combination approved by the department.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (2) (a), (4) (a) 3., (5) (d) and (f) and (7) (a) 4., Register, January, 1987, No. 373, eff. 2-1-87; r. and recr. (5) (c), Register, February, 1989, No. 398, eff. 3-1-89.

HSS 132.64 Rehabilitative services. (1) PROVISION OF SERVICES. Each facility shall either provide or arrange for, under written agreement, specialized rehabilitative services as needed by residents to improve and maintain functioning.

(2) SERVICE PLANS AND RESTRICTIONS. (a) *Conformity with orders and plan.* Rehabilitative services shall be administered as ordered by the physician and substantially in conformance with the plan of care required by s. HSS 132.60 (8).

(b) *Report to physician.* Within 2 weeks of the initiation of rehabilitative treatment, a report of the resident's progress shall be made to the physician.

(c) *Review of plan.* Rehabilitative services shall be re-evaluated at least quarterly by the physician and therapists, and the plan of care updated as necessary.

(3) SPECIALIZED SERVICES — QUALIFICATIONS. (a) *Physical therapy.* Physical therapy shall be given or supervised only by a physical therapist.

(b) *Speech and hearing therapy.* Speech and hearing therapy shall be given or supervised only by a therapist who:

1. Meets the standards for a certificate of clinical competence granted by the American speech and hearing association; or

2. Meets the educational standards, and is in the process of acquiring the supervised experience required for the certification of subd. 1.

(c) *Occupational therapy.* Occupational therapy shall be given or supervised only by a therapist who meets the standards for registration as an occupational therapist of the American occupational therapy association.

(d) *Equipment.* Equipment necessary for the provision of therapies required by the residents shall be available and used as needed.

Note: For record requirement, see s. HSS 132.45.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82.

HSS 132.65 Pharmaceutical services. (1) DEFINITIONS. As used in this section:

(a) "Medication" has the same meaning as the term "drug" defined in s. 450.06, Stats.

(b) "Prescription medication" has the same meaning as the term "prescription drug" defined in s. 450.07, Stats.

(c) "Schedule II drug" means any medication listed in s. 161.16, Stats.

(2) SERVICES. Each facility shall provide for obtaining medications for the residents from licensed pharmacies.

(3) SUPERVISION. (a) *Pharmaceutical services committee.* 1. The facility shall have a pharmaceutical services committee consisting of at least the consulting or staff pharmacist, the director of nursing services or consulting registered nurse, the administrator and a physician.

2. The committee shall meet at least quarterly and document its activities, findings and recommendations.

3. The committee shall establish, maintain, and supervise such policies and procedures as are necessary to comply with this chapter and assure that resident needs are met, including but not limited to the following:

a. In facilities maintaining a bulk supply of non-prescription medications, the procedures for handling, administering, and maintaining records of receipt and disposition of bulk supplies;

b. The automatic termination of medication orders which are not limited as to time or dosages;

c. Review of medication errors;

d. The maintenance of an emergency medication kit under sub. (4); and

e. The maintenance of a contingency supply of medications, if any, as permitted by sub. (5).

(b) *Medication consultant.* 1. Each skilled nursing facility shall retain a registered pharmacist who shall visit the facility at least monthly to review the drug regimen of each resident and medication practices. The pharmacist shall submit a written report of findings at least quarterly to the facility's pharmaceutical services committee.

2. Each intermediate care facility shall retain a registered pharmacist who shall visit the facility at least monthly to review medication practices and the drug regimen of each resident and who shall notify the attending physician if changes are appropriate.. The pharmacist shall submit a written report of findings at least quarterly to the facility's pharmaceutical services committee.

(4) EMERGENCY MEDICATION KIT. (a) A facility may have one or more emergency medication kits. All emergency medication kits shall be under the control of a pharmacist.

(b) The emergency kit shall be sealed and stored in a locked area.

(5) CONTINGENCY SUPPLY OF MEDICATIONS. (a) *Maintenance.* A facility may have a contingency supply of medications not to exceed 10 units of any medication. Any contingency supply of medications must be under the control of a pharmacist.

(b) *Storage.* Contingency drugs shall be stored at a nursing unit, except that those medications requiring refrigeration shall be stored in a refrigerator.

(c) *Single units.* Contingency medications shall be stored in single unit containers, a unit being a single capsule, tablet, ampule, tubex, or suppository.

(d) *Committee authorization.* The pharmaceutical services committee shall determine which medications and strengths of medications are to be stocked in the contingency storage unit and the procedures for use and re-stocking of the medications.

(e) *Control.* Unless controlled by a "proof-of-use" system, as provided by par. (6) (e), a copy of the pharmacy communication order shall be placed in the contingency storage unit when any medication is removed.

(6) REQUIREMENTS FOR ALL MEDICATION SYSTEMS. (a) *Obtaining new medications.* 1. When medications are needed which are not stocked, a registered nurse or designee shall telephone an order to the pharmacist who shall fill the order and release the medication in return for a copy of the physician's written order.

2. When new medications are needed which are stocked, a copy of the resident's new medication order shall be sent to the pharmacist filling medication orders for the resident.

(b) *Storing and labeling medications.* Unless exempted under par. (f), all medications shall be handled in accordance with the following provisions:

1. Storage. Medications shall be stored near nurses stations, in locked cabinets, closets or rooms, conveniently located, well lighted, and kept at a temperature of no more than 85° F. (29° C.).

2. Transfer between containers. Medications shall be stored in their original containers, and not transferred between containers, except by a physician or pharmacist.

3. Controlled substances. Separately locked and securely fastened boxes or drawers, or permanently affixed compartments, within the locked medication area shall be provided for storage of schedule II drugs, subject to 21 U.S.C. ch. 13, and Wisconsin's uniform controlled substance act, ch. 161, Stats.

4. Separation of medications. Medications packaged for individual residents shall be kept physically separated.

5. Refrigeration. Medications requiring refrigeration shall be kept in a separate covered container and locked, unless the refrigeration is available in a locked drug room.

6. External use of medications. Poisons and medications for external use only shall be kept in a locked cabinet and separate from other medications, except that time-released transdermal drug delivery systems, including nitroglycerin ointments, may be kept with internal medications.

7. Accessibility to drugs. Medications shall be accessible only to the registered nurse or designee. In facilities where no registered nurse is required, the medications shall be accessible only to the administrator or designee. The key shall be in the possession of the person who is on duty and assigned to administer the medications.

8. Labeling medications. Prescription medications shall be labeled with the expiration date and as required by s. 450.11 (4), Stats. Nonprescription medications shall be labeled with the name of the medication, directions for use, the expiration date and the name of the resident taking the medication.

(c) *Destruction of medications.* 1. Time limit. Unless otherwise ordered by a physician, a resident's medication not returned to the pharmacy for credit shall be destroyed within 72 hours of a physician's order discontinuing its use, the resident's discharge, the resident's death or passage of its expiration date. No resident's medication may be held in the facility for more than 30 days unless an order is written every 30 days to hold the medication.

2. Procedure. Records shall be kept of all medication returned for credit. Any medication not returned for credit shall be destroyed in the facility and a record of the destruction shall be witnessed, signed and dated by 2 or more personnel licensed or registered in the health field.

3. Remaining controlled substances. Any controlled substance not returned for credit and remaining after the discontinuance of a physician's orders or the discharge or death of the resident shall be inventoried on the appropriate U.S. drug enforcement agency form. One copy shall be sent to the U.S. drug enforcement agency and one copy shall be kept on file in the facility.

(d) *Control of medications.* 1. Receipt of medications. The administrator or a physician, nurse, pharmacist, or the designee of any of these may

be an agent of the resident for the receipt of medications in accordance with s. Phar. 1.19(5).

2. Signatures. When the medication is received by the facility, the person completing the control record shall sign the record indicating the amount received.

3. Discontinuance of schedule II drugs. The use of schedule II drugs shall be discontinued after 72 hours unless the original order specifies a greater period of time not to exceed 60 days.

(e) *Proof-of-use record.* 1. For schedule II drugs, a proof-of-use record shall be maintained which lists, on separate proof-of-use sheets for each type and strength of schedule II drug, the date and time administered, resident's name, physician's name, dose, signature of the person administering dose, and balance.

2. Proof-of-use records shall be audited daily by the registered nurse or designee, except that in facilities in which a registered nurse is not required, the administrator or designee shall perform the audit of proof-of-use records daily.

(f) *Resident control and use of medications.* 1. Residents may have medications in their possession or stored at their bedside on the order of a physician.

2. Medications which, if ingested or brought into contact with the nasal or eye mucosa, would produce toxic or irritant effects shall be stored and used only in accordance with the health, safety, and welfare of all residents.

Note: See s. HSS 132.60 (5) (d) 4. for permission for self-administration of medications.

(7) ADDITIONAL REQUIREMENTS FOR UNIT DOSE SYSTEMS. (a) *Scope.* When a unit dose drug delivery system is used, the requirements of this subsection shall apply in addition to those of sub. (6).

(b) *General procedures.* 1. The individual medication shall be labeled with the drug name, strength, expiration date, and lot or control number.

2. A resident's medication tray or drawer shall be labeled with the resident's name and room number.

3. Each medication shall be dispensed separately in single unit dose packaging exactly as ordered by the physician, and in a manner to ensure the stability of the medication.

4. An individual resident's supply of drugs shall be placed in a separate, individually labeled container and transferred to the nursing station and placed in a locked cabinet or cart. This supply shall not exceed 4 days for any one resident.

5. If not delivered from the pharmacy to the facility by the pharmacist, the pharmacist's agent shall transport unit dose drugs in locked containers.

6. The individual medication shall remain in the identifiable unit dose package until directly administered to the resident. Transferring between containers is prohibited.

7. Unit dose carts or cassettes shall be kept in a locked area when not in use.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; r. and recr. (3) (b), am. (6) (a), (b) 6 and (c), Register, January, 1987, No. 373, eff. 2-1-87; am. (3) (b) 2., (6) (b) 8. and (c) 1. and 3., Register, February, 1989, No. 398, eff. 3-1-89.

HSS 132.66 Laboratory, radiologic, and blood services. (1) DIAGNOSTIC SERVICES. (a) *Requirement of services.* The facility shall provide for promptly obtaining required laboratory, x-ray, and other diagnostic services.

(b) *Facility-provided services.* Any laboratory and x-ray services provided by the facility shall meet the applicable requirements for hospitals provided in ch. HSS 124.

(c) *Outside services.* If the facility does not provide these services, arrangements shall be made for obtaining the services from a physician's office, hospital, nursing facility, portable x-ray supplier, or independent laboratory.

(d) *Physician's order.* No services under this subsection may be provided without an order of a physician, except that services provided to intermediate nurse care residents may be provided under the order of a physician or physician extender.

(e) *Notice of findings.* The attending physician shall be notified promptly of the findings of all tests provided under this subsection.

(f) *Transportation.* The facility shall assist the resident, if necessary, in arranging for transportation to and from the provider of service.

Note: For record requirements, see s. HSS 132.45.

(2) BLOOD AND BLOOD PRODUCTS. Any blood-handling and storage facilities shall be safe, adequate, and properly supervised. If the facility provides for maintaining and transferring blood and blood products, it shall meet the appropriate requirements for hospitals under ch. HSS 124. If the facility only provides transfusion services, it shall meet the requirements of s. HSS 124.17 (3).

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (1) (d), Register, January, 1987, No. 373, eff. 2-1-87; correction in (1) (b) and (2) made under s. 13.93 (2m) (b) 7, Stats., Register, February, 1989, No. 398.

HSS 132.67 Dental services. (1) ADVISORY DENTIST. The facility shall retain an advisory dentist to participate in the staff development program for nursing and other appropriate personnel and to recommend oral hygiene policies and practices for the care of residents.

(2) ATTENDING DENTISTS. (a) *Arrangements for dental care.* The facility shall make arrangements for dental care for residents who do not have a private dentist.

(b) *Transportation.* The facility shall assist the resident, if necessary, in arranging for transportation to and from the dentist's office.

(3) DENTAL EXAMINATION OF RESIDENTS. Every resident shall have a dental examination by a licensed dentist within 6 months after admission unless a dental examination has been performed within 6 months before admission. Subsequent dental health care shall be provided or arranged for the resident as needed.

(4) EMERGENCY DENTAL CARE. The facility shall arrange for emergency dental care when a resident's attending dentist is unavailable.

Note: For record requirements, see s. HSS 132.45; for dentists' orders, see s. HSS 132.60 (5); for staff development programs about dental practices, see s. HSS 132.44 (2).

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; a.m (3), Register, January, 1987, No. 373, eff. 2-1-87.

HSS 132.68 Social services. (1) PROVISION OF SERVICES. Each facility shall provide for social services in conformance with this section.

(2) STAFF. (a) *Social worker.* Each facility shall employ or retain a person full-time or part-time to coordinate the social services, to review the social needs of residents, and to make referrals.

(b) *Qualifications.* The person required by par. (a) shall:

1. Have a bachelor's degree in social work, sociology, or psychology; meet the national association of social workers' standards of membership; and have one year of social work experience in a health care setting; or

2. Have a master's degree in social work from a graduate school of social work accredited by the council on social work education; or

3. Shall receive at least monthly consultation from a social worker who meets the standards of subd. 1 or 2.

(3) ADMISSION. (a) *Interviews.* Before or at the time of admission, each resident and guardian, if any, and any other person designated by the resident or guardian, shall be interviewed.

(b) *Admission history.* A social history of each resident shall be prepared.

(4) CARE PLANNING. (a) Within 2 weeks after admisison, an evaluation of social needs and potential for discharge shall be completed for each resident;

(b) A social services component of the plan of care, including preparation for discharge, if appropriate, shall be developed and included in the plan of care required by s. HSS 132.60 (8) (a); and

(c) Social services care and plans shall be evaluated in accordance with s. HSS 132.60 (8) (b).

(5) SERVICES. Social services staff shall provide the following:

(a) *Referrals.* If necessary, referrals for guardianship proceedings, or to appropriate agencies in cases of financial, psychiatric, rehabilitative or social problems which the facility cannot serve;

(b) *Adjustment assistance.* Assistance with adjustment to the facility, and continuing assistance to and communication with the resident, guardian, family, or other responsible persons;

(c) *Discharge planning.* Assistance to other facility staff and the resident in discharge planning at the time of admission and prior to removal under this chapter; and

(d) *Training.* Participation in inservice training for direct care staff on the emotional and social problems and needs of the aged and ill and on methods for fulfilling these needs.

Note: For record requirements, see s. HSS 132.45 (5) (d).

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (3) (a), (4) (a) and (5) (a), Register, January, 1987, No. 373, eff. 2-1-87.

HSS 132.69 Activities. (1) PROGRAM. (a) Every facility shall provide an activities program which meets the requirements of this section. The program may consist of any combination of activities provided by the facility and those provided by other community resources.

(b) The activities program shall be planned for group and individual activities, and shall be designed to meet the needs and interests of each resident and to be consistent with each resident's plan of care.

(2) STAFF. (a) *Definition.* "Qualified activities coordinator" means:

1. In a skilled nursing facility, a person who:

a. Has a bachelor's degree in recreation therapy and is eligible for registration as a therapeutic recreation specialist with the national therapeutic recreation society;

b. Has 2 years of experience in a social or recreational program within the last 5 years, one year of which was full-time in a patient activities program in a health care setting; or

c. Is an occupational therapist or occupational therapy assistant who meets the requirements for certification by the American occupational therapy association; and

2. In an intermediate care facility, a staff member who is qualified by experience or training in directing group activity.

(b) *Supervision.* The activity program shall be supervised by:

1. A qualified activities coordinator; or

2. An employe who receives at least monthly consultation from a qualified activities coordinator.

(c) *Program staffing hours.* Except as provided in par. (d), activities staff shall be employed to provide at least .46 total hours of activities staff time per resident each week:

Note: The required hours are the total time that activities staff must be on duty serving residents each week, not the time directed towards each resident.

(d) *Community activities.* The length of time for which residents are involved in community activities may be included in computing the staff time provided under this subsection.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (2) (a), r. and recr. (2) (c), r. (2) (d) and (f), renum. (2) (e) to be (2) (d), Register, January, 1987, No. 373, eff. 2-1-87.

HSS 132.695 Special requirements for facilities serving persons who are developmentally disabled. (1) SCOPE. The requirements in this section apply to all facilities that serve persons who are developmentally disabled.

(2) DEFINITIONS. In this section:

(a) "Active treatment" means an ongoing, organized effort to help each resident attain or maintain his or her developmental capacity through the resident's regular participation, in accordance with an individualized plan, in a program of activities designed to enable the resident to attain or maintain the optimal physical, intellectual, social and vocational levels of functioning of which he or she is capable.

(b) "Interdisciplinary team" means the persons employed by a facility or under contract to a facility who are responsible for planning the program and delivering the services relevant to a developmentally disabled resident's care needs.

(c) "IPP" or "individual program plan" means a written statement of the services which are to be provided to a resident based on an interdisciplinary assessment of the individual's developmental needs, expressed in behavioral terms, the primary purpose of which is to provide a framework for the integration of all the programs, services and activities received by the resident and to serve as a comprehensive written record of the resident's developmental progress.

(d) "QMRP" or "qualified mental retardation professional" means a person who has specialized training in mental retardation or at least one year of experience in treating or working with mentally retarded persons and is one of the following:

1. A psychologist licensed under ch. 455, Stats.;

2. A physician;

3. A social worker with a graduate degree from a school of social work accredited or approved by the council on social work education or with a bachelor's degree in social work from a college or university accredited or approved by the council on social work education.

4. A physical or occupational therapist who meets the requirements of s. HSS 105.27 or 105.28;

5. A speech pathologist or audiologist who meets the requirements of s. HSS 105.30 or 105.31;

6. A registered nurse;

7. A therapeutic recreation specialist who is a graduate of an accredited program or who has a bachelor's degree in a specialty area such as art, dance, music, physical education or recreation therapy; or

8. A human services professional who has a bachelor's degree in a human services field other than a field under subds. 1 to 7, such as rehabilitation counseling, special education or sociology.

(3) ACTIVE TREATMENT PROGRAMMING. (a) All residents who are developmentally disabled shall receive active treatment. Active treatment shall include:

1. The resident's regular participation, in accordance with the IPP, in professionally developed and supervised activities, experiences and therapies. The resident's participation shall be directed toward:

a. The acquisition of developmental, behavioral and social skills necessary for the resident's maximum possible individual independence; or

b. For dependent residents where no further positive growth is demonstrable, the prevention of regression or loss of current optimal functional status; and

2. An individual post-institutionalization plan, as part of the IPP, developed before discharge by a qualified mental retardation professional and other appropriate professionals. This shall include provision for appropriate services, protective supervision and other follow-up services in the resident's new environment.

(b) Active treatment does not include the maintenance of generally independent residents who are able to function with little supervision or who require few if any of the significant active treatment services described in this subsection.

(4) RESIDENT CARE PLANNING. (a) *Interdisciplinary team.* 1. The interdisciplinary team shall develop the resident's individual program plan.

2. Membership on the interdisciplinary team for resident care planning may vary based on the professions, disciplines and service areas that are relevant to the resident's needs but shall include a qualified mental retardation professional, a nurse and, when appropriate, a physician.

3. The resident and the resident's family or guardian shall be encouraged to participate as members of the team, unless the resident objects to the participation of family members.

(b) *Development and content of the individual program plan.* 1. Except in the case of a person admitted for short-term care, within 30 days following the date of admission, the interdisciplinary team, with the participation of the staff providing resident care, shall review the preadmission evaluation and physician's plan of care and shall develop an IPP based on the new resident's history and an assessment of the resident's needs by all relevant disciplines, including any physician's evaluations or orders.

2. The IPP shall include:

a. A list of realistic and measurable goals in order of priority, with time limits for attainment;

b. Behavioral objectives for each goal which must be attained before the goal is considered attained;

c. A written statement of the methods or strategies for delivering care, for use by the staff providing resident care and by the professional and special services staff and other individuals involved in the resident's care, and of the methods and strategies for assisting the resident to attain new skills, with documentation of which professional disciplines or which personnel providing resident care are responsible for the needed care or services;

d. Evaluation procedures for determining whether the methods or strategies are accomplishing the care objectives; and

e. A written interpretation of the preadmission evaluation in terms of any specific supportive actions, if appropriate, to be undertaken by the resident's family or legal guardian and by appropriate community resources.

(c) *Reassessment of individual program plan.* 1. Special and professional services review. a. The care provided by staff from each of the disciplines involved in the resident's treatment shall be reviewed by the professional responsible for monitoring delivery of the specific service.

b. Individual care plans shall be reassessed and updated at least quarterly by the interdisciplinary team, with more frequent updates if an individual's needs warrant it, and at least every 30 days by the QMRP to review goals.

c. Reassessment results and other necessary information obtained through the specialists' assessments shall be disseminated to other resident care staff as part of the IPP process.

d. Documentation of the reassessment results, treatment objectives, plans and procedures, and continuing treatment progress reports shall be recorded in the resident's record.

2. Interdisciplinary review. The interdisciplinary team, staff providing resident care and other relevant personnel shall review the IPP and status of the resident at least annually and make program recommendations as indicated by the resident's developmental progress. The review shall consider at least the following:

a. The appropriateness of the IPP and the individual's progress toward meeting the plan objectives;

b. The advisability of continued residence, and recommendations for alternative programs and services; and

c. The advisability of guardianship and a plan for assisting the resident in the exercise of his or her rights.

3. Individual evaluation. Individual evaluations of residents shall:

a. Make use of tests and measurements uniformly accepted within the given profession, whenever these instruments are available;

b. Provide the basis for prescribing an appropriate program of training experiences for the resident;

c. Provide written training and habilitation objectives for each resident that are based upon completed and relevant diagnostic and prognostic data and that are stated in terms that permit the progress of each resident to be assessed; and

d. Provide evidence of services designed to meet the training and habilitation objectives for each resident.

(d) *Implementation.* Progress notes shall reflect the treatment and services provided to meet the goals stated in the IPP.

Note: See ch. HSS 134 for rules governing residential care facilities that primarily serve developmentally disabled persons who require active treatment.

History: Cr. Register, January, 1987, No. 373, eff. 2-1-87; am. (2) (a), (b), (3), (4) (a), (b), (c) 1., 2. intro. and a. and (d), renum. (2) (c) to (d) and am. (intro.) and 3., cr. (2) (c), Register, February, 1989, No. 398, eff. 3-1-89.

HSS 132.70 Special requirements when persons are admitted for short-term care. (1) SCOPE. A facility may admit persons for short-term care. A facility that admits persons for short-term care may use the procedures

included in this section rather than the procedures included in ss. HSS 132.52 and 132.60 (8). Short-term care is for either respite or recuperative purposes. The requirements in this section apply to all facilities that admit persons for short-term care when they admit, evaluate or provide care for these persons. Except as specified in this section, all requirements of this chapter, including s. HSS 132.51, apply to all facilities that admit persons for short-term care.

(2) PROCEDURES FOR ADMISSION. (a) *Respite care.* For a person admitted to a facility for respite care, the following admission and resident care planning procedures may be carried out in place of the requirements under ss. HSS 132.52 and 132.60 (8):

1. A registered nurse or physician shall complete a comprehensive resident assessment of the person prior to or on the day of admission. This comprehensive assessment shall include evaluation of the person's medical, nursing, dietary, rehabilitative, pharmaceutical, dental, social and activity needs. The consulting or staff pharmacist shall participate in the comprehensive assessment as provided under sub. (4) (a). As part of the comprehensive assessment, when the registered nurse or physician has identified a need for a special service, staff from the discipline that provides the service shall, on referral from the registered nurse or physician, complete a history and assessment of the person's prior health and care in that discipline. The comprehensive resident assessment shall include:

a. A summary of the major needs of the person and of the care to be provided;

b. A statement from the attending physician that the person is free from tuberculosis and other clinically apparent communicable diseases; and

c. The attending physician's plans for discharge.

2. The registered nurse, with verbal agreement of the attending physician, shall develop a written plan of care for the person being admitted prior to or at the time of admission. The plan of care shall be based on the comprehensive resident assessment under subd. 1, the physician's orders, and any special assessments under subd. 1.

3. The facility shall send a copy of the comprehensive resident assessment, the physician's orders and the plan of care under subd. 2 to the person's attending physician. The attending physician shall sign the assessment and the plan of care within 48 hours after the person is admitted.

(b) *Recuperative care.* For a person admitted to a facility for recuperative care, the following admission and resident care planning procedures may be carried out in place of the requirements under ss. HSS 132.52 and 132.60 (8):

1. The person may be admitted only on order of a physician accompanied by information about the person's medical condition and diagnosis, the physician's initial plan of care, and either the physician's written certification that the person is free of tuberculosis and other clinically apparent communicable diseases or an order of a physician for procedures to treat any disease the person may have.

2. A registered nurse shall prepare an initial plan of care for nursing services to be implemented on the day of admission, which shall be based on the physician's initial plan of care under subd. 1 and shall be superseded by the plan of care under subd. 5.

3. A physician shall conduct a physical examination of the new resident within 48 hours following admission, unless a physical examination was performed by a physician within 15 days before admission.

4. A registered nurse shall complete a comprehensive resident assessment of the person prior to or within 72 hours after admission. The comprehensive assessment shall include evaluation of the person's nursing dietary, rehabilitative, pharmaceutical, dental, social and activity needs. The consulting or staff pharmacist shall participate in the comprehensive assessment as provided under sub. (4) (a). As part of the comprehensive assessment, when the registered nurse has identified a need for a special service, staff from the discipline that provides the service shall, on referral from the registered nurse, complete a history and assessment of the person's prior health and care in that discipline.

5. The registered nurse, with verbal agreement of the attending physician, shall develop a written plan of care for the new resident within one week after admission. The plan of care shall be based on the comprehensive resident assessment under subd. 4, the physician's orders, and any special assessments under subd. 4.

6. The facility shall send a copy of the comprehensive resident assessment, the physician's orders and the plan of care under subd. 5 to the new resident's attending physician. The attending physician shall sign the assessment and the plan of care.

(3) ADMISSION INFORMATION. (a) This subsection takes the place of s. HSS 132.31/(1) (d) 1 for persons admitted for respite care or recuperative care.

(b) No person may be admitted to a facility for respite care or recuperative care without signing or the person's guardian or designated representative signing an acknowledgement of having received a statement before or on the day of admission which contains at least the following information:

1. An indication of the expected length of stay, with a note that the responsibility for care of the resident reverts to the resident or other responsible party following expiration of the designated length of stay;

2. An accurate description of the basic services provided by the facility, the rate charged for those services, and the method of payment for them;

3. Information about all additional services regularly offered but not included in the basic services. The facility shall provide information on where a statement of the fees charged for each of these services can be obtained. These additional services include pharmacy, x-ray, beautician and all other additional services regularly offered to residents or arranged for residents by the facility;

4. The method for notifying residents of a change in rates or fees;

5. Terms for refunding advance payments in case of transfer, death or voluntary or involuntary termination of the service agreement;

6. Conditions for involuntary termination of the service agreement;

7. The facility's policy regarding possession and use of personal effects;

8. In the case of a person admitted for recuperative care, the terms for holding and charging for a bed during the resident's temporary absence; and

9. In summary form, the residents' rights recognized and protected by s. HSS 132.31 and all facility policies and regulations governing resident conduct and responsibilities.

(4) MEDICATIONS. (a) The consulting or staff pharmacist shall review the drug regimen of each person admitted to the facility for respite care or recuperative care as part of the comprehensive resident assessment under sub. (2) (a) 1 or (b) 4.

(b) The consulting or staff pharmacist, who is required under s. HSS 132.65 (3) (b) to visit the facility at least monthly to review drug regimens and medications practices, shall review the drug regimen of each resident admitted for recuperative care, and the drug regimen of each resident admitted for respite care who may still be a resident of the facility at the time of the pharmacist's visit.

(c) Respite care residents and recuperative care residents may bring medications into the facility as permitted by written policy of the facility.

(5) PHYSICIAN'S VISITS. The requirements under s. HSS 132.61 (2) (b) for physician visits do not apply in the case of respite care residents, except when the nursing assessment indicates there has been a change in the resident's condition following admission, in which case the physician shall visit the resident if this appears indicated by the resident assessment.

(6) PRE-DISCHARGE PLANNING CONFERENCE. (a) For residents receiving recuperative care, a planning conference shall be conducted at least 10 days before the designated date of termination of the short-term care, except in an emergency, to determine the appropriateness of discharge or need for the resident to stay at the facility. At the planning conference a care plan shall be developed for a resident who is being discharged to home care or to another health care facility. If discharge is not appropriate, the period for recuperative care shall be extended, if it was originally less than 90 days, for up to the 90 day limit, or arrangements shall be made to admit the person to the facility for care that is not short-term, as appropriate.

(b) Paragraph (a) takes the place of s. HSS 132.53 (3) (b) 1 and 2 for recuperative care residents.

(7) RECORDS. (a) *Contents.* The medical record for each respite care resident and each recuperative care resident shall include, in place of the items required under s. HSS 132.45 (5):

1. The resident care plan prepared under sub. (2) (a) 2 or (b) 5;

2. Admission nursing notes identifying pertinent problems to be addressed and areas of care to be maintained;

3. For recuperative care residents, nursing notes addressing pertinent problems identified in the resident care plan and, for respite care residents, nursing notes prepared by a registered nurse or licensed practical nurse to document the resident's condition and the care provided;

4. Physicians' orders;

5. A record of medications;

6. Any progress notes by physicians or health care specialists that document resident care and progress;

7. For respite care residents, a record of change in condition during the stay at the facility; and

8. For recuperative care residents, the physician's discharge summary with identification of resident progress, and, for respite care residents, the registered nurse's discharge summary with notes of resident progress during the stay.

(b) *Location and accessibility.* The medical record for each short-term care resident shall be kept with the medical records of other residents and shall be readily accessible to authorized representatives of the department.

History: Cr. Register, January, 1987, No. 373, eff. 2-1-87; am. (1), (2) (a) (intro.) and (b) (intro.), Register, February, 1989, No. 398, eff. 3-1-89.

Subchapter VII — Physical Environment

HSS 132.71 Furniture, equipment and supplies. (1) FURNITURE IN RESIDENT CARE AREAS. (a) *Beds.* 1. Each resident shall be provided a bed which is at least 36 inches wide, is equipped with a headboard of sturdy construction and is in good repair. Roll-away beds, day beds, cots, or double or folding beds shall not be used.

2. Each bed shall be in good repair and provided with a clean, firm mattress of appropriate size for the bed.

3. Side rails shall be installed for both sides of the bed when required by the resident's condition.

(b) *Bedding.* 1. Each resident shall be provided at least one clean, comfortable pillow. Additional pillows shall be provided if requested by the resident or required by the resident's condition.

2. Each bed shall have a mattress pad.

3. A moisture-proof mattress cover and pillow cover shall be provided to keep each mattress and pillow clean and dry.

4. a. A supply of sheets and pillow cases sufficient to keep beds clean, dry, and odor-free shall be stocked. At least 2 sheets and 2 pillow cases shall be furnished to each resident each week.

b. Beds occupied by bedfast or incontinent residents shall be provided draw sheets.

5. A sufficient number of blankets shall be provided to keep each resident warm. Blankets shall be changed and laundered as often as necessary to maintain cleanliness and freedom from odors.

6. Each bed shall have a clean, washable bedspread.

(c) *Other furnishings.* 1. Each resident who is confined to bed shall be provided with a bedside storage unit containing at least one drawer for personal items and a drawer or compartment for necessary nursing equipment. All other residents shall be provided with a storage unit in the resident's room, containing at least one drawer for personal items and a drawer or compartment for necessary nursing equipment.

2. a. At least one chair shall be in each room for each bed. A folding chair shall not be used. If requested by the resident or guardian, a wheelchair or geri-chair may be substituted.

b. An additional chair with arms shall be available upon request.

3. A properly shaded reading light in working condition shall be installed over or at each bed.

4. Adequate compartment or drawer space shall be provided in each room for each resident to store personal clothing and effects and to store, as space permits, other personal possessions in a reasonably secure manner.

5. A sturdy and stable table that can be placed over the bed or armchair shall be provided to every resident who does not eat in the dining area.

(d) *Towels, washcloths, and soap.* 1. Clean towels and washcloths shall be provided to each resident as needed. Towels shall not be used by more than one resident between launderings.

2. An individual towel rack shall be installed at each resident's bedside or at the lavatory.

3. Single service towels and soap shall be provided at each lavatory for use by staff.

(e) *Window coverings.* Every window shall be supplied with flame retardant shades, draw drapes or other covering material or devices which, when properly used and maintained, shall afford privacy and light control for the resident.

(2) RESIDENT CARE EQUIPMENT. (a) *Personal need items.* When a resident because of his or her condition needs a mouthwash cup, a wash basin, a soap dish, a bedpan, an emesis basin, or a standard urinal and cover, that item shall be provided to the resident. This equipment may not be interchanged between residents until it is effectively washed and sanitized.

(b) *Thermometers.* If reusable oral and rectal thermometers are used, they shall be cleaned and disinfected between use.

(c) *First aid supplies.* Each nursing unit shall be supplied with first aid supplies, including bandages, sterile gauze dressings, bandage scissors, tape, and a sling tourniquet.

(d) *Other equipment.* Other equipment, such as wheelchairs with brakes, footstools, commodes, foot cradles, footboards, under-the-mattress bedboards, walkers, trapeze frames, transfer boards, parallel bars, reciprocal pulleys, suction machines, patient lifts, and Stryker or Foster frames, shall be used as needed for the care of the residents.

(3) MAINTENANCE. All furnishings and equipment shall be maintained in a usable, safe and sanitary condition.

(4) STERILIZATION OF SUPPLIES AND EQUIPMENT. Each facility shall provide sterilized supplies and equipment by one or more of the following methods:

(a) Use of an autoclave;

(b) Use of disposable, individually wrapped, sterile supplies such as dressings, syringes, needles, catheters, and gloves;

(c) Sterilization services under a written agreement with another facility; or

(d) Other sterilization procedures when approved in writing by the department.

(5) SANITIZATION OF UTENSILS. Utensils such as individual bedpans, urinals, and wash basins which are in use shall be sanitized in accordance with acceptable sanitization procedures on a routine schedule. These procedures shall be done in an appropriate area.

(6) DISINFECTION OF RESIDENT GROOMING UTENSILS. Hair care tools such as combs, brushes, metal instruments, and shaving equipment which are used for more than one resident shall be disinfected before each use.

(7) OXYGEN. (a) No oil or grease shall be used on oxygen equipment.

(b) When placed at the resident's bedside, oxygen tanks shall be securely fastened to a tip-proof carrier or base.

(c) Oxygen regulators shall not be stored with solution left in the attached humidifer bottle.

(d) When in use at the resident's bedside, cannulas, hoses, and humidifier bottles shall be changed and sterilized at least every 5 days.

(e) Disposable inhalation equipment shall be presterilized and kept in contamination-proof containers until used, and shall be replaced at least every 5 days when in use.

(f) With other inhalation equipment such as intermittent positive pressure breathing equipment, the entire resident breathing circuit, including nebulizers and humidifiers, shall be changed daily.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (1) (e), (2) (a) and (3), Register, January, 1987, No. 373, eff. 2-1-87.

HSS 132.72 Housekeeping services. (1) REQUIREMENT. Facilities shall develop and implement written policies that ensure a safe and sanitary environment for personnel and residents at all times.

(2) CLEANING. (a) *General.* The facility shall be kept clean and free from offensive odors, accumulations of dirt, rubbish, dust, and safety hazards.

(b) *Floors.* Floors and carpeting shall be kept clean. Polishes on floors shall provide a nonslip finish. Carpeting or any other material covering the floors that is worn, damaged, contaminated or badly soiled shall be replaced.

(c) *Other surfaces.* Ceilings and walls shall be kept clean and in good repair at all times. The interior and exterior of the buildings shall be painted or stained as needed to protect the surfaces. Loose, cracked, or peeling wallpaper or paint shall be replaced or repaired.

(d) *Furnishings.* All furniture and other furnishings shall be kept clean and in good repair at all times.

(e) *Combustibles in storage areas.* Attics, cellars and other storage areas shall be kept safe and free from dangerous accumulations of combustible materials. Combustibles such as cleaning rags and compounds shall be kept in closed metal containers.

(f) *Grounds.* The grounds shall be kept free from refuse, litter, and waste water. Areas around buildings, sidewalks, gardens, and patios shall be kept clear of dense undergrowth.

(3) POISONS. All poisonous compounds shall be clearly labeled as poisonous and, when not in use, shall be stored in a locked area separate from food, kitchenware, and medications.

(4) GARBAGE. (a) *Storage containers.* All garbage and rubbish shall be stored in leakproof, nonabsorbent containers with close-fitting covers, and in areas separate from those used for the preparation and storage of food. Containers shall be cleaned regularly. Paperboard containers shall not be used.

(b) *Disposal.* Garbage and rubbish shall be disposed of promptly in a safe and sanitary manner.

(5) LINEN AND TOWELS. Linens shall be handled, stored, processed, and transported in such a manner as to prevent the spread of infection. Soiled linen shall not be sorted, rinsed, or stored in bathrooms, residents' rooms, kitchens, food storage areas, nursing units, or common hallways.

Note: For linen supplies, see s. HSS 132.71 (1) (b) 4; for change of linens, see s. HSS 132.60 (1) (a) 2; for toweling, see s. HSS 132.71 (1) (d).

(6) PEST CONTROL. (a) *Requirement.* The facility shall be maintained reasonably free from insects and rodents, with harborages and entrances of insects and rodents eliminated.

(b) *Provision of service.* Pest control services shall be provided in accordance with the requirements of s. 94.705, Stats.

(c) *Screening of windows and doors.* All windows and doors used for ventilation purposes shall be provided with wire screening of not less than number 16 mesh or its equivalent and shall be properly installed and maintained to prevent entry of insects. Screen doors shall be self-closing and shall not interfere with exiting. Properly installed airflow curtains or fans may be used in lieu of screens.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (2) (b), (c) and (e), (6) (c), Register, January, 1987, No. 373, eff. 2-1-87.

Subchapter VIII — Life Safety, Design and Construction

HSS 132.81 Scope and definitions. (1) APPLICATION. This subchapter applies to all facilities except where noted. Wherever the rules in ss. HSS 132.83 and 132.84 modify the applicable life safety code under s. HSS 132.82, these rules shall take precedence.

(2) DEFINITIONS. The definitions in the applicable life safety code required under s. HSS 132.82 apply to this subchapter. In addition, in this subchapter:

(a) "Life safety code" means the National Fire Protection Association's standard 101.

(b) "Period A facility" means a facility or a portion of a facility which before July 1, 1964, was either licensed as a nursing home or had the plans approved by the department; a county home or county mental hospital approved under former ch. PW 1 or ch. PW 2 before July 1, 1964, which is to be converted to nursing home use; a hospital approved under ch. HSS 124 before July 1, 1964, which is to be converted to nursing home use; or any other recognized inpatient care facility in operation before July 1, 1964, to be converted to nursing home use.

(c) "Period B facility" means a facility or a portion of a facility the plans for which were approved by the department on or after July 1, 1964, but no later than December 1, 1974; a county home or county mental hospital approved under former ch. PW 1 or ch. PW 2, on or after July 1, 1964, but no later than December 1, 1974, which is to be converted for nursing home use; or any other recognized inpatient care facility in operation on or after July 1, 1964, but no later than December 1, 1974, which is to be converted to nursing home use.

(d) "Period C facility" means a facility, the plans for which were approved by the department after December 1, 1974, including new additions to existing licensed facilities and major remodeling and alterations.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; r. and recr. (2), Register, January, 1987, No. 373, eff. 2-1-87; reprinted to restore dropped copy in (2) (b), Register, May, 1987, No. 377.

HSS 132.815 Fees for plan reviews. (1) REQUIREMENT. Before the start of any construction or remodeling project for a nursing home, the plans for the construction or remodeling shall be submitted to the department, pursuant to s. HSS 132.84 (17), for review and approval by the department. The fees established in this section shall be paid to the department for providing plan review services.

(2) BASIC FEE SCHEDULE. The department shall charge nursing homes the following fees for review of plans for all capital construction and remodeling projects:

(a) For projects with an estimated dollar value of less than $5,000, a fee of $100;

(b) For projects with an estimated dollar value of at least $5,000 but less than $25,000, a fee of $300;

(c) For projects with an estimated dollar value of at least $25,000 but less than $100,000, a fee of $500;

(d) For projects with an estimated dollar value of at least $100,000 but less than $500,000, a fee of $750;

(e) For projects with an estimated dollar value of at least $500,000 but less than $1 million, a fee of $1,500;

(f) For projects with an estimated dollar value of at least $1 million but less than $5 million, a fee of $2,500; and

(g) For projects with an estimated dollar value of over $5 million, a fee of $5,000.

(3) HANDLING AND COPYING FEES. (a) The department shall charge a handling fee of $50 per plan to the submitting party for any plan which is submitted to the department, entered into the department's system and then the submitting party requests that it be returned prior to review.

(b) The department may charge a photocopying fee of 25 cents per page to anyone who requests copies of construction or remodeling plans, except that a fee of $5 per plan sheet shall be charged for reproduction of plan sheets larger than legal size.

History: Emerg. cr. eff. 1-1-94; cr. Register, August, 1994, No. 464, eff. 9-1-94.

HSS 132.82 Life safety code. (1) 1967 CODE. Facilities with construction plans first approved by the department prior to June 1, 1976, shall meet the applicable provisions of either the 21st edition (1967) or 23rd edition (1973) of the Life Safety Code. (See Table 132.82).

(2) 1973 CODE. Facilities with construction plans first approved by the department on or after June 1, 1976, but before November 26, 1982, shall meet the applicable provisions of the 23rd edition (1973) of the Life Safety Code. (See Table 132.82).

(3) 1981 CODE. Facilities with construction plans first approved by the department on or after November 26, 1982, but before July 1, 1994, shall meet the applicable provisions of the 25th edition (1981) of the Life Safety Code. (See Table 132.82).

(3m) 1991 CODE. Facilities with construction plans first approved by the department on or after July 1, 1994, shall meet the applicable provisions of the 1991 edition of the Life Safety Code. (See Table 132.82).

(4) FIRE SAFETY EVALUATION SYSTEM. A proposed or existing facility not meeting all requirements of the applicable life safety code shall be considered in compliance if it achieves a passing score on the Fire Safety Evaluation System (FSES), developed by the United States department of commerce, national bureau of standards, to establish safety equivalencies under the life safety code.

Note: See par. 1-3118, 1973 Life Safety Code. The FSES has been adopted for purposes of certification under the Medicaid program. See the July 28, 1980, Federal Register (45 FR 50264).

Note: Copies of the 1967, 1973 and 1981 Life Safety Codes and related codes can be obtained from the National Fire Protection Association, Batterymarch Park, Quincy, MA 02269. Copies are kept on file in the offices of the bureau of quality compliance, the secretary of state, and the revisor of statutes.

(5) APPLICABLE CODES. The applicable provisions of the life safety codes required by subs. (1), (2), (3) and (3m) shall apply to facilities as follows:

TABLE 132.82

Life Safety Code Requirements

FACILITY TYPE AND AGE	1967 NFPA 101 LIFE SAFETY CODE (Existing)	1967 NFPA 101 LIFE SAFETY CODE (New)	1973 NFPA 101 LIFE SAFETY CODE (Existing)	1973 NFPA 101 LIFE SAFETY CODE (New)	1981 NFPA 101 LIFE SAFETY CODE (Existing)	1981 NFPA 101 LIFE SAFETY CODE (New)	1991 NFPA 101 LIFE SAFETY CODE (Existing)	1991 NFPA 101 LIFE SAFETY CODE (New)
Skilled Care								
Plans approved prior to October 28, 1971	X		0		0		0	
Plans approved on or after Oct. 28, 1971, but prior to June 1, 1976		X	0		0		0	
Plans approved on or after June 1, 1976, but prior to Nov. 26, 1982				X	0		0	
Plans approved on or after November 26, 1982, but prior to July 1, 1994					X		0	
Plans approved on or after July 1, 1994							0	X
Intermediate Care								
Plans approved prior to March 17, 1974	X		0		0		0	
Plans approved on or after March 17, 1974, but prior to June 1, 1976		X	0		0		0	
Plans approved on or after June 1, 1976, but prior to Nov. 26, 1982		X	0		0		0	
Plans approved on or after November 26, 1982, but prior to July 1, 1994					X		0	
Plans approved on or after July 1, 1994								X

X = Standard requirements apply.
0 = Alternate requirements, that is, more recent editions of the Life Safety Code, which may be substituted for standard requirements at the option of the facility.

(6) RESIDENT SAFETY AND DISASTER PLAN. (a) *Disaster plan.* 1. Each facility shall have a written procedure which shall be followed in case of fire or other disasters, and which shall specify persons to be notified, locations of alarm signals and fire extinguishers, evacuation routes, procedures for evacuating helpless residents, frequency of fire drills, and assignment of specific tasks and responsibilities to the personnel of each shift and each discipline.

2. The plan shall be developed with the assistance of qualified fire and safety experts, including the local fire authority.

3. All employes shall be oriented to this plan and trained to perform assigned tasks.

4. The plan shall be available at each nursing station.

5. The plan shall include a diagram of the immediate floor area showing the exits, fire alarm stations, evacuation routes, and locations of fire extinguishers. The diagram shall be posted in conspicuous locations in the corridor throughout the facility.

(b) *Drills.* Fire drills shall be held at irregular intervals at least 4 times a year on each shift and the plan shall be reviewed and modified as necessary. Records of drills and dates of drills shall be maintained.

(c) *Fire inspections.* The administrator of the facility shall arrange for fire protection as follows:

1. At least semiannual inspection of the facility shall be made by the local fire inspection authorities. Signed certificates of such inspections shall be kept on file in the facility.

2. Certification by the local fire authority as to the fire safety of the facility and to the adequacy of a written fire plan for orderly evacuation of residents shall be obtained and kept on file in the facility.

3. Where the facility is located in a city, village, or township that does not have an official established fire department, the licensee shall obtain and maintain a continuing contract for fire protection service with the nearest municipality providing such service. A certification of the existence of such contract shall be kept on file in the facility.

(d) *Fire equipment.* All fire protection equipment shall be maintained in readily usable condition and inspected annually. In addition to any other equipment, a fire extinguisher suitable for grease fires shall be provided in or adjacent to the kitchen. Each extinguisher shall be provided with a tag for the date of inspection.

Note: See NFPA 10, 1973 edition.

(e) *Fire report.* All incidents of fire in a facility shall be reported to the department within 72 hours.

(f) *Smoking.* Smoking by residents shall be permitted only in designated areas supervised in accordance with the conditions, needs, and safety of residents.

(g) *Prevention of ignition.* Heating devices and piping shall be designed or enclosed to prevent the ignition of clothing or furnishings.

(h) *Floor coverings.* Scatter rugs and highly polished, slippery floors are prohibited, except for non-slip entrance mats. All floor coverings and edging shall be securely fastened to the floor or so constructed that they are free of hazards such as curled and broken edges.

(i) *Roads and sidewalks.* The ambulatory and vehicular access to the facility shall be kept passable and open at all times of the year. Sidewalks, drives, fire escapes, and entrances shall be kept free of ice, snow, and other obstructions.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; r. and recr. (1) and (2), r. (4), renum. (3) and (5) to be (4) and (6), cr. (3) and (5), Register, January, 1987, No. 373, eff. 2-1-87;

emerg. am. (3), cr. (3m), r. and recr. (5) and Table, eff. 7-1-94; am. (3), cr. (3m), r. and recr. (5) and Table, Register, January, 1995, No. 469, eff. 2-1-95.

HSS 132.83 Safety and systems. (1) MAINTENANCE. The building shall be maintained in good repair and kept free of hazards such as those created by any damaged or defective building equipment.

(2) CORRIDORS. (a) *Handrails.* Corridors used by residents shall be equipped with handrails firmly secured on each side of the corridor.

(b) *Size.* 1. In period A facilities, all corridors in resident use areas shall be at least 4 feet wide.

2. In period B facilities, all corridors in resident use areas shall be at least 7 feet wide.

3. In period C facilities, all corridors in resident use areas shall be at least 8 feet wide.

(3) DOORS. (a) *Size.* 1. Doorways to residents' rooms, between residents' rooms and exits, and exit doorways shall be at least 28 inches wide.

2. In period B and C facilities, doors to residents' rooms shall not be less than 3 feet 8 inches wide and 6 feet 8 inches in height, and shall be at least one and three-quarter inches solid core wood or equivalent construction.

(b) *Latches.* Each exit door shall have such latches or hardware that the door can be opened from the inside by pushing against a single bar or plate or by turning a single knob or handle.

(c) *Locks.* 1. Exit doors from the building and from nursing areas and wards may not be hooked or locked to prevent exit from the inside, unless this is authorized under s. HSS 132.33.

Note: Written approval to lock exits must also be obtained from the department of industry, labor and human relations in accordance with ss. ILHR 51.15 (3) and 58.20.

2. No lock shall be installed on the door of a resident's room, unless:

a. The lock is operable from inside the room with a simple one-hand, one-motion operation without the use of a key unless the resident is confined in accordance with s. HSS 132.33;

b. All personnel regularly assigned to work in a resident care area have in their possession a master-key for the rooms in that area;

c. A master-key is available to emergency personnel such as the fire department; and

d. The resident is capable of following directions and taking appropriate action for self-preservation under emergency conditions.

(d) *Toilet room doors.* In period B and C facilities, resident toilet room doors shall be not less than 3 feet 0 inches by 6 feet 8 inches, and shall not swing into the toilet room unless they are provided with two-way hardware.

(e) *Thresholds.* In period B and C facilities, raised thresholds which cannot be traversed easily by a bed on wheels, a wheelchair, a drug cart, or other equipment on wheels shall not be used.

(4) EMERGENCY POWER. Emergency electrical service with an independent power source which covers lighting at nursing stations, telephone switchboards, exit and corridor lights, boiler room, and fire alarm systems, shall be provided. The service may be battery operated if effective for at least 4 hours.

(5) FIRE PROTECTION. (a) *Carpeting.* Carpeting shall not be installed in rooms used primarily for the following purposes: food preparation and storage, dish and utensil washing, soiled utility workroom, janitor closet, laundry processing, hydro-therapy, toilet and bathing, resident isolation, and resident examination.

(b) *Carpet fireproofing.* Carpeting, including underlying padding, if any, shall have a flamespread rating of 75 or less when tested in accordance with standard 255 of the national fire protection association (NFPA), or a critical radiant flux of more than 0.45 watts per square centimeter when tested in accordance with NFPA standard 253, 1978 edition. Certified proof by the manufacturer of the aforementioned test for the specific product shall be available in the facility. Certification by the installer that the material installed is the product referred to in the test shall be obtained by the facility. Carpeting shall not be applied to walls in any case except where the flamespread rating can be shown to be 25 or less.

(c) *Acoustical tile.* Acoustical tile shall be noncombustible.

(d) *Wastebaskets.* Wastebaskets shall be of noncombustible materials.

(e) *Vertical exit stairways.* At least one interior exit stairway shall be provided so that an enclosed protected path of at least one-hour fire-resistive construction is available for occupants to proceed with safety to the exterior of the facility.

(f) *Fire escapes.* In period A and period B facilities, outside fire escapes are permitted as one means of egress if they meet all of the following requirements:

1. Iron, steel, or concrete or other approved noncombustible material shall be used in the construction and support of the fire escape.

2. No part of access or travel in the path of exit shall be across a roof or other part of a facility which is of combustible construction.

3. Protection against fire in the facility shall be by blank or closed walls directly under the stairway and for a distance of 6 feet in all other directions. A window shall be permitted within this area if it is stationary, of steel sash construction, and is glazed with wire glass of not less than ¼-inch thickness. The size of wire glass shall not exceed 1296 square inches with no dimension exceeding 54 inches in either length or width.

4. The fire escape shall be protected with a roof and at least partial sidewalls to prevent the accumulation of snow and ice.

5. The bottom riser shall terminate at ground level, with the last riser not more than the spacing of the riser above.

6. A tubular or spiral slide-type fire escape shall not be permitted.

(g) *Housing blind, nonambulatory, or handicapped residents.* In an existing facility of 2 or more stories which is not of at least two-hour fire-

resistive construction, blind, nonambulatory, or physically handicapped residents shall not be housed above the street level floor unless the facility is either of one-hour protected noncombustible construction (as defined in national fire protection standard 220), fully sprinklered one-hour protected ordinary construction, or fully sprinklered one-hour protected woodframe construction.

(h) *Storage of oxygen.* Oxygen tanks, when not in use, shall be stored in a ventilated closet designated for that purpose or stored outside the building of the home in an enclosed secured area.

(6) SPRINKLERS FOR FIRE PROTECTION. (a) *Facilities licensed prior to December 1, 1974.* Unless all walls, partitions, piers, columns, floors, ceilings, roofs and stairs are built of noncombustible material, and all metallic structural members are protected by a noncombustible fire-resistive covering, facilities licensed prior to December 1, 1974 shall have automatic sprinkler protection throughout all buildings.

(b) *Facilities licensed on or after December 1, 1974.* Except for the following, all facilities licensed on or after December 1, 1974 shall have automatic sprinkler protection throughout all buildings.

1. In the event of an addition to, or remodeling of, a facility licensed prior to December 1, 1974, the entire facility shall have automatic sprinkler protection throughout unless there is a 2-hour fire-rated partition wall between the old and new construction, in which case only the new or remodeled area shall be sprinklered.

2. In the event of the conversion of a portion of a recognized inpatient care facility in operation prior to December 1, 1974 to a facility licensed under this chapter, the facility shall have automatic sprinkler protection throughout unless there is a 2-hour fire-rated partition wall separating the portion of the facility licensed under this chapter from the rest of the building, in which case only the portion of the facility licensed under this chapter shall be sprinklered.

(7) MECHANICAL SYSTEMS. (a) *Water supply.* 1. A potable water supply shall be maintained at all times. If a public water supply is available, it shall be used. If a public water supply is not available, the well or wells shall comply with ch. NR 812.

2. An adequate supply of hot water shall be available at all times. The temperature of hot water at plumbing fixtures used by residents may not exceed 110° F. (43° C.) and shall be automatically regulated by control valves or by another approved device.

(b) *Sewage disposal.* All sewage shall be discharged into a municipal sewage system if available. Otherwise, the sewage shall be collected, treated, and disposed of by means of an independent sewage system approved under applicable state law and the local authority.

(c) *Plumbing.* The plumbing for potable water and drainage for the disposal of excreta, infectious discharge, and wastes shall comply with applicable state plumbing standards.

(d) *Heating and air conditioning.* 1. The heating and air conditioning systems shall be capable of maintaining adequate temperatures and providing freedom from drafts.

2. A minimum temperature of 72° F. (22° C.) shall be maintained during the day and at least 70° F. (21° C.) during the night in all bedrooms and in all other areas used by residents.

(e) *Incineration.* 1. Facilities for the incineration of soiled dressings and similar wastes, as well as garbage and refuse, shall be provided when other methods of disposal are not available.

2. An incinerator shall not be flue fed nor shall any upper floor charging chute be connected with the combustion chamber.

(f) *Telephone.* There shall be at least one operational non-pay telephone on the premises and as many additional telephones as are deemed necessary in an emergency or required by s. HSS 132.84 (3).

(g) *General lighting.* 1. Adequate lighting shall be provided in all areas of the facility. Lighting shall be of a type that does not produce discomfort due to high brightness, glare or reflecting surface. No candles, oil lanterns, or other open flame method of illumination may be used.

2. Period C facilities shall have night lighting.

(h) *Ventilation.* 1. The facility shall be well-ventilated through the use of windows, mechanical ventilation, or a combination of both. Rooms and areas which do not have outside windows and which are used by residents or personnel shall be provided with functioning mechanical ventilation to change the air on a basis commensurate with the type of occupancy.

2. All inside bathrooms and toilet rooms shall have mechanical ventilation to the outside.

3. In period A facilities, kitchens, bathrooms, utility rooms, janitor closets, and soiled linen rooms shall be ventilated.

4. In period B facilities, when mechanical ventilation is provided, the corridors, solaria, dining, living, and recreation areas shall be under positive pressure.

5. In period C facilities:

a. Mechanical ventilation shall be provided to the resident area corridors, solaria, dining, living and recreation areas, and nursing station. These areas shall be under positive pressure.

b. All rooms in which food is stored, prepared or served, or in which utensils are washed shall be well-ventilated. Refrigerated storage rooms need not be ventilated.

(i) *Elevators.* 1. In period B facilities, at least one elevator shall be provided when residents' beds are located on one or more floors above or below the dining or service floor. The platform size of the elevator shall be large enough to hold a resident bed and attendant.

2. In period C facilities, at least one elevator shall be provided in the facility if resident beds or activities are located on more than one floor. The platform size of the elevator shall be large enough to hold a resident bed and an attendant.

(j) *Electrical.* 1. In all facilities, nonconductive wall plates shall be provided where the system is not properly grounded.

2. In period B and C facilities:

a. At least one duplex-type outlet shall be provided for every resident's bed; and

b. Silent-type wall switches shall be provided.

3. In new construction begun after the effective date of this chapter, at least 2 duplex-type outlets shall be provided for each bed.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (3) (c) 1, (5) (e) and (f) (intro), (6) (b), (7) (a), (f), (g) 1., (j) 2., Register, January, 1987, No. 373, eff. 2-1-87; emerg. am. (6) (a), r. and recr. (6) (b), eff. 7-1-94; am. (6) (a), r. and recr. (6) (b), Register, January, 1995, No. 469, eff. 2-1-95.

HSS 132.84 Design. (1) RESIDENTS' ROOMS. (a) *Assignment of residents.* Sexes shall be separated by means of separate wings, floors, or rooms, except in accordance with s. HSS 132.31 (1) (f) 1.

(b) *Location.* No bedroom housing a resident shall:

1. Open directly to a kitchen or laundry;

Next page is numbered 403

2. Be located so that a person must pass through another resident's bedroom, a toilet room or a bathroom to gain access to any other part of the facility; or

3. Be located so that a person must pass through a kitchen or laundry to gain access to the resident's room or other part of the facility.

(c) *Access to corridor and outside.* Each bedroom shall have direct access to a corridor and outside exposure with the floor at or above grade level.

(d) *Size.* 1. The minimum floor area per bed shall be 100 square feet in single rooms and 80 square feet per bed in multiple bedrooms, exclusive of vestibule, closets, built-in vanity and wardrobe, toilet rooms and built-in lockers. The department may waive this requirement in individual cases where the facility has demonstrated in writing that such variations are in accordance with the particular needs of the residents and will not adversely affect their health and safety.

2. In period C facilities, resident rooms shall be large enough to permit the sides and feet of all beds to be not less than 2 feet from the nearest walls.

3. a. In period A facilities, ceilings shall be at least 7 feet in height.

b. In period B and C facilities, ceilings shall be at least 8 feet in height.

(e) *Windows.* In period B and C facilities, the bottom sill of windows in bedrooms shall be no more than 3 feet from the floor.

(f) *Bed capacity.* No rooms shall house more than 4 beds.

(g) *Bed arrangement.* The beds shall be arranged so that the beds shall be at least 3 feet apart and a clear aisle space of at least 3 feet from the entrance to the room to each bed shall be provided.

(h) *Closet space.* A closet or locker shall be provided for each resident in each bedroom. Closets or lockers shall afford a space of not less than 15 inches wide by 18 inches deep by 5 feet in height for each resident bed.

(i) *Cubicle curtains.* 1. In period A and B facilities, each bed in a multiple-bed room shall have a flameproof cubicle curtain or an equivalent divider that will assure resident privacy.

2. In period C facilities, each bed in a multiple-bed room shall be provided with a flameproof cubicle curtain to enclose each bed and to assure privacy.

(j) *Room identification.* Each bedroom shall be identified with a unique number placed on or near the door.

(k) *Design and proximity to baths.* Residents' bedrooms shall be designed and equipped for adequate nursing care and the comfort and privacy of residents. Each bedroom shall have or shall be conveniently located near adequate toilet and bathing facilities.

(2) TOILET AND BATHING FACILITIES. (a) *General.* All lavatories required by this subsection shall have hot and cold running water. Toilets shall be water flushed and equipped with open front seats without lids.

(b) *Employe and family facilities.* Toilets, baths, and lavatories for use by employes or family members shall be separate from those used by residents.

(c) *Grab bars.* Firmly secured grab bars shall be installed in every toilet and bathing compartment used by residents.

(d) *Wheelchair facilities.* 1. On floors housing residents who use wheelchairs, there shall be at least one toilet room large enough to accommodate wheelchairs.

2. In all facilities licensed for skilled care, a bathtub or shower room large enough to accommodate a wheelchair and attendant shall be provided.

Note: Requirements for wheelchair access to public toilets are contained in ss. ILHR 52.041 and 52.042, Wis. Adm. Code.

(e) *Period A and B.* In period A and B facilities:

1. Separate toilet and bath facilities shall be provided for male and female residents in at least the following number:

a. One toilet and one lavatory for every 8 female residents;

b. One toilet and one lavatory for every 8 male residents. One urinal may be substituted for one toilet for every 24 male residents;

c. In period A facilities, one tub or shower for every 20 residents; and

d. In period B facilities, one tub or shower for every 20 female residents and one for every 20 male residents.

2. Toilet and bath facilities shall be located on the floors of the residents to be served, and shall be separated in such a manner that they can be used independently and afford privacy.

(f) *Period C.* In period C facilities:

1. Toilet facilities shall be provided in conjunction with each resident's room, with not more than 2 residents' rooms, and not more than 4 beds per toilet room.

2. One toilet and one lavatory for not more than 4 residents shall be provided and separate facilities shall be provided for each sex.

3. One tub or shower for every 20 residents of each sex shall be provided. The bath or shower shall be located on the same floor as the residents served. Facilities for showering with a wheeled shower chair shall be provided.

4. Every tub, shower, or toilet shall be separated in such a manner that it can be used independently and afford privacy.

5. On floors where wheelchair residents are cared for, there shall be a toilet room large enough to accommodate a wheelchair and attendant.

(g) The requirement in pars. (e) and (f) of separate facilities for male and female residents is not applicable to facilities used by married couples sharing a room, if the facilities are not used by other residents.

(3) NURSING FACILITIES. (a) *All facilities.* In addition to the requirements of pars. (b), (c) or (d), each facility shall have:

1. A medicine storage area;

2. Space for storage of linen, equipment, and supplies; and

3. A utility room, which shall be located, designed, and equipped to provide areas for the separate handling of clean and soiled linen, equipment, and supplies.

(b) *Period A.* 1. Period A facilities shall have a well-lighted nurse station or office in the residents' rooms area for records and charts, with at least a file cabinet, desk, residents' chart holder, and operational telephone. No nurse station shall serve more than 2 floors.

2. Each period A facility shall have a well-illuminated medication preparation area equipped with a sink and hot and cold running water.

3. In period A facilities licensed for skilled care, toilet and handwashing facilities separate from those for residents shall be provided for staff use.

(c) *Period B.* In period B facilities, each resident care area or floor shall have:

1. A lighted, centrally located nurse station with provision for records and charts, a desk or work counter, and operational telephone;

2. A medicine preparation area or room in, or immediately adjacent to, the nurse station, with a work counter, sink, and well-lighted medicine cabinet with lock;

3. A ventilated utility room with a flush-rim clinic service sink; and

4. In period B facilities licensed for skilled care, toilet and handwashing facilities separate from those of residents shall be provided for staff use.

(d) *Period C.* In period C facilities, each resident care area on each floor shall have:

1. A centrally located nurse station located to provide visual control of all resident room corridors; equipped with storage for records and charts, a desk or work counter, operational telephone, and a nurse call system as required by sub. (4);

2. A medicine preparation room immediately adjacent to the nurse station with a work counter, refrigerator, sink, and a well-lighted medicine cabinet with lock and space for medication cart. The room shall be mechanically ventilated;

3. A soiled utility room with a flush-rim siphon jet service sink, a facility for bedpan sanitization, cabinet counter, and sink with hot and cold running water. The utility room shall be mechanically ventilated and under negative pressure;

4. A clean utility area or room with a sink with hot and cold running water, counter, and cabinets;

5. Staff toilet and lavatory facilities separate from those of residents, adjacent to each nursing station; and

6. If a kitchen is not open at all times, a nourishment station with sink, hot and cold running water, refrigerator, and storage for serving be-

tween-meal nourishment. Each station may service more than one nursing area.

(4) NURSE CALL SYSTEM. (a) *Period A.* Period A facilities shall have a nurse call system as follows:

1. If licensed for skilled care, a system that registers calls at the nurse station from each resident's bed, residents' toilet rooms, and each bathtub and shower; and

2. If licensed for other than skilled care, a system that registers calls at the nurse station from each resident's room, and from each bedfast resident's bed.

(b) *Period B.* Period B facilities shall have a nurse call system as provided by par. (a), except that, in addition, the system shall register from each bed and shall register in the corridor directly outside the room and at the nurse station or office.

(c) *Period C.* In period C facilities, a nurse call station shall be installed at each resident's bed, in each resident's toilet room, and at each bathtub and shower. The nurse call at the toilet, bath, and shower rooms shall be an emergency call equipped with pull cords of sufficient length to extend to within 6 inches of the floor. All calls shall register at the nurse station and shall actuate a visible signal in the corridor at the room door, in the clean workroom medicine preparation room, soiled workroom, and nourishment station of the nursing unit. In multicorridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms containing 2 or more calling stations, indicating lights shall be provided at each call station. Nurse call systems which provide two-way voice communications shall be equipped with an indicating light at each call station which lights and remains lighted as long as the voice circuit is operative. An emergency call station shall also be provided in any enclosed room used by residents.

(5) DINING, RECREATION AND ACTIVITY AREAS. (a) *Multipurpose space.* The facility shall provide one or more appropriately furnished multipurpose areas of adequate size for dining and for diversional and social activities of residents.

(b) *Lounge.* At least one dayroom or lounge, centrally located, shall be provided for use of the residents.

(c) *Size of dining rooms.* Dining rooms shall be of sufficient size to seat all residents at no more than 2 shifts. Dining tables and chairs shall be provided. TV trays or portable card tables shall not be used as dining tables.

(d) *Space.* If a multipurpose room is used for dining and diversional and social activities of residents, there shall be sufficient space to accommodate all activities and minimize their interference with each other.

(e) *Total area.* 1. In period A and B facilities, the combined floor space of dining, recreation, and activity areas shall not be less than 15 square feet per bed. Solaria and lobby sitting space may be included, but shall not include required exit paths. Required exit paths in these areas shall be at least 4 feet wide.

2. In period C facilities, the combined floor space of dining, recreation, and activity areas shall not be less than 25 square feet per bed. Solaria

and lobby sitting areas, exclusive of traffic areas, shall be categorized as living room space.

(6) FOOD SERVICE. (a) *General.* The facility shall have a kitchen or dietary area which shall be adequate to meet food service needs and shall be arranged and equipped for the refrigeration, storage, preparation, and serving of food, as well as for dish and utensil cleaning and refuse storage and removal. Dietary areas shall comply with the local health or food handling codes. Food preparation space shall be arranged for the separation of functions and shall be located to permit efficient services to residents and shall not be used for nondietary functions.

(b) *Period A.* In period A facilities:

1. Location. The kitchen shall be located on the premises or a satisfactory sanitary method of transportation of food shall be provided.

2. Proximity. Kitchen or food preparation areas shall not open into resident rooms, toilet rooms, or laundry.

3. Handwashing. Adequate and convenient handwashing facilities shall be provided for use by food handlers, including hot and cold running water, soap, and sanitary towels. Use of a common towel is prohibited.

4. Sink. At least a 2-compartment sink for manual dishwashing shall be provided in kitchens or dishwashing areas. A minimum three-compartment sink shall be provided for replacement.

5. Sanitation. Rooms subject to sewage or wastewater backflow or to condensation or leakage from overhead water or waste lines shall not be used for storage or food preparation unless provided with acceptable protection from such contamination.

(c) *Period B.* In period B facilities:

1. Traffic. Only traffic incidental to the receiving, preparation, and serving of food and drink shall be permitted.

2. Proximity. Toilet facilities shall not open directly into the kitchen.

3. Storage. Food day-storage space shall be provided adjacent to the kitchen.

4. Lavatory. A separate handwashing lavatory with soap dispenser, single service towel dispenser, or other approved hand drying facility shall be located in the kitchen.

5. Dishwashing area. A separate dishwashing area, preferably a separate room, shall be provided.

6. Sanitation. Rooms subject to sewage or wastewater backflow or to condensation or leakage from overhead water or waste lines shall not be used for storage or food preparation unless provided with acceptable protection from such contamination.

(d) *Period C.* In period C facilities:

1. Kitchen and dietary. Kitchen and dietary facilities shall be provided to meet food service needs and arranged and equipped for proper refrigeration, heating, storage, preparation, and serving of food. Adequate

space shall be provided for proper refuse handling and washing of waste receptacles, and for storage of cleaning compounds.

2. Traffic. Only traffic incidental to the receiving, preparation and serving of food and drink shall be permitted.

3. Toilets. No toilet facilities may open directly into the kitchen.

4. Food storage. Food day-storage space shall be provided adjacent to the kitchen and shall be ventilated to the outside.

5. Handwashing. A separate handwashing sink with soap dispenser, single service towel dispenser, or other approved hand drying facility shall be located in the kitchen.

6. Dishwashing. A separate dishwashing area, preferably a separate room, with mechanical ventilation shall be provided.

7. Sink. At least a 3-compartment sink shall be provided for washing, rinsing and sanitizing utensils, with adequate drainboards at each end. In addition, a single-compartment sink located adjacent to the soiled utensil drainboard shall be available for prewashing. The additional sink may also be used for liquid waste disposal. The size of each sink compartment shall be adequate to permit immersion of at least 50 percent of the largest utensil used. In lieu of the additional sink for prewashing, a well-type garbage disposal with overhead spray wash may be provided.

8. Mechanical dishwashers. Mechanical dishwashers and utensil washers, where provided, shall meet the requirements of the current approved list from the national sanitation foundation or equivalent with approval of the department.

Note: Copies of the National Sanitation Foundation's "Listing of Food Service Equipment" are kept on file and may be consulted in the department and in the offices of the secretary of state and the revisor of statutes.

9. Temperature. Temperature gauges shall be located in the wash compartment of all mechanical dishwashers and in the rinse water line at the machine of a spray-type mechanical dishwasher or in the rinse water tank of an immersion-type dishwasher. The temperature gauges shall be readily visible, fast-acting and accurate to plus or minus 2° F. or one° C.

10. Fire extinguishers. Approved automatic fire extinguishing equipment shall be provided in hoods and attached ducts above all food cooking equipment.

11. Walls. The walls shall be of plaster or equivalent material with smooth, light-colored, nonabsorbent, and washable surfaces.

12. Ceiling. The ceiling shall be of plaster or equivalent material with smooth, light-colored, nonabsorbent, washable, and seamless surfaces.

13. Floors. The floors of all rooms, except the eating areas of dining rooms, in which food or drink is stored, prepared, or served, or in which utensils are washed, shall be of such construction as to be nonabsorbent and easily cleaned.

14. Screens. All room openings to the out-of-doors shall be effectively screened. Screen doors shall be self-closing.

15. Lighting. All rooms in which food or drink is stored or prepared or in which utensils are washed shall be well-lighted.

16. Sewage contamination. Rooms subject to sewage or waste water backflow or to condensation or leakage from overhead water or waste lines shall not be used for storage or food preparation unless provided with acceptable protection from such contamination.

(7) STORAGE. (a) *Resident's storage.* In period B and C facilities, one or more central storage spaces shall be provided in the facility building for the storing of residents' possessions such as trunks, luggage, and off-season clothing. The storage space shall total at least 50 cubic feet per resident bed.

(b) *General storage.* A general storage area shall be provided for supplies, equipment, and wheelchairs. Period C facilities shall have such storage space on each nursing unit.

(c) *Linen.* 1. Period B facilities shall provide a linen closet or cabinet for each floor or wing.

2. Period C facilities shall provide a linen storage space or cabinet for each nursing unit.

(8) FAMILY AND EMPLOYE LIVING QUARTERS. Any family and employe living quarters shall be separate from the residents' area.

(9) EMPLOYE FACILITIES. (a) In period A and B facilities, space shall be provided for employe wraps, purses, and other personal belongings when on duty, but this space shall not be located in food preparation, food storage or utensil washing areas, or in residents' rooms.

(b) In period C facilities, the following shall be provided for employes, and shall not be located in food preparation, food storage, utensil washing areas, or in resident's rooms:

1. A room or rooms for employe wraps, with lockers for purses and other personal belongings when on duty;

2. Handwashing lavatories with soap dispenser, single-service towel dispenser, or other approved hand drying equipment; and

3. Toilet facilities separate from those used by residents.

(10) JANITOR FACILITIES. (a) Period B facilities shall have a ventilated janitor closet on each floor equipped with hot and cold running water and a service sink or receptor.

(b) Period C facilities shall have a mechanically ventilated janitor closet of adequate size on each floor and in the food service area, equipped with hot and cold running water and a service sink or receptor.

(11) LAUNDRY FACILITIES. (a) *Facilities.* A laundry room shall be provided unless commercial laundry facilities are used. Laundry facilities shall be located in areas separate from resident units and shall be provided with necessary washing, drying, and ironing equipment.

(b) *Work room.* When commercial laundries are used, a room for sorting, processing, and storing soiled linen shall be provided and shall have mechanical exhaust ventilation.

(c) *Period C.* In addition to the requirements of pars. (a) and (b), period C facilities shall have:

1. A soiled linen sorting room separate from the laundry, which shall be mechanically ventilated and under negative pressure.

2. A lavatory with both hot and cold running water, soap, and individual towels in the laundry area.

(12) ISOLATION ROOM. (a) *Period B.* Period B facilities shall have available a room with handwashing facilities for the temporary isolation of a resident.

(b) *Period C.* For every 100 beds or fraction thereof, period C facilities shall have available one separate single room, equipped with separate toilet, handwashing, and bathing facilities, for the temporary isolation of a resident. The isolation room bed shall be considered part of the licensed bed capacity of the facility.

(13) ROOMS FOR OTHER SERVICES IN PERIOD C FACILITIES. (a) *Requirement.* Period C facilities which are licensed for skilled care shall have at least one room available for examinations, treatments, dental services, and other therapeutic procedures needed by residents.

(b) *Equipment.* The examination room shall be of sufficient size and shall be equipped to provide for resident needs.

(c) *Rooms for rehabilitative services.* Rooms for rehabilitative services shall be of sufficient size to accommodate necessary equipment and facilitate the movement of disabled residents. Lavatories and toilets designed for use by wheelchair residents shall be provided in these rooms.

(14) ADMINISTRATION AND ACTIVITY AREAS. In period C facilities:

(a) *Administration and resident activity areas.* Administration and resident activities areas shall be provided. The sizes of the various areas will depend upón the requirements of the facility. Some functions allotted separate spaces or rooms under par. (b) may be combined, provided that the resulting plan will not compromise acceptable standards of safety, medical and nursing practices, and the social needs of residents.

(b) Administration department areas shall include:

1. Business office;

2. Lobby and information center;

3. Office of administrator;

4. Admitting and medical records area;

5. Public and staff toilet room;

6. Office of director of nurses; and

7. Inservice training area.

(c) Resident activities areas shall include:

1. Occupational therapy;

2. Physical therapy;

3. Activity area; and

4. Beauty and barber shop.

(15) MIXED OCCUPANCY. Rooms or areas within the facility may be used for occupancy by individuals other than residents and facility staff if the following conditions are met:

(a) The use of these rooms does not interfere with the services provided to the residents; and

(b) The administrator takes reasonable steps to ensure that the health, safety and rights of the residents are protected.

(16) LOCATION AND SITE. For period C facilities:

(a) *Zoning.* The site shall adhere to local zoning regulations.

(b) *Outdoor areas.* A minimum of 15 square feet per resident bed shall be provided for outdoor recreation area, exclusive of driveways and parking area.

(c) *Parking.* Space for off-street parking for staff and visitors shall be provided.

(17) SUBMISSION OF PLANS AND SPECIFICATIONS. For all new construction:

(a) One copy of schematic and preliminary plans shall be submitted to the department for review and approval of the functional layout.

(b) One copy of working plans and specifications shall be submitted to and approved by the department before construction is begun. The department shall notify the facility in writing of any divergence in the plans and specifications, as submitted, from the prevailing rules.

(c) The plans specified in pars. (a) and (b) shall show the general arrangement of the buildings, including a room schedule and fixed equipment for each room and a listing of room numbers, together with other pertinent information. Plans submitted shall be drawn to scale.

(d) Any changes in the approved working plans affecting the application of the requirements herein established shall be shown on the approved working plans and shall be submitted to the department for approval before construction is undertaken. The department shall notify the facility in writing of any divergence in the plans and specifications, as submitted, from the prevailing rules.

(e) If on-site construction above the foundation is not started within 6 months of the date of approval of the working plans and specifications under par. (b), the approval shall be void and the plans and specifications shall be resubmitted for reconsideration of approval.

(f) If there are no divergences from the prevailing rules, the department shall provide the facility with written approval of the plans as submitted.

History: Cr. Register, July, 1982, No. 319, eff. 8-1-82; am. (3) (b) 2. and (13) (c), renum. (15) and (16) to be (16) and (17), cr. (15), Register, January, 1987, No. 373, eff. 2-1-87; am. (1) (b) 2., (2) (e) 1. c. and (5) (a).

APPENDIX A

FOOD AND NUTRITION BOARD. NATIONAL ACADEMY OF SCIENCES-NATIONAL RESEARCH COUNCIL RECOMMENDED DAILY DIETARY ALLOWANCES. [a]Revised 1980

Designed for the maintenance of good nutrition of practically all healthy people in the U.S.A.

							Fat-Soluble Vitamins		
	Age	Weight		Height		Protein	Vitamin A	Vitamin D	Vitamin E
	(years)	(kg)	(lb)	(cm)	(in)	(g)	(μ g RE)[b]	(μ g)[c]	(mg α -TE)[d]
Infants	0.0-0.5	6	13	60	24	kg x 2.2	420	10	3
	0.5-1.0	9	20	71	28	kg x 2.0	400	10	4
Children	1-3	13	29	90	35	23	400	10	5
	4-6	20	44	112	44	30	500	10	6
	7-10	28	62	132	52	34	700	10	7
Males	11-14	45	99	157	62	45	1000	10	8
	15-18	66	145	176	69	56	1000	10	10
	19-22	70	154	177	70	56	1000	7.5	10
	23-50	70	154	178	70	56	1000	5	10
	51+	70	154	178	70	56	1000	5	10
Females	11-14	46	101	157	62	46	800	10	8
	15-18	55	120	163	64	46	800	10	8
	19-22	55	120	163	64	44	800	7.5	8
	23-50	55	120	163	64	44	800	5	8
	51+	55	120	163	64	44	800	5	8
Pregnant						+30	+200	+5	+2
Lactating						+20	+400	+5	+3

						Water-Soluble Vitamins						
	Age	Weight		Height		Vitamin C	Thiamin	Riboflavin	Niacin	Vitamin B-6	Folacin[f]	Vitamin B-12
	(years)	(kg)	(lb)	(cm)	(in)	(mg)	(mg)	(mg)	(mg NE)[e]	(mg)	2f(μg)	(μg)
Infants	0.0-0.5	6	13	60	24	35	0.3	0.4	6	0.3	30	0.5[g]
	0.5-1.0	9	20	71	28	35	0.5	0.6	8	0.6	45	1.5
Children	1-3	13	29	90	35	45	0.7	0.8	9	0.9	100	2.0
	4-6	20	44	112	44	45	0.9	1.0	11	1.3	200	2.5
	7-10	28	62	132	52	45	1.2	1.4	16	1.6	300	3.0
Males	11-14	45	99	157	62	50	1.4	1.6	18	1.8	400	3.0
	15-18	66	145	176	69	60	1.4	1.7	18	2.0	400	3.0
	19-22	70	154	177	70	60	1.5	1.7	19	2.2	400	3.0
	23-50	70	154	178	70	60	1.4	1.6	18	2.2	400	3.0
	51+	70	154	178	70	60	1.2	1.4	16	2.2	400	3.0
Females	11-14	46	101	157	62	50	1.1	1.3	15	1.8	400	3.0
	15-18	55	120	163	64	60	1.1	1.3	14	2.0	400	3.0
	19-22	55	120	163	64	60	1.1	1.3	14	2.0	400	3.0
	23-50	55	120	163	64	60	1.0	1.2	13	2.0	400	3.0
	51+W	55	120	163	64	60	1.0	1.2	13	2.0	400	3.0
Pregnant						+20	+0.4	+0.3	+2	+0.6	+400	+1.0
Lactating						+40	+0.5	+0.5	+5	+0.5	+100	+1.0

	Age (years)	Weight (kg)	(lb)	Height (cm)	(in)	Minerals Cal-cium (mg)	Phos-phorus (mg)	Mag-nesium (mg)	Iron (mg)	Zinc (mg)	Iodine (μg)
Infants	0.0-0.5	6	13	60	24	360	240	50	10	3	40
	0.5-1.0	9	20	71	28	540	360	70	15	5	50
Children	1-3	13	29	90	35	800	800	150	15	10	70
	4-6	20	44	112	44	800	800	200	10	10	90
	7-10	28	62	132	52	800	800	250	10	10	120
Males	11-14	45	99	157	62	1200	1200	350	18	15	150
	15-18	66	145	176	69	1200	1200	400	18	15	150
	19-22	70	154	177	70	800	800	350	10	15	150
	23-50	70	154	178	70	800	800	350	10	15	150
	51+	70	154	178	70	800	800	350	10	15	150
Females	11-14	46	101	157	62	1200	1200	300	18	15	150
	15-18	55	120	163	64	1200	1200	300	18	15	150
	19-22	55	120	163	64	800	800	300	18	15	150
	23-50	55	120	163	64	800	800	300	18	15	150
	51+	55	120	163	64	800	800	300	10	15	150
Pregnant						+400	+400	+150	h	+5	+25
Lactating						+400	+400	+150	h	+10	+50

[a]The allowances are intended to provide for individual variations among most normal persons as they live in the United States under usual environmental stresses. Diets should be based on a variety of common foods in order to provide other nutrients for which human requirements have been less well defined.

[b]Retinol equivalents. 1 retinol equivalent = 1 μ g retinol or 6 μ g carotene. See text for calculation of vitamin A activity of diets as retinol equivalents.

[c]As cholecalciferol. 10 μ g cholecalciferol = 400 IU of vitamin D.

[d]α -tocopherol equivalents. 1 mg *d*- α tocopherol = 1 α -TE.

[e]1 NE (niacin equivalent) is equal to 1 mg of niacin or 60 mg of dietary tryptophan.

[f]The folacin allowances refer to dietary sources as determined by *Lactobacillus casei* assay after treatment with enzymes (conjugases) to make polyglutamyl forms of the vitamin available to the test organism.

[g]The recommended dietary allowance for vitamin B-12 in infants is based on average concentration of the vitamin in human milk. The allowances after weaning are based on energy intake (as recommended by the American Academy of Pediatrics) and consideration of other factors, such as intestinal absorption.

[h]The increased requirement during pregnancy cannot be met by the iron content of habitual American diets nor by the existing iron stores of many women: therefore the use of 30-60 mg of supplemental iron is recommended. Iron needs during lactation are not substantially different from those of nonpregnant women, but continued supplementation of the mother for 2-3 months after parturition is advisable in order to replenish stores depleted by pregnancy.