Chapter HFS 131

HOSPICES

Note: Chapter HSS 131 was renumbered Chapter HFS 131 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, July, 1999, No. 523.

Subchapter I — General

HFS 131.11 Authority and purpose. This chapter is promulgated under the authority of s. 50.95, Stats., to establish minimum standards for the operation of hospice programs in Wisconsin. The purpose of the chapter is to ensure that hospice patients receive safe and adequate care and support and that the health and safety of hospice patients, employees and volunteers are protected.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.12 Applicability. This chapter applies to all organizations, programs and places operating as hospices in Wisconsin.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.13 Definitions. In this chapter:

(1) "Advance directive" means a written instruction, such as a living will under ch. 154, Stats., or a durable power of attorney for health care under ch. 155, Stats., or as otherwise recognized by the courts of the state, relating to the provision or nonprovision of health care when the individual is incapacitated.

(2) "Bereavement" means the reaction to loss of a loved person.

(3) "Bereavement services" means the systematic application of services by designated hospice employees or volunteers for the reduction of grief as experienced by family members and as described in the plan of care.

(4) "Care coordinator" means an individual designated by the core team of the hospice to facilitate the provision of services to a patient or the patient's family, or both, according to the plan of care.

(5) "Core team" means a defined group within the hospice's interdisciplinary group that has represented on it physician, nurse, social worker, volunteer and bereavement or other counseling services and that is responsible for all aspects of care and services to a patient and the patient's family.

(6) "Department" means the Wisconsin department of health and family services.

(7) "Employee" means a paid staff person designated by the hospice to provide services to a patient or the patient's family under the direction of the hospice's plan of care for the patient, including an individual providing services to the patient or the patient's family under contract with the hospice.

(8) "Family member" means a hospice patient's spouse, brother, sister, child or parent, or an individual with significant personal ties to the hospice patient who is designated a family member by mutual agreement between the individual and the patient.

(9) "Family spokesperson" means the family member that the patient or patient spokesperson designates to act on behalf of the family.

(10) "Grief" means the normal psychological reaction to loss.

(11) "Hospice" means any of the following:

(a) An organization that primarily provides palliative care and supportive care to an individual with terminal illness where he or she lives or stays and, if necessary to meet the needs of an individual with terminal illness, arranges for or provides short–term inpatient care and treatment or provides respite care;

(b) A program within an organization that primarily provides palliative care and supportive care to an individual with terminal illness where he or she lives or stays, that uses designated staff time and facility services, that is distinct from other programs of care provided by the organization and, if necessary to meet the needs of an individual with terminal illness, that arranges for or provides short–term inpatient care and treatment or respite care; or

(c) A place, including a freestanding structure or a separate part of a structure in which other services are provided, that primarily provides palliative and supportive care and a place of residence to individuals with terminal illness and provides or arranges for short–term inpatient care as needed.

(12) "Hospice aide" means an individual employed by or under contract to a hospice to provide hospice aide services as specified in s. HFS 131.43 (4) (f) under the supervision of a registered nurse.

(13) "Hospice patient" or "patient" means an individual in the terminal stage of illness who has an anticipated life expectancy of 12 months or less and who, alone or in conjunction with a family member or members, has requested admission to a hospice, has been accepted into the hospice and has entered the hospice.

(14) "Initial assessment" means inquiry and observation undertaken on admission which results in a description of the patient's current physical status, including present pain status, emotional status, pertinent psychosocial or spiritual concerns and coping ability of the patient and family support system.

(15) "Interdisciplinary group" or "IDG" means the assembly of hospice employees, which has represented on it the core team services and may, in addition, have physical therapy, occupational therapy, speech pathology and home health aide services.

(16) "Occupational therapist" means a person who meets the requirements of s. HFS 105.28.

(17) "Ongoing assessment" means a continuing process of assessment of the patient and the patient's family as a means of clarifying the status of the patient.

(18) "Palliative care" means management and support provided for the reduction or abatement of pain, for other physical symptoms and for psychosocial or spiritual needs of individuals with terminal illness, including physician services, skilled nursing care, medical social services, services of volunteers and bereavement services, but it does not mean treatment provided in order to cure a medical condition or disease or to artificially prolong life.

(19) "Patient spokesperson" means an individual that the patient has agreed can act on his or her behalf.

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

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

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

(23) "Plan of care" means a document that describes a patient's needs and related needs of the patient's family, goals and interventions by specified hospice employees or volunteers as well as a means for evaluating the effectiveness of the interventions.

(24) "Registered nurse" means a person licensed as a registered nurse under ch. 441, Stats.

(25) "Respiratory therapist" means a person who is issued a certificate by the medical examining board as a respiratory care practitioner under s. 448.04 (1) (i), Stats., and ch. Med 20.

(26) "Respite care" means care provided to a terminally ill individual in order to provide temporary relief to the primary caregiver.

(27) "Service" means the provision of one or more activities for a patient or the patient's family, or both, by the hospice either directly or under contract as specified in the plan of care with services confined to either palliation or support of the patient or patient's family, or both.

(28) "Short–term inpatient care" means care provided to a terminally ill individual in an inpatient setting for brief periods of time for the purpose of pain control or acute or chronic symptom management.

(29) "Speech pathologist" means a person who possesses a certificate of clinical competence from the American speech–language– hearing association, or who has completed the equivalent educational requirements and work experience necessary for such a certificate, or who will have completed the academic program and be in the process of accumulating the supervised work experience required to qualify for such a certificate before employment by the hospice program.

(30) "Supportive care" means services provided during the final stages of an individual's terminal illness and dying and after the individual's death to meet the psychosocial, social and spiritual needs of family members of the terminally ill individual and other individuals caring for the terminally ill individual.

Note: Examples of supportive care are personal adjustment counseling, financial counseling, respite services, bereavement counseling and follow–up services provided by volunteers or other persons.

(31) "Terminal illness" means a medical prognosis that an individual's life expectancy is less than 12 months.

(32) "Universal precautions" means universal blood and body–fluid precautions to be practiced by hospice employees and volunteers in caring for patients, as recommended by the U.S. public health service's centers for disease control, to prevent transmission of blood–borne and body fluid–borne infections.

(33) "Volunteer" means an uncompensated staff person designated by the hospice to provide services to a patient or the patient's family in accordance with the hospice's plan of care for the patient.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.14 License. (1) LICENSE REQUIREMENT. (a) No person may conduct, maintain, operate or otherwise participate in conducting, maintaining or operating a hospice unless the hospice is licensed by the department.

(b) A hospice program may have more than one office or facility. Multiple units do not need to be separately licensed if the hospice is able to demonstrate supervision and administration from the central office.

(2) APPLICATION. (a) Application for a license to operate a hospice shall be made in writing on a form provided by the department.

(b) The completed form shall contain the following information:

1. The name and address of the applicant;

2. The location of the hospice; and

3. Any additional information specified by the department as necessary to determine that the applicant is a hospice.

(c) The applicant shall submit the application form to the department accompanied by the fee established under sub. (6).

Note: To obtain an application form for a license, write or phone the Facilities Regulation Section, Bureau of Quality Assurance, Division of Supportive Living, P.O. Box 2969, Madison, Wisconsin 53701, 608–266–7782. The completed application form should be sent to the same office.

(d) An application shall include:

1. Identification of the person or persons administratively responsible for the program, and the affiliation, if any, of the person or persons with a licensed home health agency, hospital, nursing home or other health care facility;

2. The proposed geographic area the hospice will serve;

3. A listing of those hospice services provided directly by the hospice, and those hospice services provided through a contractual agreement; and

4. A list of those providers under contract with the hospice to provide hospice services.

(3) REVIEW OF THE APPLICATION. (a) *Investigation.* After receiving a complete application, the department shall investigate and inspect 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. An applicant that is currently certified as meeting conditions for medicare participation under 42 USC 1395 to 1395ccc, need not be investigated or inspected as a condition for issuance of a license.

(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 health care provider with which the applicant is affiliated or was affiliated during the past 5 years. The department shall consider at least the following:

1. 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 hospice, home health agency, residential care facility 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 hospice, home health agency, residential care facility or health care facility operated by the applicant;

2. Any adverse action against the applicant based upon noncompliance with federal statutes or regulations in the applicant's

operation of a hospice, home health agency, residential care facility or health care facility in this state or any other state. In this subdivision, "adverse action" means an action by a state or federal agency which resulted in civil money penalties, termination of a provider agreement, suspension of payments or the appointment of temporary management of a hospice, home health agency, residential care facility or health care facility operated by the applicant;

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

4. Any denial, suspension, enjoining or revocation of a license that 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;

5. Any conviction of the applicant for a crime involving neglect or abuse of patients, or involving assaultive behavior, wanton disregard for the health or safety of others or any act of elder abuse under s. 46.90, Stats.;

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

7. Any conviction of the applicant for a crime involving controlled substances under ch. 961, Stats.;

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

9. Any prior financial failure of the applicant that resulted in bankruptcy or in the closing of a hospice, home health agency or an inpatient health care facility or the relocation of its patients.

(4) PROVISIONAL LICENSE. After receiving a complete application for a new license, the department shall investigate the applicant to determine the applicant's ability to comply with this chapter. Prior to completing its investigation or if the hospice is not in operation at the time that application is made, the department may issue a provisional license. Unless sooner revoked or suspended, a provisional license shall be valid for no more than 24 months from the date of issuance.

(5) REGULAR LICENSE. The department shall inspect a hospice prior to issuing a regular license unless sub. (3) (a) applies and the hospice need not be inspected. A regular license is valid indefinitely unless revoked or suspended.

(6) PROVISIONAL AND REGULAR LICENSING FEE. The fee for a provisional or regular license shall be $300, except that:

(a) The fee for a hospice that is a nonprofit corporation and is served entirely by uncompensated volunteers or employs persons in not more than 1.5 positions at 40 hours of employment per week shall be $25; and

(b) The fee for a hospice that is a nonprofit organization, that is served entirely by uncompensated volunteers and that charges no fees may be waived by the department upon request.

(7) ONGOING LICENSURE. A regular license shall be valid indefinitely if both of the following conditions are satisfied:

(a) Every 12 months, on a schedule determined by the department, the hospice submits an annual report to the department in the form and containing the information that the department requires, including payment of the fee required under par. (b). If a complete annual report is not timely filed, the department shall issue a warning to the licensee. If a hospice that has not filed a timely report fails to submit a complete report to the department within 60 days after the date established under the schedule determined by the department, the department may revoke the license.

(b) Unless waived under sub. (6) (b), the application is accompanied by a licensing fee which shall be an amount equal to 0.15% of the net annual income of the hospice, based on the hospice's most recent annual fiscal report or, if that amount is less than $200, the renewal fee shall be $200 and if that amount is greater than $1,000, the renewal fee shall be $1,000. The fee for a hospice that is a nonprofit corporation and that is served entirely by uncompensated volunteers or employs persons in not more than 1.5 positions at 40 hours of employment per week shall be $10. No fee may be charged to a hospice for which the initial licensing fee was waived under sub. (6) (b) unless one or more of the conditions under which the initial licensing fee was waived have changed.

Note: To obtain an application form for renewal of a license, write or phone the Facilities Regulation Section, Bureau of Quality Assurance, Division of Supportive Living, P.O. Box 2969, Madison, Wisconsin 53701, 608–266–7782.

(8) 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. (3) (b) 1. to 3., of substantial noncompliance with federal or this state's or any state's requirements, who fails under sub. (3) (b) 4. to 9. to qualify for a license, or who is found not in substantial compliance with this chapter. 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 under sub. (11) for appealing the denial.

(9) SCOPE OF LICENSE. A license is issued only for the premises identified in the license application, if the hospice is a residential facility, and only for the persons named in the license application, and may not be transferred or assigned by the licensee.

(10) SUSPENSION OR REVOCATION. The department by written notice to the applicant or recipient may suspend or revoke a license if the department finds that there has been a substantial failure to comply with the requirements of ss. 50.90 to 50.98, Stats., or this chapter. The notice shall identify the violation and the statute or rule violated, and shall describe the process under sub. (11) for appealing the decision.

(11) APPEAL OF DECISION TO DENY, SUSPEND OR REVOKE A LICENSE. (a) Any person aggrieved by the department's decision to deny a license or to suspend or revoke a license may request a hearing on that decision under s. 227.42, Stats., which shall be limited to the issues stated as the bases for denial, suspension or revocation in the written notice under sub. (10).

(b) The request for hearing shall be in writing, shall be filed with the department of administration's division of hearings and appeals, and shall be sent to that office so that it is received there within 10 days after the date of the notice under sub. (10). A request for a hearing is considered filed upon its receipt by the division of hearings and appeals. Review is not available if the request is received more than 10 days after the date of the notice under sub. (10).

Note: The mailing address of the Division of Hearings and Appeals is P.O. Box 7875, Madison, Wisconsin 53707.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92; **am. (5), (6), (8), (10) and (11) (a), r. and recr. (7) (intro.) and (a), Register, August, 2000, No. 536, eff. 9–1–00.**

HFS 131.15 Inspections of licensed programs. The department shall conduct unannounced inspections of a hospice which may include home visits with prior patient consent or a review of the health care records of any individual with terminal illness served by the hospice. The department may inspect or investigate a hospice as it deems necessary.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.16 Waivers and variances. (1) DEFINITIONS. In this section:

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

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

(2) REQUIREMENTS FOR WAIVERS AND 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 patient and that:

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

(b) An alternative to a requirement, including a new concept, method, procedure or technique, other equipment, other personnel qualifications, or the conducting of a pilot project, is in the interests of better care or management.

(3) PROCEDURES. (a) *Application.* 1. An application for a waiver of or variance from a requirement of this chapter shall be made in writing to the department, specifying all of 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 a requirement under sub. (2) would be satisfied.

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

3. The department may require additional information from the hospice 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. A notice of denial 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 the hospice.

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

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

(c) *Hearings.* 1. Denial of a requested waiver or variance 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 for any of the following reasons:

1. The department determines that the waiver or variance is adversely affecting the health, safety or welfare of the patients;

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

3. The licensee notifies the department in writing of the desire to relinquish the waiver or variance and be subject to the requirement previously waived or varied; or

4. Revocation is required by a change in law.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

Subchapter II — Patient and Family Rights

HFS 131.21 Patient rights. (1) GENERAL INFORMATION. A hospice shall provide each patient and patient's spokesperson, if any, with a written statement of the rights of patients and their families before services are provided, and shall fully inform each patient and patient's spokesperson, if any, of the following:

(a) Those patient and family rights and all hospice rules and regulations governing patient and family responsibilities, which shall be evidenced by written acknowledgement provided by the patient, if possible, or a family member, prior to receipt of services;

(b) Prior to admission, the types of services available from the hospice, including contracted services and specialized services for unique patient groups such as children;

(c) Those items and services that the hospice offers and for which the resident may be charged, and the amount of charges for those services;

(d) Any significant change in the patient's needs or status; and

(e) The hospice's criteria for discharging the individual from the program.

(2) RIGHTS OF PATIENTS. In addition to rights to the information under sub. (1), each patient shall have the following rights:

(a) To participate in planning care and in planning changes in care;

(b) To select or refuse services;

(c) To confidential treatment of personal and health care record information and to approve or refuse release of information to any individual outside the hospice, except in the case of transfer to another health care facility, or as required by law or third party payment contract;

(d) To request and receive an exact copy of one's health care record;

(e) To be free from chemical and physical restraints except as authorized in writing by the attending physician to provide palliative care for a specified and limited period of time and documented in the plan of care;

(f) To be treated with courtesy, respect and full recognition of dignity and individuality and to choose physical and emotional privacy in treatment, living arrangements and the care of personal needs;

(g) To privately and without restrictions communicate with others by mail, telephone and private visits;

(h) To be permitted to receive visitors at any hour, including small children, and to refuse visitors;

(i) To be free from mental and physical abuse incurred from acts or omissions of hospice employees; and

(j) To prepare an advance directive.

(3) FAMILY SPOKESPERSON. The patient and the other family members have the right to designate a family member to act on behalf of the family.

(4) PATIENT COMPLAINT PROCEDURE. Each patient shall have the right, on his or her own behalf or through others, to:

(a) Express a complaint to hospice employees, without fear of reprisal, about the care and services provided and to have the hospice investigate the complaint in accordance with an established complaint procedure. The hospice shall document both the existence of the complaint and the resolution of the complaint;

(b) Express complaints to the department, and to be given a statement provided by the department setting forth the right to and procedure for filing verbal or written complaints with the department; and

(c) Be advised of the availability of a toll–free hotline, including its telephone number, to receive complaints or questions about local hospices, and be advised of the availability of the long term care ombudsman to provide patient advocacy and other services under s. 16.009, Stats.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.22 Family rights. (1) GENERAL INFORMATION. Prior to providing services to the family, the hospice shall provide the family spokesperson with a written notice of family rights. Family members have the following rights:

(a) To be fully informed, as evidenced by the family's written acknowledgement, of those rights and all hospice rules and regulations governing patient and family responsibilities;

(b) To be fully informed, prior to the patient's admission, of the types of services available from the hospice;

(c) To be fully informed of any charges for services for which the family or insurer will be responsible;

(d) To be fully informed of the hospice's grounds for discharging the patient from the program; and

(e) To have the family spokesperson fully informed of any significant changes in the patient's needs or status.

(2) FAMILY COMPLAINT PROCEDURE. A family member shall have the right to:

(a) Express complaints without fear of reprisal about the care and services provided and to have the hospice investigate those complaints in accordance with an established complaint procedure. The hospice shall document both the existence of the complaint and the resolution of the complaint;

(b) Express complaints to the department, and be given a statement provided by the department, setting forth the right to and procedure for filing verbal or written complaints with the department; and

(c) Be advised of the availability of a toll–free hotline, including its telephone number, to receive complaints or questions about local hospices, and be advised of the availability of the long term care ombudsman to provide patient advocacy and other services under s. 16.009, Stats.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.23 Service agreement. No hospice may provide services to a patient until the patient or patient's spokesperson acknowledges in writing receipt of a written agreement identifying the services to be provided by the hospice, in what setting those services will be provided and the fees that will be charged for those services.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

Subchapter III — Management

HFS 131.31 Governing body. (1) Each hospice shall have a governing body that assumes full legal responsibility for determining, implementing and monitoring the overall conduct and operation of the program, including the quality of the care and services.

(2) The governing body shall:

(a) Be responsible for the establishment and maintenance of policies and for the management, operation and evaluation of the hospice;

(b) Adopt a statement that designates the services the hospice will provide and the setting or settings in which the hospice will provide care;

(c) Ensure that all services are provided consistent with accepted standards of professional practice;

(d) Appoint an administrator and delegate to the administrator the authority to operate the hospice in accordance with policies established by the governing body;

(e) Ensure that a system is established and maintained to document the disposal of controlled drugs; and

(f) Appoint an individual to assume overall responsibility for a quality assurance program for monitoring and evaluating the quality of patient care in the hospice on an ongoing basis.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.32 Administration. (1) ADMINISTRATOR. The administrator shall be responsible for day–to–day operation of the hospice.

(2) DUTIES OF THE ADMINISTRATOR. The administrator shall:

(a) Implement and regularly evaluate policies for the management and operation of the hospice and evaluation of the overall program performance of the hospice, and implement and regularly evaluate procedures consistent with those policies;

(b) Establish an organizational structure appropriate for directing the work of the hospice's employees in accordance with the program's policies and procedures;

(c) Maintain a continuous liaison between the governing body and the hospice employees;

(d) Ensure that employees are oriented to the program and their responsibilities, that they are continuously trained and that their performance is evaluated; and

(e) Designate in writing, with the knowledge of the governing body, a qualified person to act in his or her absence.

(3) UNIVERSAL PRECAUTIONS. Hospices shall:

(a) Develop and implement initial orientation and ongoing education and training for all hospice workers, including students, trainees and volunteers, in the epidemiology, modes of transmission and prevention of human immunodeficiency virus (HIV) and other blood–borne infections and the need for routine use of universal blood and body–fluid precautions for all patients;

(b) Provide equipment and supplies necessary to minimize the risk of infection with HIV and other blood–borne pathogens; and

(c) Monitor adherence to the U.S. centers for disease control (CDC) recommended protective measures, known as universal blood and body–fluid precautions, as set out in the CDC's *publication,Recommendations for Prevention of HIV Transmission in Health Care Settings,* August 1987 and the update published in *Morbidity and Mortality Weekly Report* (MMWR), Vol. 37/No. 24, June 24, 1988, pp. 377–382. When monitoring reveals a failure to follow recommended precautions, counseling, education or re–training shall be provided and, if necessary, appropriate disciplinary action shall be taken for failure to comply with policies under this subsection.

Note: The CDC's recommended universal precautions may be consulted at the offices of the Department's Bureau of Quality Assurance or at the Secretary of State's Office or the Revisor of Statutes Bureau. A copy of the CDC's recommended universal precautions may be obtained from the Bureau of Quality Assurance, Division of Supportive Living, P.O. Box 2969, Madison, Wisconsin 53701.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.33 Employees. (1) GENERAL REQUIREMENTS. (a) Prior to beginning patient care, every employee shall be oriented to the hospice program and the job to which he or she is assigned.

(2) ORIENTATION PROGRAM. A hospice's orientation program shall include:

(a) An overview of the hospice's goal in providing palliative care and supportive services;

(b) Policies and services of the program;

(c) Information concerning specific job duties;

(d) The role of the plan of care in determining the services to be provided; and

(e) Ethics, confidentiality of patient information, patient and family rights and grievance procedures.

(3) DUTIES. Hospice employees may be assigned only those duties for which they are capable, as evidenced by documented training or possession of a license or certificate.

(4) CONTINUOUS TRAINING. A program of continuing training directed at maintenance of appropriate skill levels shall be provided for all hospice employees providing services to patients and their families.

(5) DISEASE CONTROL. Hospices shall develop and implement written policies for control of communicable diseases which take into consideration control procedures incorporated by reference in ch. HFS 145 and which ensure that employees 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's assistant.

(6) EVALUATION. A hospice shall evaluate every employee annually for quality of performance and adherence to the hospice's policies. Evaluations shall be followed up with appropriate action.

(7) PERSONNEL PRACTICES. (a) Hospice personnel practices shall be supported by appropriate written personnel policies.

(b) Personnel records shall include evidence of qualifications, licensure, performance evaluations and continuing training, and shall be kept up–to–date.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.34 Volunteers. Prior to beginning patient care, a volunteer shall be oriented to the hospice program and shall have the training for the duties to which he or she is assigned.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.35 Program management responsibility. (1) PROGRAM RESPONSIBILITY. The hospice is responsible for providing services to the patient or family, or both, based on assessed need and as established by the plan of care.

(2) CONTRACT SERVICES. The hospice may contract with other providers for the provision of services to a patient or the patient's family, or both, in which case the hospice shall retain responsibility for the quality, availability, safety, effectiveness, documentation and overall coordination of the care provided to the patient or the patient's family, or both, as directed by the hospice plan of care. The hospice shall:

(a) Ensure that there is continuity of care for the patient or the patient's family, or both, in the relevant care setting; and

(b) Be responsible for all services delivered to the patient or the patient's family, or both, through the contract. The written contract shall include the following:

1. Identification of the services to be provided;

2. Stipulation that services are to be provided only with the authorization of the hospice and as directed by the hospice plan of care for the patient;

3. The manner in which the contracted services are coordinated and supervised by the hospice;

4. The delineation of the roles of the hospice and service provider in the admission process, assessment, interdisciplinary group meetings and on–going provision of palliative and supportive care;

5. A method of evaluation of the effectiveness of those contracted services through the quality assurance program under s. HFS 131.37; and

6. The qualifications of the personnel providing the services.

(c) Evaluate the services provided under a contractual arrangement on an annual basis.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.36 Health care record. (1) GENERAL. A hospice shall establish a single and complete health care record for every patient. Health care record information shall remain confidential except in the case of the patient's transfer to another hospice or as required by law or a third–party payment contract.

(2) DOCUMENTATION AND ACCESSIBILITY. The health care record shall be completely accurate and up–to–date, readily accessible to all individuals providing services to the patient or the patient's family, or both, and shall be systematically organized to facilitate prompt retrieval of information. Written record policies shall ensure that all record information is safeguarded against loss, destruction and unauthorized usage.

(3) CONTENT. A patient's health care record shall contain:

(a) Patient and family identification information;

(b) The physician's certification of terminal illness;

(c) The initial and ongoing assessments of patient needs;

(d) Referral information, medical history and pertinent hospital discharge summaries;

(e) The initial and integrated plans of care prepared under s. HFS 131.42;

(f) Physician orders for medications, procedures and tests.

(g) A current medications list;

(h) Complete documentation of all services provided to the patient or the patient's family or both, including:

1. Assessments;

2. Interventions;

3. Instructions given to the patient or family, or both; and

4. Coordination of activities;

(i) The signed service agreement;

(j) A statement of whether or not the patient, if an adult, has prepared an advance directive; and

(k) Transfer and discharge summaries.

(4) ENTRIES. (a) A written record shall be made for every service provided on the date the service is provided. This written record shall be incorporated into the health care record no later than 7 calendar days after the date of service.

(b) All entries shall be legible, permanently recorded, dated and authenticated by the person making the entry, and shall include that person's name and title.

(c) Medical symbols and abbreviations may be used in health care records if approved by a written program policy which defines the symbols and abbreviations and controls their use.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.37 Quality assurance. (1) GENERAL REQUIREMENT. The hospice shall develop and maintain a quality assurance program that evaluates the quality and effectiveness of the program and its services in all patient and family care settings.

(2) MEETINGS. The individual responsible for the quality assurance program may draw on selected members of the interdisciplinary group to conduct studies, and shall convene meetings of hospice staff at least annually to review progress and findings and to produce recommendations for improvements in policies and practices.

(3) ANNUAL REPORT. The quality assurance program findings shall be developed into an annual report for the governing body along with appropriate recommendations for changes to current policies and procedures based on those findings.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

Subchapter IV — Patient Care

HFS 131.41 Admission. (1) PROGRAM DESCRIPTION. A hospice shall have a written description of its program that clearly describes the general patient and family needs that can be met by the hospice, and that includes written admission policies that:

(a) Clearly define the philosophy of the program;

(b) Limit admission to individuals with terminal illness as defined under s. HFS 131.13 (31);

(c) Clearly define the hospice's limits in providing services and the settings for service provision;

(d) Ensure protection of patient and family rights;

(e) Provide clear information about services available for the prospective patient and his or her family; and

(f) Allow an individual to receive hospice services whether or not the individual has executed an advance directive.

(2) PROGRAM EXPLANATION. (a) A hospice employee designated by the care coordinator shall at the time of assessment inform the person and his or her family of admission policies under sub. (1).

(3) INITIAL DETERMINATION. (a) The hospice employee shall, based on the needs described by the person seeking admission or that person's family, or both, make an initial determination as to whether or not the hospice is generally able to meet those needs.

(b) If the hospice employee determines that the hospice does not have the general capability to provide the needed services, the hospice may not admit the person but rather shall suggest to the referring source alternative programs that may meet the described needs.

(4) ASSESSMENT. If the hospice determines that it has the general capability to meet the prospective patient's described needs, then before services are provided, an employee designated by the care coordinator shall perform an assessment of the person's condition and needs and shall describe in writing the person's current status, including physical condition, present pain status, emo-

tional status, pertinent psychosocial and spiritual concerns and coping ability of the prospective patient and family support system, and shall determine the appropriateness or inappropriateness of admission to the hospice based on the assessment. The designated hospice employee shall confer with at least one other core team member and receive that person's views in order to start the initial plan of care.

(5) PATIENT ACKNOWLEDGEMENT AND HOSPICE ACCEPTANCE. The person seeking admission to the hospice shall be recognized as being admitted after:

(a) Completion of the assessment under sub.(4); and

(b) Completion of a service agreement in which:

1. The person or the person's spokesperson acknowledges that he or she has been informed about admission policies and services;

2. The hospice agrees to provide care for the person; and

3. The person or the person's spokesperson authorizes services.

(6) PROHIBITION. Any person determined not to have a terminal illness as defined under s. HFS 131.13 (31) may not be admitted to the hospice program.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.42 Plan of care. (1) GENERAL REQUIREMENTS. (a) A written plan of care shall be established and maintained for each patient admitted to the hospice program and his or her family. The hospice plan of care is a document that describes both the palliative and supportive care to be provided by the hospice to the patient and the patient's family, as well as the manner by which the hospice will provide that care. The care provided to the patient and the patient's family shall be in accordance with the plan of care.

(b) The registered nurse shall immediately record and sign a physician's oral orders and shall obtain the physician's countersignature within 10 days.

(2) INITIAL PLAN OF CARE. (a) The hospice shall develop, with the patient and family, an initial plan of care that:

1. Defines the services to be provided to the patient and the patient's family; and

2. Incorporates physician orders and medical procedures.

(b) The initial plan of care shall be developed upon conclusion of the assessment under s. HFS 131.41 (4).

(3) INTEGRATED PLAN OF CARE. (a) The hospice core team shall develop an integrated plan of care for the new patient within 72 hours after the admission. The integrated plan of care shall be developed jointly by the employee who performed the initial assessment and at least one other member of the core team. The core team shall use the initial plan of care as a basis for team decision–making and shall update intervention strategies as a result of core team assessment and planning collaboration. The care coordinator is responsible for ensuring that ensuing interventions by hospice employees are consistent with the initial and integrated plans of care.

(b) The integrated plan of care shall detail the scope and range of services to be provided, and shall:

1. Identify patient and family needs;

2. Specify service interventions to meet the identified needs;

3. Identify the employees responsible for providing the interventions;

4. Include physician orders and medical procedures. If the physician's orders were originally given orally, the registered nurse shall have immediately recorded and signed them and obtained the physician's countersignature on the record within the next 10 days; and

5. Establish timeframes for evaluating the interventions needed to achieve the long–term and short–term goals and the effectiveness of those interventions as they relate to the identified patient and family problems or needs and the expected outcomes.

(4) REVIEW OF PLAN OF CARE. (a) Hospice staff shall review the integrated plan of care at least every 2 weeks after the initiation of services or at more frequent intervals specified in the plan, and more frequently in response to a significant change in the individual's condition. If the core team determines that the written goals and interventions are not effective in meeting the needs of the patient or the patient's family, or both, or that their needs have changed, the plan of care shall be revised to provide for updated goals and intervention strategies to meet those needs. Any revision shall include outcomes expected and dates for evaluation as provided under sub. (3) (b) 5. All members of the hospice core team shall participate in the plan of care review. The plan of care shall be updated as necessary.

(b) The core team shall develop a system for recording and maintaining a record of notes within the plan of care.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.43 Services. (1) GENERAL REQUIREMENTS. (a) A hospice is responsible for providing care and services to a patient and, as necessary, the patient's family, based on the plan of care developed by the core team. Volunteers shall participate in the delivery of program services.

(b) The hospice shall ensure that nursing and physician services are available 24 hours a day.

(2) CORE TEAM. (a) Each member of the core team shall:

1. Be an employee or volunteer of the hospice;

2. Participate in developing and revising written patient care policies and procedures;

3. Participate in the development, review and updating of a patient's plan of care; and

4. Actively participate in the hospice's quality assurance program.

(b) With respect to services provided to a patient, each core team member shall:

1. Assess patient and family needs as directed by the care coordinator;

2. Promptly notify the care coordinator of any change in patient status that suggests a need to update the plan of care ;

3. Provide services consistent with the patient plan of care; and

4. Provide education and counseling to the patient and, as necessary, to the patient's family, consistent with the plan of care.

(3) REQUIRED SERVICES. The hospice shall provide the following services:

(a) *Medical services.* The hospice shall have a medical director who shall be a medical doctor or a doctor of osteopathy. The medical director shall:

1. Direct the medical components of the program;

2. Ensure that the terminal status of each individual admitted to the program has been established;

3. Ensure that medications are utilized within accepted standards of practice;

4. Ensure that a system is established and maintained to document the disposal of controlled drugs;

5. Ensure that the medical needs of the patients are being met; and

6. Provide liaison as necessary between the core team and the attending physician;

(b) *Nursing services.* Nursing services shall be provided by a registered nurse and shall consist of:

1. Regularly assessing the patient's nursing needs, implementing the plan of care provisions to meet those needs and reevaluating the patient's nursing needs;

2. Supervising and teaching other nursing personnel, including licensed practical nurses, home health aides and hospice aides; and

3. Evaluating the effectiveness of delegated acts performed under the registered nurse's supervision;

(c) *Social services.* Social services shall be provided by an individual who possesses at least a baccalaureate degree in social work from a college or university or a baccalaureate degree in a human services field such as sociology, special education, rehabilitation, counseling or psychology and shall be available to the extent necessary to meet the needs of patients and their families for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions. An individual providing social services who does not possess the appropriate degree as of June 1, 1992 shall have 5 years after June 1, 1992 to obtain the appropriate degree. The duties of the individual providing social services shall include the following:

1. Regularly assessing the patient's social service needs, implementing the plan of care provisions to meet those needs and reevaluating the patient's needs and providing ongoing psychosocial assessment of the family's coping capacity relative to the patient's terminal condition; and

2. Linking patient and family with needed community resources to meet ongoing social, emotional and economic needs;

(d) *Bereavement services.* Bereavement services shall be provided to families of hospice patients. Bereavement services shall be:

1. Coordinated by an individual recognized by the governing body to possess the capacity by training and experience to provide for the bereavement needs of families, including the ability to organize a program of directed care services provided to family members;

2. Compatible with the core team's direction within the plan of care for the patient;

3. Available for one year following the patient's death as part of an organized program under the general direction of the care coordinator. The program shall provide the following:

a. Orientation and training to individuals providing bereavement services to ensure that there is continuity of care;

b. Service intervention either directly or through trained bereavement counselors;

c. Assignment, supervision and evaluation of individuals performing bereavement services; and

d. Referrals of family members to community programs where appropriate.

(4) OPTIONAL SERVICES. The hospice may provide other services as follows:

(a) *Spiritual counseling.* If spiritual counseling is provided, it shall be provided by a spiritual counselor recognized by the governing body to possess the capability to provide spiritual, religious and emotional support to the patient and, as necessary, the patient's family. Neither the patient nor the patient's family may be required or requested to accept any value or belief system. The spiritual counselor shall:

1. Regularly reassess the patient and family spiritual needs relative to the changing status of the patient's terminal condition;

2. Support and assist the patient or the patient's family or both; and

3. Develop and maintain contact, subject to the patient's approval, with the patient's identified religious representative;

(b) *Other counseling services.* Counseling services other than bereavement services may be made available to the patient or the patient's family, or both, while the patient is in the program. These services shall be available to meet the needs of patients and their families for counseling that is reasonable and necessary for the palliation and management of terminal illness and related conditions;

(c) *Dietary services.* If dietary services are provided, they shall be provided only as authorized by the hospice and in conjunction with the plan of care. The services shall be provided by a registered dietician or an individual who has documented equivalency in education or training. Dietary services shall be supervised and evaluated by a registered dietician or other individual qualified under this paragraph who may delegate acts to other employees. Dietary services shall consist of:

1. Assessment of nutritional needs and food patterns;

2. Planning diets appropriate for meeting patient needs and preferences; and

3. Providing nutrition education and counseling to meet patient needs, as well as necessary consultation to hospice employees;

(d) *Therapy services.* If therapy services are provided, they shall be provided in accordance with the plan of care for the patient and by individuals who meet qualification requirements for therapy service delivery such as evidence of current licensure or registration and academic training. Therapy services shall consist of:

1. Physical, occupational, speech and language pathology or respiratory therapy;

2. The provision of a patient assessment as directed by the plan of care under the supervision of the care coordinator; and

3. The development of a therapy plan of intervention based on consultation with the care coordinator which shall state specific patient needs and goals and outline interventions and approaches to meet patient needs.

(e) *Licensed practical nursing services.* If licensed practical nursing services are provided, the licensed practical nurse shall function under the supervision of a registered nurse with duties specified in a written assignment prepared and updated by a registered nurse;

(f) *Hospice aide services.* If hospice aide services are provided, they shall:

1. Be given in accordance with the patient's plan of care;

2. Be assigned by a registered nurse through a written document that is updated consistent with the plan of care and with service provision supervised by a registered nurse;

3. Be provided by a hospice aide who is subject to an on−site supervision visit by a registered nurse every 2 weeks;

4. Consist of, but not be limited to:

a. Assisting patients with personal hygiene;

b. Assisting patients into and out of bed and with ambulation;

c. Assisting with prescribed exercises which patients and hospice aides have been taught by appropriate health care personnel;

d. Assisting patients to the bathroom or in using a bedpan;

e. Assisting patients with self−administration of medications;

f. Administering medications to patients if the aide has completed a state−approved medications administration course and has been delegated this responsibility in writing for the specific patient by a registered nurse;

g. Reporting changes in the patient's condition and needs; and

h. Completing appropriate records;

(g) *Homemaker services.* If homemaker services are provided, they shall be provided in accordance with the patient's plan of care and shall consist of:

1. Housekeeping activities;

2. Performing errands and shopping;

3. Providing transportation;

4. Preparing meals; and

5. Other assigned tasks intended to maintain the capacity of the household; and

(h) *Patient and family companion services.* If patient and family companion services are provided, they shall:

1. Be provided by an individual introduced to the patient by the care coordinator or designee;

2. Be provided as directed by written assignment of the care coordinator or designee;

3. Be documented interventions with the patient or family, or both; and

4. Have assignments supervised and evaluated by the patient care coordinator or designee at intervals consistent with the current plan of care.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.44 Discharge. (1) OBLIGATION. Once a hospice has admitted a patient to the program, and the patient or the patient's spokesperson has signed the acknowledgement and authorization for services under s. HFS 131.41 (5), the hospice is obligated to provide care to that patient.

(2) WRITTEN POLICY. The hospice shall have a written policy that details the manner in which the hospice is able to end its obligation to a patient. This policy shall be provided to the patient or patient's spokesperson as part of the acknowledgement and authorization process at the time of the patient's admission. The policy shall include the following bases for discharging a patient:

(a) *Voluntary discharge.* The hospice shall discharge a patient from the program if the patient:

1. Elects care other than hospice care at any time;

2. Elects active treatment, inconsistent with the role of palliative hospice care;

3. Moves beyond the geographical area served by the hospice;

4. Decides to transfer to another hospice program; or

5. Chooses to withdraw from the program with or without cause.

(b) *Involuntary discharge.* The hospice may discharge a patient from the program against the patient's will:

1. If the patient requests services in a setting that exceeds the limitations of the hospice's authority;

2. For the patient's safety and welfare or the safety and welfare of others; or

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

(3) PROCEDURE. When a patient is being discharged pursuant to sub. (2) (a) 1., 2. or 3. or (b) 1. or 3., the hospice shall give written notice to the patient or patient spokesperson, family spokesperson and attending physician at least 14 days prior to the date of discharge, with a proposed date for a pre–discharge planning conference.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

Subchapter V — Physical Environment

HFS 131.51 Definitions. In this subchapter and subch. VI:

(1) "Existing construction" or "existing facility" means a building which is in place or is being constructed with plans approved by the department prior to June 1, 1992.

(2) "Freestanding hospice facility" means a residential facility serving 3 or more patients which is not located in a licensed hospital or nursing home.

(3) "Life Safety Code" means the National Fire Protection Association's (NFPA) Standard 101.

(4) "New construction" means construction for the first time of any building or addition to an existing building, the plans for which are approved on or after June 1, 1992.

(5) "Remodeling" means to make over or rebuild any portion of a building or structure and thereby modify its structural strength, fire hazard character, exits, heating and ventilating systems, electrical system or internal circulation, as previously approved by the department. Where exterior walls are in place but interior walls are not in place at the time of the effective date of this chapter, June 1, 1992, construction of interior walls shall be considered remodeling. "Remodeling" does not include repairs necessary for the maintenance of a building or structure.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.52 Scope. This subchapter applies to freestanding hospice facilities.

Note: Inpatient hospices located in nursing homes or hospitals must meet applicable administrative codes.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.53 Physical plant. (1) GENERAL REQUIREMENTS. The building of a freestanding hospice shall be constructed and maintained so that it is functional for the delivery of hospice services, appropriate to the needs of the community and protects the health and safety of the patients. The provisions of this section apply to all new, remodeled and existing construction unless otherwise noted. Wherever a requirement in this section is in conflict with the applicable Life Safety Code under s. HFS 131.63, the Life Safety Code shall take precedence.

(2) APPROVALS. The hospice shall keep documentation of approvals on file in the hospice following all inspections by state and local authorities.

(3) PLANS FOR NEW CONSTRUCTION OR REMODELING. The hospice shall submit its plans and specifications for any new construction or remodeling to the department according to the following schedule:

(a) One copy of preliminary or schematic plans shall be submitted to the department for review and approval;

(b) One copy of final plans and specifications which are used for bidding purposes shall be submitted to the department for review and approval before construction is started;

(c) If on–site construction above the foundation is not started within 12 months after the date of approval of the final plans and specifications, the approval under par. (b) shall be void and the plans and specifications shall be resubmitted for reconsideration of approval; and

(d) Any changes in the approved final plans affecting the application of the requirements of this subchapter shall be shown on the approved final plans and shall be submitted to the department for approval before construction is undertaken. The department shall notify the hospice in writing of any conflict with this subchapter found in its review of modified plans and specifications.

(4) ADDITIONAL REQUIREMENTS FOR NEW CONSTRUCTION. (a) All newly constructed hospice facilities shall meet the relevant construction requirements affecting new construction found in chs. Comm 50 to 64 and this subsection.

(b) All newly constructed hospice facilities shall be built to meet the accessibility requirements of chs. Comm 50 to 64.

(c) All public spaces shall be accessible to persons who use wheelchairs.

(d) At least one wheelchair–accessible toilet room shall be provided in the facility.

(e) Electrical switches, receptacles and other devices shall be mounted at accessible heights and locations, but at least 18 inches above floor and no more than 42 inches above the floor.

(5) PATIENT BEDROOMS. (a) *Design and location.* 1. Patient bedrooms shall be designed and equipped for the comfort and privacy of the patient and shall be equipped with or conveniently located near toilet and bathing facilities.

2. Patient bedrooms shall be enclosed by full–height partitions and rigid, swing–type doors, may not be used to gain access to any other part of the facility or to any required exit, and may not be used for purposes other than sleeping and living.

3. Transoms, louvers and grills are not permitted in or above patient's bedroom door exiting to the corridor.

(b) *Capacity.* 1. A patient bedroom may accommodate no more than 3 patients except that in new construction a patient bed-

room may accommodate no more than 2 persons. Patients of the opposite sex may not be required to occupy the same sleeping room.

2. The minimum floor area per bed shall be 80 square feet in multiple patient rooms and 100 square feet in single patient rooms. The distance between patient beds in multipatient rooms shall be at least 3 feet.

(c) *Bed arrangements.* 1. Beds shall be located the minimum distance from heat producing sources recommended by the manufacturer or 18 inches, whichever is greater, except that a bed may be closer than 18 inches to a forced air register but may not block it.

2. There shall be at least 3 feet between beds where the space is necessary for patient or staff access.

3. Visual privacy shall be provided for each patient in multibed patient rooms. In new or remodeled construction, cubicle curtains shall be provided.

(d) *Semiambulatory and nonambulatory patients.* For rooms with semiambulatory or nonambulatory patients, mobility space at the end and one side of each bed may not be not less than 4 feet. Adequate accessible space for storage of a patient's wheelchair or other adaptive or prosthetic equipment shall be provided and shall be readily accessible to the patient. In this paragraph, "semiambulatory" means able to walk with difficulty or able to walk only with assistance of an aid such as crutches, a cane or a walker, and "nonambulatory" means not able to walk at all.

(e) *Equipment and supplies.* Each patient shall be provided with:

1. A separate bed of proper size and height for the convenience of the patient. Beds shall be at least 36 inches wide and shall be maintained in good condition;

2. Drawer space available in the bedroom for personal clothing and possessions; and

3. Closet or wardrobe space with clothes racks and shelves in the bedroom. Closets or wardrobes shall have an enclosed space of not less than 15 inches wide by 18 inches deep by 5 feet in height for each patient.

(6) HABITABLE ROOMS. All habitable rooms shall have an average ceiling height of not less than 7 feet.

(7) WINDOWS. (a) *Minimum size.* Every living and sleeping room shall have one or more outside–facing windows with a total sash area of at least 8% of the floor area of the room. The openable area of a window shall be equal to not less than 4% of the floor area of the room.

(b) *Openable bedroom window.* At least one outside window in a bedroom shall be openable from the inside without the use of tools.

(c) *Storm windows and screens.* All windows serving habitable rooms shall be provided with storm windows in winter, except insulated windows, and openable windows serving habitable rooms shall be provided with insect–proof screens in summer.

(8) ELECTRICAL. (a) Every hospice facility shall be supplied with electrical service and shall have wiring, outlets and fixtures properly installed and maintained in good and safe working condition.

(b) All bathroom outlets and all outlets on the exterior of the facility and in the garage shall have ground fault interrupt protection.

(c) Outlets shall be located to minimize the use of extension cords.

(d) When extension cords are needed, they shall be rated appropriately for the ampere capacity of the appliance being used.

(e) An extension cord may not extend beyond the room of origin, may not be a substitute for permanent wiring, may not be located beneath rugs or carpeting and may not be located across any pathways.

(f) There shall be a switch or equivalent device for turning on at least one light in each room or passageway. The switch or equivalent device shall be located so as to conveniently control the lighting in the area.

(g) All electrical cords and appliances shall be maintained in a safe condition. Frayed wires and cracked or damaged switches, plugs and electric fixtures shall be repaired or replaced.

(9) PATIENT CALL SYSTEM. A reliable call mechanism shall be provided in every location where patients may be left unattended, including patient rooms, toilet and bathing areas and designated high risk treatment areas from which individuals may need to summon assistance.

(10) BEDDING AND LAUNDRY. There shall be separate clean linen and dirty linen storage areas.

(b) Each patient shall have available:

1. Sufficient blankets to keep warm;

2. A pillow; and

3. Mattress and pillow covers as necessary to keep mattresses and pillows clean and dry.

Note: When plastic mattress covers are used, there shall be a mattress pad the same size as the mattress over the plastic mattress cover.

(c) Clean sheets, pillowcases, towels and washcloths shall be available at least weekly and shall be changed as necessary to ensure that at all times they are clean and free from odors.

(11) DAYROOM OR LOUNGE. At least one dayroom or lounge, centrally located, shall be provided for use of the patients.

(12) SIZE OF DINING ROOM. Dining rooms shall be of sufficient size to seat all patients at no more than 2 shifts. Dining tables and chairs shall be provided. Television trays or portable card tables may not be used as the primary dining tables.

(13) KITCHEN. The kitchen shall be located on the premises, or a satisfactory sanitary method of transportation of food shall be provided. If there is a kitchen on the premises, it shall meet food service needs and be 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.

(14) MULTIPURPOSE ROOM. If a multipurpose room is used for dining, diversional and social activities of patients, there shall be sufficient space to accommodate all activities and minimize their interference with each other.

(15) TOTAL AREA. (a) In existing 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. A required exit path in these areas shall be at least 4 feet wide.

(b) In new construction, the combined floor space of dining, recreation, and activity areas shall not be less than 25 square feet per bed. Solaria and lobby areas, exclusive of traffic areas, shall be categorized as living room space.

(c) All required dining and living areas within the building shall be internally accessible to every patient of the hospice.

(d) Each habitable room shall contain furnishings appropriate to the intended use of the room. Furnishings shall be safe for use by patients, and shall be comfortable, clean and maintained in good repair.

(e) Adequate space and equipment shall be designated to meet the needs of the patients and family members for privacy and social activities.

(16) HEATING. (a) The facility shall have a heating system capable of maintaining a temperature of 72º F. (20º C.) during periods of occupancy. Temperatures during sleeping hours may be reduced to 68º F. (18º C.). Higher or lower temperatures shall be available upon request.

(b) The heating system shall be maintained in a safe and properly functioning condition.

(c) The use of portable space heaters is prohibited except for permanently wired electric heaters which have an automatic thermostatic control and are attached to a wall.

(17) BATH AND TOILET FACILITIES. (a) *General.* 1. Each hospice shall have at least one separate bath and one separate toilet room or one combination bath and toilet room for the use of patients which is accessible from public, nonsleeping areas, except where private bath and toilet rooms are adjacent to each sleeping room.

2. Each floor in which patient sleeping, dining and living rooms are located shall have bath and toilet facilities or one combination bath and toilet room for use of patients which is accessible from public, nonsleeping areas, except where private bath and toilet rooms are adjacent to each bedroom.

3. All bath and toilet areas shall be well lighted. Bath and toilet rooms shall be provided with at least one electrical fixture to provide artificial light.

4. Toilets, bathtubs and showers used by residents shall provide for individual privacy. If door locks are used for privacy they shall be operable from both sides in an emergency.

5. All toilet and bathing areas, facilities and fixtures shall be kept clean, in good repair and in good working order.

(b) *Number of fixtures.* 1. Toilets and sinks shall be provided in the ratio of at least one toilet and at least one sink for every 4 residents and other occupants or a fraction thereof. At least one bathtub or shower shall be available for every 8 residents and other occupants or a fraction thereof.

2. Where fixtures are accessible only through a sleeping room, they may be counted as meeting the requirements for only the occupants of the sleeping room.

(18) WATER SUPPLY. (a) Each sink, bathtub and shower shall be connected to hot and cold water, and adequate hot water shall be supplied to meet the needs of the patients.

(b) Hot water at taps accessible to patients may not exceed 110º F.

(c) Where a public water supply is not available, the well or wells shall be approved by the Wisconsin department of natural resources. Water samples from an approved well shall be tested at least annually at the state laboratory of hygiene or another laboratory approved under 42 CFR 493 (CLIA).

(d) The hospice shall make provision for obtaining emergency fuel and water supplies.

(19) SEWAGE DISPOSAL. (a) *Discharge.* If a municipal sewer system is available, all sewage shall be discharged into it. If a municipal sewer system is not available, the sewage shall be collected, treated, and disposed of by means of an independent sewer system approved under ch. Comm 83.

(b) *Septic systems.* If a septic system is used it shall meet the requirements of s. Comm 83.055.

Note: Comm 83.055 was repealed eff. 7–1–00.

(c) *Plumbing.* The plumbing and drainage for the disposal of wastes shall be approved under chs. Comm 82 and 84.

(20) FACILITY MAINTENANCE. (a) The building shall be maintained in good repair and free of hazards such as cracks in floors, walls or ceilings; warped or loose boards; warped, broken, loose or cracked floor covering such as tile or linoleum; loose handrails or railings; and loose or broken window panes.

(b) All electrical, mechanical, water supply, fire protection and sewage disposal systems shall be maintained in a safe and functioning condition.

(c) All plumbing fixtures shall be in good repair, properly functioning and satisfactorily provided with protection to prevent contamination from entering the water supply piping.

(d) Rooms shall be kept clean, well–ventilated and tidy.

(e) All furniture and furnishings shall be kept clean and maintained in good repair.

(f) Storage areas shall be maintained in a safe, dry and orderly condition. Attics and basements shall be free of accumulation of garbage, refuse, soiled laundry, discarded furniture, old newspapers, boxes, discarded equipment and similar items.

(g) Abrasive strips or non–skid surfaces to reduce or prevent slipping shall be used where slippery surfaces present a hazard.

(h) The grounds, yards, and sidewalks shall be maintained in a neat, orderly and safe condition.

(21) FLOORS AND STAIRS. Floors and stairs shall be maintained in a nonhazardous condition.

(22) EXITS. Sidewalks, doorways, stairways, fire escapes and driveways used for exiting shall be kept free of ice, snow and obstructions.

(23) DOOR LOCKS. The employee in charge of the facility on each work shift shall have a key or other means of opening all locks or closing devices on all doors in the facility.

(24) EMERGENCY PLAN. (a) Each hospice shall have a written plan posted in a conspicuous place which specifies procedures for the orderly evacuation of patients in case of an emergency. The plan shall include an evacuation diagram. The evacuation diagram shall in addition be posted in a conspicuous place in the facility.

(b) The licensee, administrator and all staff who work in the hospice facility shall be trained in all aspects of the emergency plan.

(c) The procedures for exiting or taking shelter in the event of a fire, tornado, flooding or other disaster to be followed for patient safety shall be clearly communicated by the staff to the patients within 72 hours after admission and practiced at least quarterly by staff.

(25) ZONING. A hospice site shall adhere to local zoning regulations, including flood plain management under ch. NR 116.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

Subchapter VI — Life Safety Code

HFS 131.61 Definitions. The definitions in s. HFS 131.51 apply to this subchapter.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.62 Scope. This subchapter applies to freestanding hospice facilities. Wherever a requirement in s. HFS 131.64 conflicts with the applicable life safety code under s. HFS 131.63, the life safety code shall take precedence.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.63 Fire protection. (1) BASIC RESPONSIBILITY. The hospice shall provide fire protection adequate to ensure the safety of patients, staff and others on the hospice's premises. Necessary safeguards such as extinguishers, sprinkling and detection devices, fire and smoke barriers and ventilation control barriers shall be installed to ensure rapid and effective fire and smoke control.

(2) NEW CONSTRUCTION. Any new construction or remodeling shall meet the applicable provisions of either the 1985 edition of the Life Safety Code for health care occupancies or, for facilities with fewer than 16 beds, the applicable provisions of the 26th edition (1985) of the Life Safety Code for board and care occupancies.

(3) EXISTING FACILITIES. (a) An existing facility shall be considered to have met the requirements of this subsection if, prior to the promulgation of this chapter, the hospice complied with and continues to comply with the applicable provisions of the 1967, 1973 or 1981 edition of the Life Safety Code, with or without waivers.

(b) An existing facility that does not meet all requirements of the applicable Life Safety Code may be considered in compliance with it if the facility achieves a passing score on the Fire Safety Evaluation System (FSES) developed by the U.S. department of commerce, national bureau of standards, to establish safety equivalencies under the Life Safety Code.

Note: Copies of the 1967, 1973, 1981 and 1985 Life Safety Codes can be obtained from the National Fire Protection Association, Battery March Park, Quincy, MA 02269. The National Bureau of Standards' Fire Safety Evaluation System is printed as Appendices C and G to the 1985 Life Safety Code. Copies of the Life Safety Codes may be consulted at the Offices of the Department's Bureau of Quality Assurance or at the Secretary of State's Office or the Revisor of Statutes Bureau.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.

HFS 131.64 Fire safety. (1) FIRE INSPECTION. The licensee of the hospice shall arrange for the following:

(a) At least an annual inspection of the facility by the local fire authority; and

(b) Certification by the local fire authority as to the adequacy of the written plan for orderly evacuation of patients in case of fire, as well as to the fire safety of the hospice facility.

(2) SMOKING. (a) A written policy on smoking shall be developed by the licensee of the facility which shall designate areas where smoking is permitted, if any, and shall be clearly communicated by the staff to a patient within 24 hours after the patient's admission.

(b) Any patient who has a respiratory or other condition for which the patient's physician has recommended clean air shall be provided with smoke–free sleeping, eating and recreational areas.

(3) FIRE EXTINGUISHER. (a) At least one fire extinguisher with a minimum 2A, 10–B–C rating shall be provided on each floor of the facility. A fire extinguisher shall be located at the head of each stairway. In addition, an extinguisher shall be located so that the maximum area per extinguisher does not exceed 3000 square feet and travel distance to an extinguisher does not exceed 75 feet. The extinguisher on the kitchen floor level shall be mounted in or near the kitchen.

(b) All fire extinguishers shall be maintained in readily useable condition and inspected annually. One year after the initial purchase of a fire extinguisher and annually after that the extinguisher shall be provided with a tag which indicates the date of the most recent inspection.

(c) An extinguisher shall be mounted on a wall or a post where it is clearly visible, unobstructed and mounted so that the top is not over 5 feet high. An extinguisher may not be tied down, locked in a cabinet or placed in a closet or on the floor except that it may be placed in a clearly marked, unlocked wall cabinet used exclusively for that purpose.

(4) OPEN FLAME LIGHTS. Candles and other open flame lights are not permitted as a substitute for the building lighting system.

(5) FIRE PROTECTION SYSTEMS. (a) *Location.* No facility may install a smoke detection system that is not approved by the department.

(b) *Smoke detection systems.* Each facility shall have, at a minimum,a low–voltage interconnected smoke detection system to protect the entire facility so that if any detector is activated it triggers an alarm audible throughout the building.

(c) *Installation, testing and maintenance.* 1. Smoke detectors shall be installed, tested and maintained in accordance with the manufacturer's recommendations, except that they shall be tested not less than once a month. The hospice shall maintain a written record of tests.

2. Smoke detection systems and integrated heat detectors, if any, shall be tested annually for reliability and sensitivity by a reputable service company in accordance with the specifications in National Fire Protection Association (NFPA) standard 72E and the manufacturer's specifications. Detectors found to have a sensitivity outside the approved range shall be replaced. Detectors listed as field adjustable may be either adjusted within the approved range or replaced. A detector's sensitivity may not be tested or measured using a spray device that administers an unmeasured concentration of aerosol into the detector.

Note: NFPA's Standard 72E may be consulted at the offices of the Department's Bureau of Quality Assurance or at the Secretary of State's Office or the Revisor of Statutes Bureau. A copy can be obtained from the National Fire Protection Association, Battery March Park, Quincy, MA 02269.

(d) *Location of detectors.* 1. At least one smoke detector shall be located at each of the following locations:

a. At the head of every open stairway;

b. On the stair side of every enclosed stairway on each floor level;

c. In every corridor, spaced not more than 30 feet apart and not further than 15 feet from any wall;

d. In each common use room, including living rooms, dining rooms, family rooms, lounges and recreation rooms but not including kitchens, bathrooms or laundry rooms;

e. In each sleeping room in which smoking is allowed;

f. In each room of the staff living quarters, including the staff office but not including kitchens and bathrooms;

g. In the basement or in each room in the basement except a furnace room or laundry room; and

h. In rooms which are differentiated by one or more ceiling drops which exceed 12 inches in height.

2. Detectors in rooms shall be mounted no more than 30 feet apart and no more than 15 feet from the closest wall unless the manufacturer specifies a greater or lesser distance for effective placement. Large rooms may require more than one smoke detector in order for the detection system to provide adequate protection.

(6) HEAT DETECTION. (a) Hospice facilities licensed after June 1, 1992 which were not previously licensed shall install at least one heat detector integrated with the smoke detection system at each of the following locations:

1. The kitchen; and

2. Any attached garage.

(b) Smoke and heat detectors installed under this section shall be listed by a nationally recognized testing laboratory that maintains periodic inspection of production of tested equipment and the listing of which states that the equipment meets nationally recognized standards or has been tested and found suitable for use in a specified manner.

(7) ATTACHED GARAGES. (a) Common walls between a hospice facility and an attached garage shall be protected with not less than one layer of 5/8–inch Type X gypsum board with taped joints, or equivalent, on the garage side and with not less than one layer of 1/2–inch gypsum board with taped joints, or equivalent, on the hospice side. The walls shall provide a complete separation.

(b) Floor–ceiling assemblies between garages and the hospice facility shall be protected with not less than one layer of 5/8–inch type X gypsum board on the garage side of the ceiling or room framing.

(c) Openings between an attached garage and a hospice facility shall be protected by a self–closing 1–3/4 inch solid wood core door or an equivalent self–closing fire–resistive rated door.

(d) The garage floor shall be pitched away from the hospice facility and at its highest point shall be at least 1–1/2 inches below the floor of the facility.

(e) If a required exit leads into the garage, the garage shall have at least a 32 inch wide service door.

Note: Interior access from the garage may be ramped for accessibility.

History: Cr. Register, May, 1992, No. 437, eff. 6–1–92.