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mission 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. HFS 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 assurance 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 assurance 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 assurance 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 assurance 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 assurance 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 assurance in writing to the department of administration's division of hearings and appeals within 5 days after receipt of the decision.

Note: The mailing address of the Division of Hearings and Appeals 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.

HFS 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. HFS 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

HFS 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).

5. The nursing home shall provide appropriate assessment and treatment of pain for each resident suspected of or experiencing pain based on accepted standards of practice that includes all of the following:

a. An initial assessment of pain intensity that shall include: the resident's self-report of pain, unless the resident is unable to communicate; quality and characteristics of the pain, including the onset, duration and location of pain; what measures increase or decrease the pain; the resident's pain relief goal; and the effect of the pain on the resident's daily life and functioning.

b. Regular and periodic reassessment of the pain after the initial assessment, including quarterly reviews, whenever the resident's medical condition changes, and at any time pain is suspected, including prompt reassessment when a change in pain is self-reported, suspected or observed.

c. The delivery and evaluation of pain treatment interventions to assist the resident to be as free of pain as possible.

d. Consideration and implementation, as appropriate, of non-pharmacological interventions to control pain.

(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. HFS 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

Unofficial Text (See Printed Volume). Current through date and Register shown on Title Page.

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. HFS 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. HFS 132.60 (1) (c) 4; for records, see s. HFS 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 an authorized prescriber 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 an authorized prescriber's written order which shall be filed in the resident's clinical record.

2. 'Oral orders.' Oral orders shall be immediately written, signed and dated by the nurse, pharmacist or therapist on the prescriber's order sheet, and shall be countersigned by the prescriber and filed in the resident's clinical record within 10 days of the order.

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. HFS 132.65.

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.

(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. 450.01 (17), 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 acquisition, receipt, dispensing and 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 pre-discharge 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 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. HFS 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. HFS 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. The use of restraints shall be consistent with the provisions under s. HFS 132.31 (1) (k).

(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. HFS 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 necessary, 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. HFS 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.

Unofficial Text (See Printed Volume). Current through date and Register shown on Title Page.

(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. HFS 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. HFS 132.52. For requirements for short-term care residents, see s. HFS 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 Assurance, 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; correction in (5) (d) made under s. 13.93 (2m) (b) 7., Stats., Register, August, 2000, No. 536; **CR 04-053; cr. (1) (c) 5., am. (5) (a) 1. and 2., (5) (d) 2., and (6) (b), r. (5) (a) 3. and (c) Register October 2004 No. 586, eff. 11-1-04.**

HFS 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 employees. 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. HFS 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. HFS 132.52 (2) (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. HFS 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. HFS 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. HFS 132.45 (5) (c) 4; for requirements to notify others, see s. HFS 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; correction in (2) (b) made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1996, No. 492.

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

(b) "Ward clerk" means an employee 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).

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;

Unofficial Text (See Printed Volume). Current through date and Register shown on Title Page.

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.* Each nursing home, other than nursing homes that primarily serve people with developmental disabilities, shall provide at least the following hours of service by registered nurses, licensed practical nurses or nurse's assistants:

1. For each resident in need of intensive skilled nursing care, 3.25 hours per day, of which a minimum of 0.65 hour shall be provided by a registered nurse or licensed practical nurse.

2. For each resident in need of skilled nursing care, 2.5 hours per day, of which a minimum of 0.5 hour shall be provided by a registered nurse or licensed practical nurse.

3. For each resident in need of intermediate or limited nursing care, 2.0 hours per day, of which a minimum of 0.4 hour shall be provided by a registered nurse or licensed practical nurse.

(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. HFS 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. HFS 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; **CR 04-053: am. (2) (a) 1. and r. and recr. (3) (a) Register October 2004 No. 586, eff. 11-1-04.**

HFS 132.63 Dietary service. (1) DIETARY SERVICE. The facility shall provide each resident a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

(2) **STAFF.** (a) *Dietitian.* The nursing home shall employ or retain on a consultant basis a dietitian to plan, direct and ensure implementation of dietary service functions.

(b) *Director of food services.* 1. The nursing home shall designate a person to serve as the director of food services. A qualified director of food services is a person responsible for implementation of dietary service functions in the nursing home and who meets any of the following requirements:

a. Is a dietitian.

Unofficial Text (See Printed Volume). Current through date and Register shown on Title Page.

b. Has completed at least a course of study in food service management approved by the dietary managers association or an equivalent program.

c. Holds an associate degree as a dietetic technician from a program approved by the American dietetics association.

2. If the director of food services is not a dietitian, the director of food services shall consult with a qualified dietitian on a frequent and regularly scheduled basis.

(c) *Staffing.* The nursing home shall employ a sufficient number of dietary personnel competent to carry out the functions of the dietary service.

(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. HFS 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 research 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 accommodate 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.

(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.

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. HFS 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; **CR 04-053: am. (1), r. and recr. (2), r. (6) (c) and (7) (a) 4. Register October 2004 No. 586, eff. 11-1-04.**

HFS 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. HFS 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.

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

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

HFS 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. 961.16, Stats.

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

(b) The facility shall establish, maintain, and implement such policies and procedures as are necessary to comply with this section and assure that resident needs are met.

(3) SUPERVISION. (a) *SNF medication consultant.* 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 quality assessment and assurance committee.

(b) *ICF medication consultant.* 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 quality assessment and assurance 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 quality assessment and assurance 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 sub. (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 nurse's 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 USC ch. 13, and Wisconsin's uniform controlled substance act, ch. 961, 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. Non-prescription 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.

(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.

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

Unofficial Text (See Printed Volume). Current through date and Register shown on Title Page.

shall be stored and used only in accordance with the health, safety, and welfare of all residents.

Note: See s. HFS 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; correction in (1) (c) made under s. 13.93 (2m) (b) 7., Stats., Register, August, 2000, No. 536; correction made to (6) (d) 1. under s. 13.93 (2m) (b) 7., Stats., Register December 2003 No. 576; **CR 04-053; am. (2) and (5) (d), r. (3) (a), renum. and am. (3) (b) 1. and 2., r. (6) (c) 3. Register October 2004 No. 586, eff. 11-1-04.**

HFS 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. HFS 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 the order of a physician, physician assistant or an advanced practice nurse prescriber.

(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. HFS 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. HFS 124. If the facility only provides transfusion services, it shall meet the requirements of s. HFS 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; CR 03-033; r. (1) (d) Register December 2003 No. 576, eff. 1-1-04; **CR 04-053; cr. (1) (d) Register October 2004 No. 586, eff. 11-1-04.**

HFS 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 per-

sonnel 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. HFS 132.45; for dentists' orders, see s. HFS 132.60 (5); for staff development programs about dental practices, see s. HFS 132.44 (2).

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

HFS 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 HISTORY. The facility shall prepare a social history of each resident.

(4) CARE PLANNING. (a) 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. HFS 132.60 (8) (a).

(b) Social services care and plans shall be evaluated in accordance with s. HFS 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. HFS 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; **CR 04-053; r. and recr. (3) and (4) Register October 2004 No. 586, eff. 11-1-04.**

HFS 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

Unofficial Text (See Printed Volume). Current through date and Register shown on Title Page.

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:
 - 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 employee 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; **CR 04-053: r. (2) (a) 1. a. Register October 2004 No. 586, eff. 11-1-04.**

HFS 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 col-

lege or university accredited or approved by the council on social work education.

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

5. A speech pathologist or audiologist who meets the requirements of s. HFS 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 subs. 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

Unofficial Text (See Printed Volume). Current through date and Register shown on Title Page.

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. HFS 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; correction in (2) (d) 4. made under s. 13.93 (2m) (b) 7., Stats., Register, August, 2000, No. 536.

HFS 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. HFS 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. HFS 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. HFS 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. HFS 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 resi-

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dent 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. HFS 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. HFS 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. HFS 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. HFS 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. HFS 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. HFS 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**HFS 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.