Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Mount Washington Residence	9/4/02	83.43(4)(b)3	In the summer of 2001, facility requested an FSES evaluation in lieu of installing smoke and heat detectors (for which bids had come in between $125,000 - $190,000). Facility was not notified of FSES results until 6/21/02, which stated the facility needed to install smoke and heat detectors or a sprinkler system. Facility has not installed either.	$480 forfeiture as of 9/6/02 ($10/day from 7/21 to 9/4) + $10/day until plans are submitted for approval + $10/day from aprroval date until installed	
Eau Claire					
Eau Claire					
Western					
Wellington Place of Biron	9/4/02	83.14(8)	Facility did not have training approval from the Department for its training in universal precautions (5 of 5 had not completed) and medication administration (4 of 5 staff).	$200 forfeiture	Paid
Wisconsin Rapids		83.43(3)(b)1	Facility had not had its interconnected heat and smoke detection system tested since 2/1/01 (now 6 months overdue).	Order to have tested within 10 days.	
Wood		83.42(3)(a)	Facility had not submitted plans for evacuation of a resident who was unable to evacuate under 4 minutes. Fire department had not received anything six days after survey.	Order to submit a plan to the fire department within 10 days.	
Northern		83.21(4)(g)	Caregiver placed a resident on a hard wooden chair, away from her walker and call light, as punishment for having wet herself. Resident was found crying by another caregiver, who removed her from the chair. Facility fired the caregiver who had committed the abuse.	$300 forfeiture	Paid
Wells Nature View VII	9/4/02	83.14(1)(d)	3 of 6 staff had not completed training in fire safety.	$100 forfeiture	Paid
Marshfield		83.33(2)(c)	Facility had sparse activities for the month of August - and included such things as having a snack, doing nails, and watching workers seal the driveway.	$300 forfeiture	Paid
Wood					
Northern					
Golden Years	9/3/02	83.14(1)(c)	2nd cite. 1 of 7 staff had not completed training in universal precautions prior to beginning work.	$50 forfeiture	Appealed
DeForest		83.15(1)(a)	2nd cite. Facility has a resident who requires the assist of 2 to transfer and sometimes needs assist of 3 to be gotten up. Two staff had hurt themselves in August while trying to get the resident up after she had fallen.	$3390 forfeiture (171 hrs. 6AM - 3PM + 168 hrs. 3PM - 9PM [8/1 - 8/28/02] x $10/hr.). Order to transfer resident or to staff with 2 people.	Appealed
Dane				Initial installment of $875 due 12/15 with 3 payments of $1250 due through March 2003.	Per stip 12/3/02, total forf. $4625 for SODs #10006475 & 10006528.
Southern					

Facility Name, City, County, Region	*Citation Date*	*Codes*	*Descriptions*	*Remedies*	*Outcomes*
Shiloh Suites Ashland Ashland Northern	9/3/02	83.33(2)	The facility did not consistently apply bed and/or chair alarms for one resident identified as requiring such devices. Resident fell from bed on 6/23/02 and immediately sustained "excruciating pain." The resident was transferred to the hospital, where she died the following day. Facility staff had not applied the bed alarm, which they had also failed to do on 3/13 and 6/21, when the resident had also fallen and sustained injuries (e.g, lacerations, bruises, pain).	$750 forfeiture	Paid

Appendix C
Forfeiture Timelines and Monitoring

Region	Facility	Survey	Completed	Days
NERO	Century Ridge I	11/6/02	2/7/03	93
NERO	Encore Sr Living	10/3/02	1/2/03	91
NERO	Liberty House	10/10/02	1/29/03	111
NERO	Plainfield Community Home	12/10/02	1/24/03	45
NERO	Rose Acres I	1/15/03	2/7/03	23
NRO	Cedar Ridge Elder	11/29/02	1/10/03	42
NRO	Family Matters Adult Family Home	1/13/03	2/19/03	37
NRO	Inncare of Minocqua I	12/18/02	2/6/03	50
NRO	Inncare of Minocqua II	12/30/02	2/6/03	38
NRO	Inncare of Minocqua West	1/2/03	1/31/03	29
NRO	Mishomis House	12/11/02	1/16/03	36
NRO	New Century Adult Living	1/8/03	2/7/03	30
NRO	Our House Plover 1	8/28/02	1/16/03	141
NRO	Our Way Group Home	12/23/02	2/5/03	44
NRO	Queen of Angels Convent	12/13/02	1/27/03	45
NRO	Wellington Place of Biron	11/13/02	1/22/03	70
NRO	Westhill AFH	1/14/03	2/10/03	27
SERO	Alterra Clare Bridge Brookfield	1/14/03	2/5/03	22
SERO	Alterra Sterling Sussex	1/3/03	1/16/03	13
SERO	Brotoloc Greenfield	1/7/03	1/16/03	9
SERO	Brotoloc Lakewood	11/7/02	1/9/03	63
SERO	Clark Place Riverside	2/7/03	2/17/03	10
SERO	Congregational Home	1/28/03	2/10/03	13
SERO	Countryside Manor	11/20/02	1/16/03	57
SERO	Harmony of Racine	12/6/02	1/2/03	27
SERO	Heavenly Care Group Home	1/16/03	2/17/03	32
SERO	Heavenly Care Group Home	1/15/03	1/29/03	14
SERO	HIL Drake House	10/29/02	1/2/03	65
SERO	HIL Hillside	12/5/02	1/10/03	36
SERO	Hillcrest Home	1/23/03	2/17/03	25
SERO	Marian Heights Home	12/2/02	1/10/03	39
SERO	Maxson Manor	1/9/03	1/27/03	18
SERO	New Perspective Brookfield I	12/11/02	1/27/03	47
SERO	New Perspectives Brookfield II	12/11/02	1/27/03	47
SERO	Onxy House	12/6/02	1/27/03	52
SERO	REM Wisconsin II	1/9/03	2/6/03	28
SERO	St. Coletta/Patrick	12/11/02	1/2/03	22
SERO	White Birch Terrace	1/21/03	2/10/03	20
SRO	Alterra Wynwood	12/27/02	1/9/03	13
SRO	Encore Sr. Villa Fitchburg East 2	2/17/03	2/20/03	3
SRO	Encore Stoughton West	1/7/03	1/15/03	8
SRO	Forest Manor	2/4/03	2/4/03	0
SRO	Hammersley House	1/24/03	2/5/03	12
SRO	Harbor House II	1/28/03	2/5/03	8
SRO	Harbor Suites	1/29/03	2/6/03	8
SRO	Harmony of McFarland	1/13/03	1/16/03	3
SRO	Inncare of Evansville	1/14/03	1/16/03	2

Region	Facility	Survey	Completed	Days
SRO	Morning Sun Care	12/12/02	1/3/03	22
SRO	Our House Baraboo	2/4/03	2/10/03	6
SRO	Parkside Heights Group Home	1/15/03	1/24/03	9
SRO	Rock Valley Community Programs	2/13/03	2/14/03	1
SRO	State Street Care Home	1/8/03	1/22/03	14
SRO	Sun Valley	1/28/03	2/10/03	13
SRO	Sun Valley Terrace	1/28/03	2/10/03	13
SRO	Sunny Ridge	12/18/02	1/2/03	15
SRO	Sylvan Crossings at Hunter Ridge	2/12/03	2/14/03	2
SRO	Tellurian Ucan Jackson	1/31/03	2/10/03	10
WRO	Ain Dah Ing	1/29/03	2/10/03	12
WRO	Bothne House	1/22/03	2/7/03	16
WRO	Comforts of Home	12/10/02	1/2/03	23
WRO	Harmony Living	12/10/02	1/2/03	23
WRO	Old Times	1/24/03		
WRO	Sherry House	1/23/03	2/10/03	18

EXHIBIT 3

DIVISION OF SUPPORTIVE LIVING

BUREAU OF QUALITY ASSURANCE
1 WEST WILSON STREET
P O BOX 2969
MADISON WI 53701-2969

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Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

CIVIL MONEY PENALTY FUND USE

Effective February 1, 2000

Written and developed in conjunction with Bureau of Quality Assurance (BQA) Manual Code #2556 – Civil Money Penalty Determination

Pursuant to federal requirements, 488.442 Civil Money Penalties: Due date for payment of penalty, "penalties collected by the State must be applied to the protection of the health or property of residents of facilities that the State or HCFA finds deficient such as:

(1) Payment for the cost of relocating residents to other facilities;
(2) State costs related to the operation of a facility pending correction of deficiencies or closure; and
(3) Reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or by individuals used by the facility to provide services to residents."

Monies collected by or returned to the State of Wisconsin as a result of provider CMP payments are deposited in a general revenue account, and therefore disbursement of funds from this account must comply with Department of Health and Family Service fiscal procedures. This procedure establishes parameters by which the State of Wisconsin, Division of Supportive Living, Bureau of Quality Assurance will expend CMP funds.

Fifty percent of the Civil Money Penalty Fund will be reserved by BQA and applied toward the Department's costs for monitoring a facility while under a state imposed monitor remedy or in the event that the Department is appointed the receiver of a facility under Chapter 50, Wis. Stats. A petition for receivership occurs when:

- A facility is operating without a license.
- The department has suspended or revoked the existing license of the facility.
- The department initiates revocation procedures and determined that lives, health, and safety or welfare of residents cannot be adequately assured.
- The facility is closing or intends to close and adequate resident relocation initiatives are not in place.

The remaining fifty percent of the Civil Money Penalty Fund will be utilized for the purpose of funding projects that improve the health and safety and quality of care provided to residents, pursuant to item (4), s. 49.499 Wis. Stats. Expenditure of CMP funds received by the State of Wisconsin, per s. 49.499 Wis. Stats., may be utilized for the following:

(1) Relocating residents to other facilities.
(2) Reimbursement for state costs related to operating a facility pending correction of deficiencies or closure.
(3) Reimbursement to residents for funds or property lost as a result of a facility's action or inaction.
(4) Innovative projects that improve the health and safety and quality of care provided to residents.

CMP funds are not intended to be a patient/resident compensation fund, unless the Department is the receiver or operator of the facility pursuant to s. 50.05(4), Wis. Stats. Facilities are responsible for establishing mechanisms to handle resident claims.

File: m:/do/CMPuse.doc

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

Ref:S&C-02-42

Date: **August 8, 2002**

From: Director
Survey and Certification Group
Center for Medicaid and State Operations

Subject: Use of Civil Money Penalty (CMP) Funds by States

To: Associate Regional Administrator
Divisions of Medicaid & State Operations
Regions I – X
State Survey Agency Directors

The purpose of this memorandum is to provide information regarding how states may use CMP funds collected from nursing homes that have been out of compliance with Federal requirements. It has come to our attention that guidance is needed to ensure that states use CMP funds in accordance with the law and in a consistent manner, while maintaining some flexibility in the use of those funds.

Background – States collect CMP funds from Medicaid nursing facilities and from the Medicaid part of dually-participating skilled nursing facilities (SNFs) that have failed to maintain compliance with Federal conditions of participation. These CMP funds are state, not Federal funds. CMP funds collected from Medicare-participating SNFs and the Medicare part of dually-participating SNFs are Federal funds and are returned to the Medicare Trust Fund.

Section 1919(h)(2)(A)(ii) of the Social Security Act (the Act) provides that CMP funds collected by a state as a result of certain actions by nursing facilities or individuals must be applied to the protection of the health or property of residents of nursing facilities that the state or the Secretary finds deficient. These actions include CMPs assessed against:

(1) A nursing facility that is not in compliance with Federal requirements in sections 1919(b), (c), (d) of the Act;
(2) An individual who willfully and knowingly certifies a material and false statement in a resident assessment (section 1919(b)(3)(B)(ii)(I) of the Act);
(3) An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment (section 1919(b)(3)(B)(ii)(II) of the Act); and
(4) An individual who notifies (or causes to be notified) a nursing facility of the time or date on which a standard survey is scheduled to be conducted (section 1919(g)(2)(A)(i) of the Act).

The Act cites three examples of uses for CMPs:

(1) Payment for the costs of relocation of residents to other facilities;
(2) Maintenance of operation of a facility pending correction of deficiencies or closure; and
(3) Reimbursement of residents for personal funds lost.

The regulations, at 42 CFR 488.442(g), contain similar language, with some very minor wording changes that make it clear that the costs of relocation of residents to other facilities are for state costs. The regulations also indicate that the personal funds lost at a facility are the result of actions by the facility or by individuals used by the facility to provide services to residents. Section 7534B of the State Operations Manual (SOM) contains similar language, but specifies that the funds must be used to protect the health or property of residents of deficient facilities.

In the preamble to the final enforcement regulations published on November 10, 1994, we indicated that the law suggests that CMP revenues be applied to administrative expenses rather than direct care costs, although it is clear that states have broad latitude to determine which of these types of expenses best meet the needs of their residents (page 56210 of the Federal Register, Volume 59, No. 217). Further, the preamble is very clear that the Act permits each state to implement its own procedures with respect to the use of CMPs. Our previous direction to CMS regional offices has been that the specified uses of CMP funds in the Act and section 488.442(g) are not exhaustive, that states need flexibility in determining the appropriate use of funds, and that regional offices have some oversight responsibility. Beyond this, we have not provided general guidance to all states and regional offices on what is considered appropriate use of these funds within the scope of the law and regulations. Due to the lack of guidance, a number of states have been reluctant to use a majority of the money. As a result, some states have a significant amount of money on deposit and this amount is continuously growing.

Flexibility in Use of CMP Funds -- While the Act provides states with much flexibility to be creative in the use of CMP funds, this flexibility is limited by the requirement that CMP funds are to be focused on facilities that have been found to be deficient. However, the law does not specify when a facility must have been determined to be deficient to qualify for benefits under a state project funded by CMPs. Most nursing facilities have had one or more deficiencies either recently or in the past. Rather than setting forth rigid criteria on when it is that a facility must have been deficient to be an eligible target for the application of CMP revenues, we believe that the best course is to offer states maximum flexibility to make this determination. Apart from this, we believe that projects funded by CMP collections should be limited to funding on hand and should be relatively short-term projects.

Each state is responsible for ensuring that CMP funds are applied in accordance with the law. Regional oversight should be general in nature, responding to questions from states or commenting on the occasional project proposal submitted for regional office input, but there is no requirement that a regional office review and approve each state project before it is implemented.

Appropriate CMP Fund Use --As we stated in the preamble to the 1994 final enforcement regulations, CMP revenues should be spent on administrative expenses, rather than direct care costs, as applied to deficient facilities. If the purpose of the state project is related to deficient practice, the CMP funds could be used to prevent continued noncompliance by nursing facilities through educational or other means. For example, to address particular areas of noncompliance, a state could develop videos, pamphlets, or other publications providing best practices, with these educational materials being distributed to all deficient nursing facilities. Other uses could include, for example, the development of public service announcements on issues directly related to the identified deficient area, and employment of consultants to provide expert training to deficient facilities. North Carolina and other states have issued grants to several nursing facilities to fund Eden Alternative Projects, which provide training and other services necessary to support the use of animals in nursing facilities for therapeutic purposes. Because CMP funds collected by a state are state funds, the state may use the money for any project that directly benefits facility residents, in accordance with section 1919(h)(2)(A)(ii) of the Act, including funding an increase in ombudsman services.

Inappropriate CMP Fund Use – We believe that it is not appropriate for states to use CMP funds for a loan to a deficient facility that is having financial difficulty meeting payroll or paying vendors. As pointed out in the preamble, if the CMP is used by the facility to correct the noncompliance that led to its imposition, it is, in effect, not a remedy.

If you believe that a state is not spending collected CMPs in accordance with the law or regulations, or not at all, you should refer this matter to your regional office account representative so that he or she may discuss this matter with the state.

Effective Date: This guidance is effective on the date of issuance.

Training: This policy should be shared with all survey and certification staff, surveyors, their managers and the state/regional training coordinator.

/s/
Steven A. Pelovitz

WAHSA
Wisconsin Association
of Homes and Services for the Aging

MAR 19 2003

WHCA
Wisconsin Health Care Association

March 18, 2003

Representative Suzanne Jeskewitz
Co-Chair, Joint Legislative Audit Committee
314 North Capitol
P.O. Box 8952
Madison, WI 53708

Dear Representative Jeskewitz:

At the conclusion of our February 19th meeting to discuss the LAB audit of nursing home and assisted living facility regulations, you kindly offered us the opportunity to compile a list of suggested statutory changes which we believe would improve the quality of care in our state's nursing homes and assisted living facilities. Our response will focus first on the LAB recommendations contained in Legislative Audit Bureau Report 02-21, "Regulation of Nursing Homes and Assisted Living Facilities," and secondly on suggested revisions to Chapter 50, Wis. Stats., the Uniform Licensure statute.

Response to the LAB Recommendations in LAB Report 02-21

Support: 60 Day Timeframe for Provider Appeals (Page 62 of the report): Expanding the timeframe to file appeals from 10 days after receiving a statement of deficiency or a forfeiture assessment to 60 days is consistent with the federal appeals process and will save needless administrative expenses.

Support with Modifications: Improvements in the Informal Dispute Resolution (IDR) Process (Pages 59-61): Any efforts which would improve the timeliness of the IDR decision-making process warrant our support. Our concern is who is making these decisions. Under the current system, state survey agency supervisors in the Bureau of Quality Assurance (BQA) review the decisions of their peers in other parts of the state. We support Recommendation #210 of Department of Health and Human Services Secretary Tommy Thompson's Advisory Committee on Regulatory Reform, which would require IDR programs to be conducted through an independent third party not connected to either the state survey agency or to a nursing facility. Alternatively, if a truly independent process is not implemented at this time, the Department of Health and Family Services (DHFS) should assign staff to administer the IDR process who do not directly supervise or oversee BQA surveyors or BQA regional operations.

Oppose: Diversion of Assisted Living Facility (ALF) Forfeitures to the DHFS (Page 46): We simply object to providing a perverse incentive to the DHFS to fund its internal operations by maximizing the assessment of forfeitures.

Oppose: Restrict Nursing Home Admissions (Page 50): This remedy only should be imposed for serious violations of state code or statutes. Its imposition could be particularly devastating for prospective residents seeking admission to the facility of their choice if that facility becomes subject to this restriction, especially in a rural setting where the next closest facility might be 50 miles from home and family. In addition, you heard the administrator of Park Manor in Park Falls state five serious violations cited against that facility were later overturned upon appeal. To impose an admissions prohibition upon a facility without enabling that facility to exercise its full due process rights is simply unjust.

No Position: Assisted Living Survey Revisions (Page 37): The BQA already has implemented most of these suggested changes. They have hired eight registered nurses solely to survey assisted living facilities and they have invoked an internal directive to survey each of the over 2,000 ALFs at least once every 24 months.

Written Procedures for ALF Forfeitures (Page 46): The BQA has indicated they intend(ed) to implement such written procedures as of 3/1/03.

Other Suggested Revisions to Chapter 50, Wis. Stats.

- **Require BQA surveyors to issue either a state or a federal citation, but not both, for the same deficient practice.**

1) Medicaid- and Medicare-certified nursing homes in Wisconsin are subject to both state and federal regulations and enforcement systems. BQA surveyors enforce both systems. In many instances, this results in a "double jeopardy" situation where a single deficient practice receives both a federal and a state citation and the corresponding penalty each invokes. The current system is both duplicative and punitive.

2) Since the state is obligated to enforce federal requirements, we suggest Chapter 50 be amended to require BQA surveyors to issue a state citation only if an applicable federal citation is not available. This proposed change would ensure that all deficient practices would be adequately and appropriately addressed without needlessly imposing a "double jeopardy" penalty on the offending facility.

3) The federal enforcement system has a wide array of remedies/penalties, including temporary management, denial of payment for new admissions, denial of Medicaid/Medicare payments, state monitoring, directed plans of correction, directed in-service training, closure of a facility/transfer of residents, termination of Medicaid/Medicare provider agreement, and civil monetary penalties ranging from $50 - $10,000 per day. There are ample tools under the federal system to compel compliance.

4) The federal enforcement system is less reliant on the civil monetary penalty remedy than the state system is on the forfeiture remedy. The difference in approach is significant since the DHFS found in an internal review it conducted late last year that 50.9% of the state's nursing homes are at "financial risk." Placing a monetary penalty on a facility at financial risk would seem to be at odds with the intended goal of any enforcement system: To ensure quality care.

5) Because there would be significantly fewer state citations issued if this proposed change were enacted into law, there would be significantly fewer forfeitures assessed. This should quickly

eliminate both the current forfeiture assessment review backlog and delays in forfeiture assessment reviews in the future. Indeed, this suggested change could result in the elimination of at least one of the three current forfeiture specialist positions and the corresponding savings that cut would generate.

- **Amend state law to: 1) Permit state forfeiture assessments to be deposited either in the Medicaid Trust Fund or some other fund created to subsidize quality improvement projects; and 2) Permit the BQA to direct a facility to expend a dollar amount equal to the forfeiture assessment the BQA would have imposed on internal quality improvement projects.**

  1) We are unaware of any empirical evidence which proves that the assessment of forfeitures and the imposition of other punitive measures are effective tools to compel or entice compliance. Indeed, this approach would appear to be counterproductive for facilities at financial risk.

  2) The Wisconsin system is even more perplexing because all forfeiture assessments by law must be deposited in the Common School Fund and cannot be used to improve quality or address the deficient practices which yielded the forfeitures. However, it would appear a constitutional amendment would be required to implement this proposed change.

  3) One option to avoid the constitutional pitfall may be simply to change the statutory penalty from a forfeiture to a civil monetary penalty or some other similar designation.

  4) The imposition of a forfeiture is purely punitive; it does nothing to improve quality and it is questionable whether it effectively compels compliance.

  5) The goal of this proposal is to permit facilities with deficient practices to utilize their limited resources to address those deficiencies rather than simply toss those scarce dollars into the state school fund.

  6) The need for this proposed change would be less significant if the "double jeopardy" proposal described above were adopted.

- **Modify statutory requirements to eliminate the need to file separate appeals for both the state citation(s) and the forfeiture assessment(s).**

  1) Under the current system, a facility first receives a state deficiency/citation. Weeks, months, or in some cases, years later, they will receive a forfeiture assessment for that citation. Under current law, a facility must appeal both the issuance of the citation and the assessment of the forfeiture.

  2) A facility might be of the belief a citation is not worth the time or money to appeal, that is until the forfeiture assessment arrives. Since the citation and the forfeiture assessment don't arrive simultaneously, or even close to it, the facility is forced to decide whether to appeal a citation without having all the facts available. To protect themselves, some believe facilities are forced to appeal all citations even if their original instincts, that the citation is not significant enough to appeal, were correct. This adds needless costs to both the provider and the state because both are forced into the appeals process. On the other hand, if a provider decides not to appeal a citation and later is hit with a hefty forfeiture assessment, they no longer have the ability to appeal the original citation.

3) Filing a single appeal after receipt of both the citation and the forfeiture assessment will protect a provider's due process rights while reducing state and provider costs for appeals that ultimately prove to be unnecessary.

We appreciate the opportunity you provided us to comment on both the Legislative Audit Bureau report on long-term care provider regulations and on other changes we believe could improve quality care in our nursing homes and assisted living facilities. If you should have any questions concerning these comments, please do not hesitate to contact any one of us.

Sincerely,

Tom Ramsey
Director of Government Relations
Wisconsin Association of
Homes and Services for
the Aging (WAHSA)

Jim McGinn
Director of Government Relations
Wisconsin Health Care
Association (WHCA)

Forbes McIntosh
Broydrick and Associates

cc: Karen Asbjornson
Senator Carol Roessler's office

State of Wisconsin
Department of Health and Family Services

MAR 18 2003

Jim Doyle, Governor
Helene Nelson, Secretary

March 14, 2003

The Honorable Carol Roessler
Wisconsin Senate
Room 130 South, State Capitol
P.O. Box 7882
Madison, WI 53707-7882

The Honorable Suzanne Jeskewitz
Wisconsin Assembly
Room 314 North, State Capitol
P.O. Box 8952
Madison, WI 53708-8952

Dear Senator Roessler and Representative Jeskewitz:

Thank you for your letter regarding the Medicaid prior authorization process. We, too, want to have a process that serves the needs of the people both efficiently and effectively, while also assuring that the Wisconsin Medicaid program only pays for services that are appropriate and medically necessary.

Since July 2001, when the Legislative Audit Bureau issued its report, Department staff have implemented its two recommendations, and have made significant other improvements. The attached grid provides information on these initiatives and their status.

In addition, I have asked Mark Moody, my new Administrator of the Division of Health Care Financing, to make recommendations to me regarding further improvements to the Medicaid prior authorization process. I regard this as a top priority and so does he. However, I do not expect these recommendations to be ready until early summer. I can assure you that he is ready to review and seek input from staff, providers and consumers as part of that review process.

Thank you, again, for your letter and for your continued interest in the Wisconsin Medicaid program.

Sincerely,

Helene Nelson
Secretary

Attachment

THERAPY PRIOR AUTHORIZATION (PA) PROJECTS

Issue	**Current Status**
LAB RECOMMENDATION Publish specific guidance regarding how the concept of medical necessity is applied in the evaluation of therapy prior authorization requests.	COMPLETED Published on website, May 2002. Mailed to all Wis. Medicaid certified therapy providers in June 2002.
LAB RECOMMENDATION Revision of notice of recipient's right to appeal letter.	COMPLETED Letter in final draft shared with Home Care Consumer Advisory Committee July 2, 2002. Comments due back by 7/16/02. No comments received. New letter being used effective November 2002.
ETN re: revised PA/TA	COMPLETED ETN presented February 19, 2002
Therapy PA 101 CD	COMPLETED Mailing to providers in October 2002
Eliminate on-going PA for recipients enrolled in Birth to 3 (0-3) Program	COMPLETED Update published in June 2002. ETN held with 0-3 staff & providers on July 11, 2002.
Parental PA Request/Informational Form	COMPLETED DHCF will continue to encourage parent involvement.
Physician's prescription requirement/frequency	COMPLETED Requirement to submit M.D. script with Therapy PA eliminated Update published effective July 2002.
Administrative support staff to assist therapy providers: • LTE: clerical support assistant at EDS. • Ombudsman	COMPLETED No further consideration Determined to be cost prohibitive. LAB Committee notified in letter.

THERAPY PRIOR AUTHORIZATION (PA) PROJECTS

Evaluation of Training Effectiveness	Evaluation results will be shared with the therapy associations at a quarterly meeting.
Longer Approval Periods	Discussions with the therapy associations continue at quarterly meetings to elicit input. DHCF continues to analyze data through prior authorization record review.
Therapy Appeal Statistics	COMPLETED BHCPI developed & maintains an Appeals Database. Information collected is being reviewed. Information regarding appeals requested & DHA determinations shared with Therapy Associations quarterly
Stat PA for Spell of Illness	BHCPI staff has collected data regarding use of Spell of Illness (SOI). Information regarding SOI was discussed at March 2002 All Therapy Association meeting. Evaluation of specific therapy CPT codes &/or diagnosis completed. DHCF currently evaluating the process to implement this initiative.
Enhanced reimbursement for service in the natural environment	COMPLETED Birth to 3 Program therapy providers being reimbursed quarterly for services provided in the natural environment.
Electronic PA Submission	No current funding to pursue this.

THERAPY PRIOR AUTHORIZATION (PA) PROJECTS

Addition of 18 new Speech Codes for reimbursement	COMPLETED Update published online & mailed to all therapists. Multiple meetings with state therapy associations & representatives to reach agreement regarding codes & reimbursement rates. ETN regarding use of new codes 9/23/02
Therapy Association requesting changes to Adm. Code definition of medical necessity.	Initial crosswalk with WI & Kennedy model completed by DHCF. At June 2002 quarterly meeting, Therapy Association representatives were asked to identify how the Kennedy model of medical necessity would better address their concerns. Therapy Association & Survival Coalition, WCDD sponsored a "summit" Aug 14, 2002, with author of Kennedy model. Therapy Associations shared information of their summit at October 2002 meeting.

WISCONSIN STATE LEGISLATURE

Joint Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

March 21, 2003

Ms. Helene Nelson, Secretary
Department of Health and Family Services
1 West Wilson Street
Madison, Wisconsin 53707-7850

Dear Secretary Nelson:

Thank you for all of the information that you have provided concerning the audit of the Regulation of Nursing Homes and Assisted Living Facilities. The information provided at the hearing as well as the follow up provides great insight into the Department's relationship with these institutions.

After reviewing the report you submitted to the Committee on February 28, 2003, we have identified some follow-up questions to which we request a response. As we have already asked for additional information to be submitted by July 1, 2003, we would ask that these questions be answered by that date also. Our questions are organized by report section and include the following:

- In the *FY 2001 and FY 2002 Forfeiture Update*, you note a reduction in the number of forfeitures awaiting assessment, and cite the December 31, 2002 count at 275. You also note that streamlining the review process and temporary staff assignments have helped to reduce the backlog. Would you please provide an update on the number of forfeitures awaiting assessment, and information on the specific streamlining techniques and staffing requirements that were employed to reduce, or eliminate, the backlog?

- While it is helpful to see the data reported under *Administrative Ratios for Forfeiture Assessment*, the audit report did not recommend a surcharge, as included in the 2003-05 Executive Budget, to cover the administrative costs associated with the assessment process. Would you please explain the rationale for a surcharge, which would result in a larger net payment by the facility, as opposed to the Department's withholding of a percentage of the forfeiture, as a means of covering the administrative costs?

- The *New Assisted Living Forfeiture Procedures* help to clarify the Department's intentions in this area. Given the concerns expressed in the audit report and at the public hearing of the report, two additional questions arise. First, is it appropriate to apply, verbatim, the statutory factors for nursing home forfeitures to assisted living facility forfeitures? Second, is the Department developing a guideline, as it did for nursing home forfeitures and is included as Appendix 5 to the audit report, to help to establish the forfeiture amounts?

- The discussion of *BQA Central Office Staff Resources* notes regional oversight at 14 percent. The audit report looked at central office staffing, as opposed to regional office oversight. What is the Caregiver Program, referenced in Exhibit 1 of your follow-up report?

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- A number of questions arise in your discussion *of Collection and Use of Federal Civil Money Penalty Funds in FY 2000-01 and FY 2001-02.*
  - It is unclear whether CMS approval is required for projects the Department initiates. The text preceding Table 2 reads, "A CMS approval is not necessary for a specific project." The text following Table 2 notes, "The Department has achieved success in obtaining federal approval for the use of Civil Money Penalty funds on a number of projects."
  - A balance of $1.2 million in the Civil Money Penalty account is noted. What was the account balance at the end of the following calendar years: 1998, 1999, 2000, and 2001? Would it not be possible to provide enhanced technical assistance with the account balance?
  - Table 3 shows a significant portion of the FY 2000-01 expenditures were for facility monitoring. Who conducted the monitoring activities for each of the facilities named?

In addition, while looking through our notes as well as the written testimony submitted at the hearing, we have generated the following list of additional questions to which we ask the Department to respond by July 1, 2003:

- It has been suggested that during inspections of nursing homes and long term care facilities that some of the time be spent documenting what the home does well and then share those best practices with other facilities. Is there a way for the industry to do sharing of best practices? If not, does the Department have any plans for implementation of best practice sharing?

- The area of penalties has been highlighted by both the Department and the industry.
  - Has the Department been working to change the timeline for appeals and compliance? Could this decrease costs because more issues could be resolved before they entered the court system?
  - Does the Department support sending some fine money back for administrative costs? How can this be done without creating an incentive for the Department to fine?

- Seeing as there are a large number of unsubstantiated complaints, is there a way to better "weed out" some of these so as to save the time and money of the Department?

- Why aren't the qualifications of the nursing home inspectors and the assisted living inspectors the same? Why shouldn't the inspectors of the assisted living facilities include a medical professional? Why are the inspection schedules different?

- Why is it that the number of citations issued increases when the federal regulators accompany state inspectors?

- Why are the numbers of citations disproportionate around the state?

- Do we need to put more time in the failing facilities and ease up on the facilities that are having little or no deficiencies?

- What is the difference in cost breakdown for subsidies to assisted living facilities as opposed to nursing homes?

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- Does the Department support expanding the Board on Aging and Long Term Care's Ombudsman services into the residential care apartment complexes?

- What can be done to increase the retention of trained employees in nursing homes and long term care facilities?

- Is there a timeline for establishing written procedures to guide the assessment process for assisted living facilities?

Should you have any questions or wish to speak with us directly, please do not hesitate to contact either of our offices.

Thank you,

Senator Carol Roessler, Co-chair
Joint Legislative Audit Committee

Representative Suzanne Jeskewitz, Co-chair
Joint Legislative Audit Committee

cc: Janice Mueller, State Auditor

JUN 05 2003

Wisconsin Association of Homes and Services for the Aging, Inc.
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June 4, 2003

State Senator Carol Roessler
State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Dear Senator Roessler:

We would like to share with you the attached document which was prepared by a group of WAHSA Housing Committee members. Its intent is self-explanatory; its development into a work product was far more difficult than many would have imagined.

It is our hope that the document is viewed as an objective piece of analysis which captures the primary distinctions between the regulatory philosophies behind nursing home care and assisted living. Where there are areas of disagreement, we hope you will share your perspectives so there is some degree of mutual understanding, if not acceptance. Where we agree, we hope this document can serve as a guideline for providers, regulators, legislators and advocates alike. Please freely share this document with your staff and others interested in facility-based care.

We don't presume to tell surveyors how to survey in this document. We do suggest to those who are not trained surveyors that the most effective way to ensure quality (specifically in assisted living, because federal oversight does not allow such flexibility in nursing homes) is to allow trained professionals to use their training, experience and expertise to do their jobs. Let nurses be nurses; unlike nursing home surveyors, don't require blind adherence to a set of regulations which all too often are politically driven rather than quality driven. Let the experts decide where their services are most needed rather than wasting valuable resources by treating all facilities the same, as we see in the nursing home arena. In other words, allow trained professionals to distinguish the poor performing facility from facilities which provide quality care and focus our limited resources, both monetary and manpower, to bringing the poor performers into compliance. In addition, let's begin the process of sharing best practices and recognizing/celebrating the work of quality providers.

If you should have any comments or suggestions to improve this document, please do not hesitate to contact me at (608) 255-7060 or jsauer@wahsa.org. Thank your for your consideration.

Sincerely,

John Sauer
Executive Director

WAHSA's Assisted Living Document: A Discussion on the Differences Between AL and Nursing Homes

WAHSA members worked tirelessly a decade ago to keep the "community" emphasis in the rewrite of the community-based residential facility (CBRF) rule, HFS 83. At the same time, we were presenting our concept of what is now the residential care apartment complex (RCAC) to representatives of the Department of Health and Family Services (DHFS) and to interested legislators.

Our members have been leaders in the provision of congregate care for the elderly and disabled and have been instrumental in the development of the programs that fall under the umbrella of assisted living. Much of what they brought to assisted living care came from years of experience in providing nursing home care, both the good and the bad. They vowed to fight a regulatory environment which would attempt to mirror the nursing home survey and enforcement system.

With the creation earlier this year of a new section in the Bureau of Quality Assurance (BQA) dedicated solely to assisted living came hope and a fair amount of skepticism. While consistently stating its intent was a regulatory system in assisted living that would incorporate collaboration and best practices, one of the first acts of this new section was to hire eight nurse surveyors from the BQA Resident Care Review (nursing home) Section). Thus, both hope and skepticism: the hope that a new assisted living regulatory system will be better and improved from the system regulating nursing homes and the skepticism it will not.

In the context of discussions on the new Assisted Living Section and what it might mean, several members of the WAHSA Housing Committee noted that we speak about the differences between the philosophy of assisted living and how it should be regulated and that of nursing homes, but nowhere are those differences clearly delineated. The document you have before you is an attempt by a number of Housing Committee members to delineate those distinctions.

Approved by the WAHSA Housing Committee
and Board of Directors, May 2003

WAHSA Housing Committee
Assisted Living Task Force

We wish to acknowledge and extend our sincerest appreciation to the following people who gave of their time and expertise to produce this document.

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Nancy Cywinski, NIC Health Care Services, Stevens Point

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Chris Quandt, Oakwood Village Covenant Oaks, Madison

Ann Eckstein, The Willows, La Crosse

Craig Ubbelohde, Lutheran Homes of Oshkosh, Oshkosh, Chair, WAHSA Housing Committee

Purpose of the Housing Committee Task Force

The State of Wisconsin has shifted resources into the monitoring and oversight of assisted living facilities by creating a separate section in the BQA. Early in 2003, the Bureau moved eight nurses from the Resident Review Section into the Assisted Living Section to support the existing licensing specialists and provide closer supervision over the growing number of assisted living providers.

While the WAHSA Housing Committee doesn't necessarily disagree with these moves, there is concern that this may result in a regulatory environment similar to the nursing home survey process that we believe to be seriously flawed. Further, the Housing Committee feels there is an urgent need to clearly articulate the practical and philosophical differences between nursing homes and assisted living facilities so that BQA staff members who have transferred into the Assisted Living Section do not carry a nursing home bias into this environment. It was for these reasons that a Task Force of the Housing Committee met to create a document that would describe these differences.

Task Force Process

The Task Force agreed that the primary audience for the results of this process would be the BQA leadership, Assisted Living Section staff, ombudsmen, assisted living and nursing home providers, residents, families, staff and the general public. Members of the Task Force agreed that our goal was to create a document highlighting the practical and philosophical differences between nursing homes and assisted living facilities.

The Task Force identified 10 broad categories where it was felt that it was possible to identify differences. These categories included:

-Who We Serve
-Program Philosophy
-Activities
-Meals/Nutrition/Diets
-Documentation
-Resident Competency
-Negotiated Risk
-Minimum Required and Defined Services
-Staff Requirements
-Staff Training

The Task Force has attempted to explain the differences between nursing homes and assisted living facilities in these 10 areas by citing actual sections of the appropriate administrative rule (HFS 132, HFS 83, and HFS 89) and, whenever possible, provide actual examples.

Resident Choice/Control in Nursing Homes versus Assisted Living Facilities

While it is difficult to define what is meant by resident choice/control, perhaps the best place to begin is in the Authority and Purpose provisions of the codes governing nursing facilities (NF), community-based residential facilities (CBRF) and residential care apartment complexes (RCAC). If the degree of resident choice/control is thought of as a continuum, it could be argued that RCACs are on one end, NFs are on the other and, depending on the persons they are serving, CBRFs are somewhere in between.

For purposes of clarification, it should be noted that CBRFs serve thirteen different client groups: advanced aged, alcohol/drug dependent, correctional clients, developmentally disabled, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, MA waiver contract, persons with AIDS, physically disabled, pregnant women/counseling, terminally ill, traumatic brain injury and Veterans Administration. Because of the make-up of our membership, our discussions of CBRFs refer primarily to those serving the advanced aged and persons with irreversible dementia/Alzheimer's.

The Authority and Purpose sections of the codes governing these three entities is the logical place to begin an examination of the degree of resident choice/control either allowed or encouraged. In HFS 89.11 of the RCAC code, it states that these facilities are to *"operate in a manner that protects tenants' rights, respects tenant privacy, enhances tenant self-reliance and supports tenant autonomy in decision-making including the right to accept risk"* (emphasis added). In HFS 83.01(2) of the CBRF code, it states that facilities are obligated to provide a living environment that is as homelike as possible and *"is the least restrictive of each resident's freedom as is compatible with the resident's need for care and services...and that care and services are provided in such a manner that the resident is encouraged to move toward functional independence in daily living or to continue functioning independently to the extent possible"* (emphasis added). Similar language does not exist in the statutory authority section of HFS 132, the nursing home code.

How then are the differences defined in the degree of resident choice/control in assisted living facilities (ALFs) versus NFs? Or, stated another way, what factors seem to influence the extent to which residents have control over day-to-day activities in ALFs versus NFs? (ALFs are defined to include both CBRFs and RCACs).

Before addressing those questions, there is a simple philosophy which neatly conveys a key difference between the role of a nursing home and an assisted living facility. In a nursing home, "we will take care of you;" in an assisted living facility, "we will help you take care of yourself." Another distinction is in terminology: While it might appear that the terminology distinguishing a nursing home resident from a RCAC tenant is a mere case of innocuous semantics, it wasn't intended to be. The Legislature specifically referred to the occupant of a RCAC as a "tenant" to highlight the distinction between an individual who lives in his/her own apartment and has their needed health care and supportive services brought to that apartment and an individual residing in a regulated health care setting. The distinction may be slight and subtle but it was intended.

The regulatory environment and the threat of sanctions by the BQA certainly influence the extent to which providers feel comfortable allowing residents to exercise choice/control. Indeed, nursing home providers really are in no position to either allow or disallow residents from exercising choice; they don't have the authority. Resident autonomy and control are limited in nursing facilities not because that's the way nursing facilities want it or prefer it but because federal and state statutes and codes

require it, because the law demands it. All a nursing home provider has to do is permit a resident to choose a standard of care outside the scope of a "community standard of care;" the facility, by law, will be held accountable for any poor outcome regardless of the resident's choice.

In the RCAC environment, however, the tenant is able to exercise independent control and decision-making in nearly all aspects of his or her life, including medical care, largely without the need for approval from the RCAC provider. In those situations where the tenant is acting in a manner that goes against the recommendations of the facility, the RCAC code permits the parties to negotiate a risk agreement that incorporates the tenant's wishes while recognizing the provider's concerns. CBRFs stand somewhere in the middle. CBRF providers who serve residents with dementia are probably more likely to attempt to influence the decisions of residents while facilities that serve a geriatric population might be more willing to allow the resident to make decisions independently. CBRF and RCAC operators are willing, able and, in some instances, required to permit residents to exercise greater control of their lives because, unlike nursing homes, they are not hamstrung by federal oversight or limiting rules and regulations.

Families of residents in NFs tend to exert greater control over resident decision-making than they do in RCACs and CBRFs. By and large, residents who live in NFs are more physically and cognitively impaired than those living in RCACs and CBRFs and the physical losses that lead to nursing home placement have also affected the resident's ability to make independent choices. The RCAC code, on the other hand, assumes that the individual tenant is capable of independent decision-making since the code prohibits a RCAC from admitting anyone who has an activated power of attorney for health care or has been declared incompetent. By definition, the RCAC is intended for an individual who is capable of entering into a contract and making his/her own choices. The role of the family is primarily one of support rather than decision-making. The families of residents living in dementia-specific CBRFs are likely more actively engaged in the decision-making process than are the families of residents in non-dementia-specific CBRFs and are more closely aligned with families of NF residents. Families of residents of non-dementia-specific CBRFs are more closely aligned with families of RCAC tenants.

Resident choice/control and privacy also can be either enhanced or limited by facility design and corresponding regulations. In RCACs, apartments are required, usually with more space, functional variation of space, and privacy (e.g., choice of roommate, private bathroom, and locked door). Common space expands options for personal decision-making. CBRFs can offer increased privacy, but without the mandated resident choice/control available in RCACs. Nursing home residents, due to federal and state statutes and regulations, frequently have little or no choice/control over space use, and options are limited.

Resident control also is dictated by the policies and procedures of the facility. By their very nature (and licensure), NFs are much more policy-and procedure-driven than ALFs. This is due partially to regulatory requirements but in large measure to the environment of NFs, which is often described as a medical model. The policies which dictate how care is delivered tend to reduce the amount of choice/control residents are able to exercise in their day-to-day lives. ALFs are typically considered to be a more social environment, and provide supportive services based on resident/tenant preferences rather than facility policy considerations or requirements. Indeed, in the Authority and Purpose sections of the RCAC and CBRF codes, it is clear that both types of facilities are intended to provide living accommodations that are home-like and residential in nature rather than institutional. **Homes don't require policies and procedures; institutions do.**

A final and unique aspect of RCACs is the concept of tenant autonomy in decision-making, including the right to accept risk. Negotiated risk agreements give the tenant significant opportunity to exert

control over the most fundamental aspects of their lives. Tenants are free to make decisions, even in cases where the decision might be against the advice of family, the facility or their physician. For the most part, these choices relate to relatively simple issues – conforming to a prescribed diabetic diet, using a cane instead of a walker, self-administering medications. And yet, research clearly shows that greater personal control significantly increases the individual's perceived quality of life and well-being.

The ability and right of a resident/tenant to exercise control over decisions that affect his or her everyday life is a fundamental difference between ALFs and NFs. Many ALF staff who previously worked in NFs find themselves stepping back and rethinking their approach to various resident situations. Procedures and approaches that were clearly defined in the NFs become less so in the ALF when the resident expresses his or her opinion about (or at times, objection to) an issue. That is the beauty of assisted living and the key to its operating philosophy.

Recommendations on Assisted Living Survey Processes

Members of the WAHSA Housing Committee's Assisted Living Task Force believe that there is a place for State oversight in assisted living. Because State resources are limited however, the Task Force recommends that the focus of the assisted living survey process should be on poor providers and not a broad brush or one size fits all approach to facility oversight. The Task Force recommends the following process of review:

1. **Visit and tour the building.** Look at the condition of the residents. Look at the condition of the building. Smell for odors (urine, feces, etc.). Look into a couple of resident apartments or rooms. Look for an activity calendar. Page through a couple of charts to see if there is reasonable documentation (assessments, care or service plans, progress notes, etc.) – but this is only at the 35,000 foot level – not a detailed review. Look at the staff schedules. Walk through the kitchen. Walk through the dining room. Review how medications are administered.

2. **Interview several residents** and ask about their satisfaction with the facility. Are they satisfied with the way they are treated by the staff of the facility? How is the food? How are the activities? Is the building comfortable in winter and summer? Is the manager approachable? Do their concerns get addressed? Do they feel safe? Does the facility seem to operate well?

3. **Meet with several family members,** particularly in those situations where the facility primarily serves residents with dementia. Discuss their satisfaction with the facility. Are their concerns addressed? Do their loved ones seem well cared for? Are the manager and staff approachable?

4. **Ask about the availability of the services of a registered nurse.** Is an RN available on a regular basis and is the RN a permanent staff member or under contract from an outside entity? What happens if a resident's need for nursing care increases?

5. If concerns arise from steps 1-4, **conduct a more thorough evaluation.**

Task Force members understand that this approach is rather subjective but they believe that if it were followed, an experienced surveyor would quickly separate the facilities that need closer inspection from those that do not.

WAHSA members also promote the use of the assisted living checklists and compliance statements available online from the Department of Health and Family Services (CBRF Checklist: http://www.dhfs.state.wi.us/bqaconsumer/AssistedLiving/CBRFchoose.htm; RCAC Compliance Statement: http://www.dhfs.state.wi.us/forms/DSL/dsl2381.pdf) as helpful tools in reviewing the quality of assisted living facilities.

Finally, WAHSA members are committed to pursuing a peer assistance program under which assisted living providers offer technical assistance and quality improvement services to facilities in need. Although this concept has not yet been fully developed, the WAHSA Housing Committee Assisted Living Task Force is interested in working with BQA staff to determine if these peer-directed services can be utilized within the State's quality assurance and oversight system.

Subject	Nursing Homes	CBRFs	RCACs
Who We Serve	HFS 132. 13 (28): "Resident" means a person *cared for* or *treated* in any facility on a 24-hour basis irrespective of how the person has been admitted to the facility. **Discussion:** One key differentiation between a nursing home resident and residents/ tenants of a CBRF or RCAC is that nursing home residents often do not have a choice in being admitted to a nursing home. Admissions are frequently based on an unanticipated physical setback, or a health crisis of some sort. In the nursing home setting, choices are limited due to the stringent nature of nursing home regulation. Providers are inclined to "protect" nursing home residents given the nature or the statutes and costs under which they operate. Unlike nursing home regulations, which primarily are driven by federal law, CBRF and RCAC regulations are state-driven and provide for greater opportunities for provider/regulator collaboration and the sharing of technical assistance.	HFS 83.04 (53): "Resident" means an adult unrelated to the licensee or administrator who lives and sleeps in the facility and receives care, treatment of services *in addition to room and board* **Discussion:** It should also be noted that because the CBRF regulations govern a variety of different client populations (i.e., elderly, persons with physical and developmental disabilities, corrections, AODA treatment, chronically mentally ill, etc), these CBRF provisions are somewhat more extensive than found in the nursing home regulations. CBRFs generally serve a more diverse population than nursing homes.	HFS 89.13 (32): "Tenant" means an individual who resides in and has a service agreement with a residential care apartment complex. **Discussion:** The creation of the residential care apartment complex (then referred to as an "assisted living facility") was authorized under 1995 Wisconsin Act 27, the 1995-97 biennial budget. The Legislature created the RCAC as a congregate replica of one's own home, a "house" where needed services could be delivered to the RCAC tenant just as they would be to an individual living in their own house or a tenant in their own apartment. The philosophy behind the RCAC was to treat this entity as housing with services, not as another regulated health care setting such as a CBRF or a nursing home. The intended regulatory distinction between a RCAC and other health care settings was clearly delineated in a May 17, 1995 issue paper (Paper #533 "Assisted Living Initiative") written by the Legislative Fiscal Bureau. The issue paper states in part: "The Administration states an objective in establishing the assisted living (RCAC) initiative…is to avoid creating another highly-regulated type of facility in the long-term care industry. Since assisted living would involve independent residential units controlled by residents with services individually established by a private contract, the Administration notes that it is not necessary to impose a highly-regulated structure."

Subject	Nursing Homes	CBRFs	RCACs
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Program Philosophy	Authority -HFS.132.11/s.50.02(2), Stats. Rule is established to enforce regulations and standards for the care, treatment, health safety, rights, welfare and comfort of residents. *Rule is established to promote safe and adequate accommodation, care and treatment and to promote and enforce rules. In addition to the HFS 132 regulations, extensive federal statutes, regulations and interpretive guidelines, many of which are the product of the 1987 federal OBRA nursing home reform initiatives, significantly dictate the oversight of nursing homes and limit the flexibility in the manner in which care and services are provided. **Discussion:** While there is no statement of purpose under HFS 132, as there is in HFS 89 and 83, there is reference to s.50.02, Stats. In the Uniform Licensure Statute, the department is authorized to develop and enforce regulations for nursing homes (and community-based residential facilities) for the purpose of promoting safe and adequate accommodations, and care and treatment for residents. (s.50.02 (2)(a)). Since this statute directed the DHFS to promulgate rules to enforce regulations and standards of care, treatment, health safety, rights, welfare and comfort of	Authority and Purpose – HFS 83.01 *Rule is written to safeguard and promote the health, safety, well-being, rights and dignity of each resident. *Rule is intended to ensure a living environment for residents which is as homelike as possible and least restrictive of each resident's freedom and is compatible with the need for care and services. *Rule is intended to encourage resident to move towards functional independence in daily living. *Rules designed to provide range of services to persons who need supportive or protective services or supervision because they cannot or do not wish to live independently yet do not need a hospital or a nursing home. **Discussion:** While CBRFs are combined with nursing homes under s.50.02 (2) for purposes of rule establishment and enforcement, there is some additional conditional consideration given to CBRFs as it relates to the department establishing standards and regulations. Unlike the nursing home regulations and statute, S.50.02 (3)(b) specifically authorizes the department to consider residents' needs and abilities ***and the increased cost*** in relation to the proposed	Authority and Purpose-HFS 89.11 *Rules are established to promote health and safety of persons residing in and receiving services. *Rules are intended to ensure a setting that is home-like and residential in character. *Rule is established to make sure personal, supportive and nursing services are **available** to meet the appropriate needs, abilities and preferences of individual tenants. *Rules are established to protect tenant rights, respect privacy, enhance tenant self-reliance and rights, support tenant autonomy in decision-making, including the right to accept risk. **Discussion:** The purpose of the RCAC rule is to provide a home-like setting and to make sure personal, supportive and nursing services are **available** to meet the appropriate needs and abilities of individual tenants based on their expressed preferences. Further, the rule was established to enhance tenant self-reliance and support tenant autonomy in decision-making, including the right to accept risk. While there is a regulatory minimum amount of service that must be made available, services received and the right to accept risk for his/her decisions are rights unique to RCAC tenants. This philosophy and purpose supports a "shared responsibility role" with the control and

Subject	Nursing Homes	CBRFs	RCACs
Program Philosophy (continued)	residents, one could conclude that the regulatory environment/rule would concentrate heavily on what constitutes a safe environment as it relates to both the physical environment and the health safety environment. This environment of skilled care is based on a "medical" model. The rule enforces this philosophy by specifying very detailed service and staff requirements that reflect the higher complexity and skilled needs of the resident. Further, one might conclude that resident control over their own environment in this setting may be somewhat limited even with the residents' right to choose because of the statutory authority given to the department to enforce a rule that is based on safe and adequate accommodation and care and treatment of residents. Creating a home-like environment in a nursing home has not been defined as a purpose for regulation in this setting.	benefits received and provided by the facility and the relationship between the physical structure and the objective of the facility program. Further, this statute recognizes that size and structure will influence the ability of CBRFs to provide a home-like environment and encourages the department to develop rules to the extent possible to integrate residents into the community and provide a home-like setting. So, while the purpose of the rule is to safeguard and promote the health, safety, and well-being of the resident (HFS 83.01), ***the rule is intended to ensure a living environment for residents which is home-like and the least restrictive (HFS 83.01).*** The rule is intended to encourage residents to move towards functional independence in daily living by providing a range of services. ***This rule also makes reference to persons who need supportive or protective services or supervision because they do not wish to or cannot live independently and yet do not need the services of a nursing home.*** Standards of care may be enforced and prescribed differently for those CBRFs with dementia specific care. There is no special set of guidelines for residents living in dementia specific CBRFs vs. non-dementia-specific CBRFs. However, program differences to meet the needs of the residents are important.	the care and services received being much more directed and controlled by the tenant than by the RCAC. ***This is substantially and fundamentally different then the nursing home and CBRF setting.*** With this type of control given to the tenant, the need for a certain higher level of cognitive functioning is important and crucial in their decision-making process because the tenant has the ability to accept a service or not accept a service (even if not having a service puts the tenant at risk for a potential bad outcome.) This gives the tenant the right to control his/her environment and the scope of the personal, supportive and nursing services they wish.

Subject	Nursing Homes	CBRFs	RCACs
Program Philosophy (continued)		Residents with higher levels of dementia who are judged to be incapacitated are required to have a signed, activated power of attorney for health care (POAHC) or, if determined incompetent, a legal guardian with an order for protective placement. These residents are still encouraged to exercise their own rights (e.g. choosing to attend or not attend activities, selecting items from a selective menu, deciding what to wear, and refusing medications). In dementia-specific CBRFs, egress may be restricted for the safety of the dementia residents. In non-dementia CBRF settings, the residents are more mentally capable of self-determination and are able to exercise choice and control. The residents are able to self-medicate, if appropriate, egress out of the building without restriction, shape policies through active resident councils, and file grievances on their own behalf without having to rely on others to make that determination. The non-dementia CBRF can provide an environment where residents can control and direct their own care to a higher degree than those CBRFs that are dementia specific.	
**********	**********	**********	**********
Activities	HFS132.69 (1) Program (a) Every facility shall provide an activities program which meets the requirements of this section. The program may	HFS 83.33. (2)(c) Leisure time activities. The CBRF shall provide and actively promote resident participation in a program of daily activities designed to	**Discussion:** Activities are not defined or required by code. The service agreement may include

Subject	Nursing Homes	CBRFs	RCACs
Activities (continued)	consist of any combination of activities provided by the facility and those provided by other community resources. (b) The activities program shall be planned for group and individual activities, and shall be designed to meet the needs and interests of each resident and to be consistent with each resident's plan of care. (2) Staff (a) *Definition.* "Qualified activities coordinator" means: 1. In a skilled nursing facility, a person who: a. Has a bachelor's degree in recreation therapy and is eligible for registration as a therapeutic recreation specialist with the national therapeutic recreation society; b. Has 2 years of experience in a social or recreational program within the last 5 years, one year of which was full-time in a patient activities program in a health care setting; or c. Is an occupational therapist or occupational therapy assistant who meets the requirements for certification by the American occupational therapy association; and 2. In an intermediate care facility, a staff member who is qualified by experience or training in directing group activity. (b) *Supervision.* The activity program shall be supervised by: 1. A qualified activities	provide needed stimulation consistent with the interests of the resident. Watching television does not, by itself, meet this requirement. Participation in an adult day care program outside the CBRF may meet this requirement. HFS 83.33 (2)(d) Community Activities. Each CBRF shall provide information and assistance to facilitate each resident's participation in personal and community activities outside the CBRF. Monthly schedules and notices of community and CBRF activities, including costs to the resident, shall be developed, updated and made visually accessible to all residents. For residents who are unable or choose not to leave the CBRF, the CBRF shall make a good faith effort to involve persons not living in the CBRF in activities provided in the CBRF. **Discussion:** CBRF residents are encouraged to facilitate smaller group activities, such as card games and discussion groups. While activities are offered in a CBRF setting, they are not of a structured nature, and documentation of participation is not required. Residents are encouraged to get involved with internal as well as community programs.	the activities and social connections that the tenant will be assisted in maintaining. Tenants are encouraged to pursue the independent activities they have enjoyed all of their lives. Staff members assist with logistics, but group activities are not part of the normal schedule.

Subject	Nursing Homes	CBRFs	RCACs
Activities (continued)	coordinator; or 2. An employee who received 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. In the nursing facility, there is an MDS-driven goal that the resident is engaged 1/3 of the time in either individual or group activities. **Discussion:** The nursing home activity expectations are very structured, including documentation of attendance, level of participation and regular reviews of resident engagement. If the goal is not met, the MDS triggers "under stimulation," and a specialized care plan is required. .		

Subject	Nursing Homes	CBRFs	RCACs
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Meals/Nutrition/ Diets	HFS 132.63 (5) At least 3 meals not more than 6 hours apart; no more than 15 hours between substantial evening meal and breakfast. **Discussion:** Documentation required of food and fluid intake, offering snacks, residents' choice not to finish meals coupled with regulators expectations that resident conditions not decline have limited residents' choices and preferences. Documentation needed for all who deviate from the dictated parameters. Required to provide and monitor therapeutic diets.	HFS 83.35(1)(b) Provide 3 meals unless the CBRF's Program Statement or the resident's individualized service plan says otherwise. HFS 83.35(1)(c) If 14 hours or more between meals, a nutritious snack must be offered. **Discussion:** Meal monitoring is required only if required under the ISP or program statement. Time between meals not dictated. Expectation that meal be served family or restaurant style. There should be reasonable adjustments to the food lines, habits, customs, conditions and appetites of the individual resident.	HFS 89.23 (2)(a)2.a. The facility must have the capacity, either directly or under contract, to provide meals. HFS 89.23 (3)(f) Meals and snacks served to tenants should be prepared, stored and served in a safe and sanitary manner. 89.34(3) Right to self-direction in daily routines. **Discussion:** Number of meals not dictated. Time between meals not dictated. Tenant able to freely eat when, where and what they choose. The tenant has the right to eat quantity desired without documentation of such.
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Documentation	HFS 132.31(6): Complaints. (a) Filing complaints. Any person may file a complaint with a licensee or the department regarding the operation of a facility. Complaints may be made orally or in writing.	HFS 83.21(5): Grievance Procedure. (a) Requirement. All CBRFs shall have a written grievance procedure and shall provide a copy to each resident and the resident's guardian or agent.	HFS 89.35: Grievances. (1) A RCAC shall have a written grievance procedure and shall provide a copy to each tenant and tenant's representative. (3) The RCAC shall provide a written summary of the grievance, findings, conclusions and any action taken as a result of the grievance to the tenant, the tenant's designated

Subject	Nursing Homes	CBRFs	RCACs
Documentation (continued)	HFS 132.45 (5): Medical Records – Content. Except for persons admitted for short-term care, for whom HFS 132.70 (7) applies, each resident's medical record shall contain: HFS 132.45 (5)(c): Nursing service documentation. 1. A history and assessment of the resident's nursing needs as required by HFS 132.52 (5); 2. Initial care plan as required by HFS 132.52(4), and the care plan required by HFS 132.60 (8); 3. Nursing notes are required as follows: a. For residents requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident condition, but at least weekly; and b. For residents not requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least every other week; 4. In addition to subds. 1., 2., and 3., nursing documentation describing: a. The general physical and mental condition of the resident, including any unusual symptoms or actions; b. All incidents or accidents including time, place, details of incident or accident, action taken and follow-up care; (plus c. through j.). HFS 132.45(5)(d): Social service records. 1. A social history of the resident as required by s. HFS 132.45 (6); and 2. Notes regarding pertinent	HFS 83.18: Resident record. (1) General Requirements. (a) A CBRF shall maintain a record for each resident. (d) A resident's record shall include all of the following…2. Results of initial and subsequent health assessments or medical examinations, the admissions agreement, the evaluation for evacuation limitations, significant incident and illness reports, the assessment report, the resident's individualized service plan, the evaluations and reviews under s. HFS 83.32(2)(c) and (d), discharge papers, department-approved use of a physical restraint and a summary of any grievances filed by the resident with the facility. 3. Copies of the plan of care under s. HFS 83.34 (3) for a terminally ill resident and all physicians' orders. 4. A description of any behavior patterns of the resident which are or may be harmful to the resident or other persons. HFS 83.19: Notification of changes and reporting of incidents: (1) Change Affecting a Resident. (a) Parties to be notified. A CBRF shall provide written notice to a resident, the resident's guardian and the resident's designated representative or agent of any change or occurrence that affects the resident. Thirty day written notices must be given for: (b) A transfer or discharge; (c) Any change in services available or charges for services. Immediate notice must be given when there is an injury to the resident or a significant adverse change in the resident's physical or mental condition; (d) Under (c), immediate notice must be given when physical, sexual or mental abuse of a	representative, if any, and the county department or aging unit which administers the MA waiver if the tenant is a waiver client. HFS 89.26: Comprehensive Assessment. (1) Requirement. A comprehensive assessment shall be performed prior to admission for each person seeking admission as a basis for developing the service agreement and risk agreement. HFS 89.27: Service Agreement. (1) Requirement. A RCAC shall enter into a mutually agreed-upon written service agreement with each of its tenants consistent with the comprehensive assessment. **Discussion:** In the RCAC setting, which is more of a social model, the documentation requirements are reasonable when interpreted and applied in a responsible manner. Changes in tenants' conditions, as well as other important exceptions to the tenants' normal daily routine, should be documented.

Subject	Nursing Homes	CBRFs	RCACs
Documentation (continued)	social data and action taken. 132.45 (5)(e): Activities records. Documentation of activities programming, a history and assessment as required by s. HFS 132.52 (6), a summary of attendance and quarterly progress notes. Continue through the rest of this section....(f) Rehabilitative services. (g) Dietary assessment. (h) Dental services. (i) Diagnostic services. (j) Plan of care. (k)Authorization or consent. (L) Discharge or transfer information. HFS 132.52 (2): Physician's Orders. No person may be admitted as a resident except upon: (a) Order of a physician; (b) Receipt of information from a physician... HFS 132.52 (3): Medical Examination and Evaluation HFS 132.52 (4): Initial Plan of Care HFS 132.52(5): Resident History and Assessment HFS 132.52 (6): Specialty Assessments HFS 132.52 (7): Family Care Information and Referral HFS 132.60(1-2)-Requires individual plan of care, and specifies and describes requirements for hygiene, deceit prevention, basic nursing care, rehab measures, TB retesting, nourishment and adaptive devices.	resident is alleged, while notice within 72 hours must be given if misappropriation of property is alleged. HFS 83.19(2) requires the reporting of certain deaths of CBRF residents; HFS 83.19(3) requires the reporting of certain incidents at CBRFs. HFS 83.32: Assessment and individualized service plan. (1)(b) A written report of the results of the assessment shall be prepared and retained in the resident's record. HFS 83.32 (2): Individualized Service Plan. (a) Scope. Based on the assessment under sub. (1), an individualized service plan shall be developed for each resident... HFS 83.32 (2)(c): Annual evaluation. 1. Within 30 days prior to the annual evaluation under subd.2., the resident and his or her guardian or agent shall be offered the opportunity to complete a written or oral evaluation of the resident's level of satisfaction with the facility's services....The evaluation shall be either a department form or a form developed by the facility which is approved by the department. HFS 83.32 (2)(d): Review of progress. Each resident's progress or regression on each element of care, treatment and service shall be reviewed and documented in the resident's individualized service plan at 6 month intervals following each evaluation under par. (c) or more often when indicated by a change in the resident's condition.	

Subject	Nursing Homes	CBRFs	RCACs
Documentation (continued)	HFS 132.60 (8): Resident Care Planning. (a) Development and content of care plans. (b) Evaluations and updates. (d) Assessment instrument. HFS 132.61(2)(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....6. The physician shall write, date and sign a note on the resident's progress at the time of each visit. HFS 132.64 (2)(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. HFS 132.65 (3)(b):...The pharmacist shall submit a written report of findings at least quarterly to the facility's pharmaceutical services committee. HFS 132.66 (1)(e): Notice of findings. The attending physician shall be notified promptly of the findings of all tests provided under this subsection. HFS 132.45(2): Personnel Records. A separate record of each employee shall be maintained, be kept current, and contain sufficient information to support	HFS 83.16: Admissions agreement. (1) Specifications. A CBRF shall have a written admissions agreement with each resident. **Discussion:** The CBRF regulations, under HFS 83, have become more slanted towards nursing home regulations and have become much more prescriptive. Facilities often are asked to produce documentation heretofore required only of skilled nursing facilities.	

Subject	Nursing Homes	CBRFs	RCACs
Documentation (continued)	assignment to the employee's current position and duties. **Discussion:** The medical model focus of nursing home regulations has resulted in extreme amounts of documentation – even more than one would encounter in a hospital setting. The nursing home regulations require that nearly all activities of a resident's daily life be addressed with an attitude of "if it isn't documented, it didn't happen." This approach requires more staff time and significantly contributes to the cost of nursing home care. It also creates a more regimented setting, often resulting in conflicts between the desires of the residents/staff and the process-driven regulatory system.		
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Miscellaneous Documentation (not aligned)	HFS 132.14 (8): Reporting. Every 12 months, on a schedule determined by the department, a nursing home licensee shall submit a report to the department… HFS 132.31(1)(d): Admission information. Every resident shall have the right to be fully informed in writing, prior to or at the time of admission, of all services and the charges for these services, and be informed in writing,	HFS 83.21(2)(a): Explanation of Resident Rights and House Rules. …The resident or the resident's guardian or agent shall sign a statement to acknowledge having received an explanation of resident rights. HFS 83.33 (3): Medications. (a) Practitioner's order. 1. There shall be a practitioner's written order for any prescription medication taken by or administered to a CBRF resident and that medication shall be labeled by a	HFS 89.54: Reporting of changes. A certified RCAC operator shall report to the department any change which may affect its compliance with this chapter. HFS 89.29(3)(c) 2: Procedures for Termination – No 30-day notice is required in an emergency. In this subdivision, "emergency" means an immediate and documented threat to the health or safety of the tenant or of others in the facility.

Subject	Nursing Homes	CBRFs	RCACs
Miscellaneous Documentation (not aligned) **(continued)**	during the resident's stay, of any changes in services… HFS 132.45 (4)(c): Unit Record. A unit record shall be maintained for each resident and day care client. HFS 132.45 (4)(d): Indexes. 1. A master resident index shall be maintained. 2. A disease index shall be maintained which indexes medical records at least by final diagnosis. HFS 132.45(6): Other Records. The facility shall retain: (a) Dietary records. (b) Staffing records. (c) Safety tests. (d) Resident census. (e) Professional consultations. (f) In-service and orientation programs. (g) Transfer agreements. (h) Funds and property statement. (i) Court orders and consent forms. HFS 132.51(2)(b)3: Reportable diseases. Suspected diseases reportable by law shall be reported.	pharmacist. HFS 83.33 (3)(a) 2: The administrator or designee shall arrange for a pharmacist or a physician to review each resident's medication regimen…A written report of findings shall be prepared… HFS 83.33(3)(c)2: For schedule II drugs a proof-of-use record shall be maintained which lists… HFS 83.33 (3)(d) 2: When supervision of self-administration of medication occurs, staff providing the supervision shall record in the resident's medical record the type of medication taken, the dose taken… HFS 83.33 (3)(d) 3: When a resident self-administers a prescription medication under the supervision of a staff member and a prescription medication error or adverse drug reaction occurs, if known, or the resident refuses to take the medication, that fact shall be documented in the resident's medical record. HFS 83.33 (3)(i) 1: The facility shall maintain a record of receipt and disposition appropriate for the type of medication for all prescribed and over-the-counter medications managed or administered by the facility. HFS 83.33 (4)(j) 2: The nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures with a resident	HFS 89.32: Facility policies and procedures. A RCAC shall establish written policies regarding tenant rights.

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Documentation (not aligned) **(continued)**		shall be recorded in the resident's record when given. HFS 83.17: Resident funds. (1) Authorization. Except for correctional clients, a CBRF may not obtain, hold or spend a resident's funds without written authorization from the resident.	
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Resident Competency	HFS 132.31 (2) Incompetence – If the resident is found incompetent by a court under Chapter 880, Stats., and not restored to legal capacity, the rights and responsibilities established under this section which the resident is not competent to exercise shall devolve upon the resident's guardian. HFS 132.33 (3) Placement - Discusses the requirements which must be met to place a resident of a SNF on a locked unit within the facility. **Discussion:** Within current legal guidelines, a SNF may admit either competent or incompetent individuals and continue to address their care and services needs over time The SNF generally is the most regulated long term care setting and has the highest level of protections for individual resident rights. SNFs typically have long histories of working with substitute decision-makers (when present), adhering to detailed resident	HFS 83.05 (2), defines Classes of CBRF. Class "A" requires that residents be "mentally and physically capable" of responding to an electronic fire alarm. Additionally, a Class "A" CBRF may admit those who are ambulatory, semi-ambulatory, or non-ambulatory. In all instances, a Class "A" CBRF has an expectation that residents can function independently in the event of an emergency. Class "C" facilities are those that serve "one or more (residents)" who are not physically or mentally capable of responding to an electronic fire alarm and exiting the building without help or verbal or physical prompting. Class "C" CBRFs also can admit individuals who are ambulatory, semi ambulatory, or non-ambulatory. HFS 83.06(5) contains prohibitions on the admittance of a protectively placed individual to a CBRF licensed for 16 or more residents unless there is a court-	HFS 89.13(15) defines "Incapable of making care decisions" (as) "unable to understand one's own needs for supportive, personal or nursing services; to choose what, if any, services one wants to receive to meet those needs; and to understand the outcome likely to result from that choice." The terms refer to the ability to make a decision and not to the content or result of the decision. HFS 89.29: Admission and Retention of Tenants: • Admission: No RCAC may admit any of the following persons, unless the person being admitted shares an apartment with a competent spouse or other person who has legal responsibility for the individual: A person who has a court determination of incompetence and is subject to guardianship…A person who has an activated Power of Attorney for Health Care or a person who has been found by a physician or psychologist to be incapable of recognizing danger, summoning assistance, expressing

Subject	Nursing Homes	CBRFs	RCACs
Resident Competency (continued)	rights and including all appropriate representatives in care/service decisions.	ordered protective placement under s.55.06, Stats., prior to admission. HFS 83.07(2) discusses the requirements for an individualized program statement. This statement shall detail the client groups the facility shall serve and the types of services available to meet the needs of those residents. Persons needing services in excess of or in conflict with the services provided by a CBRF shall not be admitted or retained. HFS 83.21(4) (t) addresses incompetence/ resident/guardian decision-making. It states "A resident who has been adjudicated incompetent has a right to have his or her guardian fully informed and involved in all aspects of his or her relationship to the CBRF. The guardian may exercise any and all rights to consent or refuse which the resident is granted under this section. A resident who has been adjudicated incompetent shall be allowed decision-making participation to the extent possible as agreed to by the guardian and facility." **Discussion:** A person's mental capacity is a key indicator in whether they may be admitted to certain licensure categories of CBRFs. Persons who are intermittently mentally incapable of independent action for self-preservation under emergency conditions may be admitted or retained only in a Class "C" CBRF. Individual CBRFs shall define what services will be provided	need or making care decisions. HFS 89.29(2)(b): Discusses the requirements for a provider to retain a person who has become incompetent or incapable of recognizing danger, summoning assistance, expressing need or making care decisions, provided that certain conditions are met. **Discussion:** Under HFS 89, tenants need to be competent to understand and express their needs and preferences, to enter into a service agreement and to understand and accept risk. The development of the RCAC setting was clearly predicated on the availability of an informed decision-maker who can participate in the development of a service plan. RCACs since their inception have been predicated on the ability of individual tenants to function competently, and be able and willing to participate in the identification of needed care services. Some facilities may choose to retain incapacitated individuals who become incompetent over time but each facility must be able to enumerate its discharge policies to potential clients, and define when a tenant may exceed the limits of what the facility may be able/wishes to provide. (See section on Risk Agreements).

Subject	Nursing Homes	CBRFs	RCACs
Resident Competency (continued)		within the facility, and define the types of client groups that are to be served by the facility. CBRFs can admit and retain incompetent residents if they are properly licensed and have developed a program statement which assures that incompetent residents will receive all needed services and that staff are trained to adequately meet their needs. As clients age, their needs may change, and depending on the licensure type of the facility, a resident may need to move to secure needed and appropriate services. Since some facilities choose not to provide dementia services, it is important for the consumer to understand what services a given facility is capable of performing and what they are not.	
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Negotiated Risk	Not addressed in the code. No limits on hours of care or services.	Not addressed in the code.	HFS 89.13(27). "Risk Agreement" means a binding stipulation identifying conditions or situations which could put the tenant at risk of harm or injury and the tenant's preference for how those conditions or situations are to be handled. HFS 89.28 Risk Agreement. (1) Requirement. As a protection for both the individual tenant and the RCAC, a RCAC shall enter into a signed, jointly negotiated risk agreement with each tenant by the date of occupancy. (2) Content. A risk agreement shall identify and state all of the

Subject	Nursing Homes	CBRFs	RCACs
Negotiated Risk (continued)			following: (a) Risk to tenants. (b) Unmet needs. (3) No Waiver of rules or rights. (4) Obligation to negotiate in good faith. (5) Signed and dated. (6) Updated. **Discussion:** Negotiated risk agreements support tenant autonomy in decision-making by identifying those areas where the tenant and the facility disagree about a particular course of action or decision. The process of negotiating a risk agreement allows the tenant to make decisions that are consistent with his or her preferences and it allows the facility to express concerns regarding those decisions. The tenant is able to exercise choice and control by assuming responsibility for decisions.
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Minimum Required and Defined Services	No limits on hours of care or services; however, throughout HFS 132, a medical model of care is assumed and emphasis is on medical needs. HFS 132.13 - Defines dietitian, direct supervision, intermediate nursing care, limited nursing care, nurse, nurse practitioner, nursing assistant, personal care, pharmacist, physical therapist, physician, physician extender, physician's assistant, practitioner,	HFS 83.06(1)(a): A CBRF may not admit or retain any person who is in need of more than 3 hours of nursing care per week except for a temporary condition lasting no more than 90 days (NOTE: No limits on non-nursing service). However, state statute, which in this case supersedes HFS 83, redefines a CBRF under s.50.01(1g) to mean "a place where 5 or more adults who are not related to the operator or administrator and who do not require care above intermediate level nursing care reside and receive care,	HFS 89.24(1) - A RCAC shall provide no more than 28 hours per week of personal, supportive, and nursing care to each tenant; No limit on type or amount of other services, activities, or amenities. HFS 89.24(2) - Individual tenant services defined by "needs and preferences," as documented in service agreement. HFS 89.24(2)(b) - Allows tenants to contract for non-facility services, subject to outside providers meeting facility

Subject	Nursing Homes	CBRFs	RCACs
Minimum Required and Defined Services (continued)	recuperative care, respite care, skilled nursing services and supervision. **Discussion:** In addition to the HFS 132 regulations, extensive federal statutes, regulations and interpretive guidelines, many of which are the product of the 1987 federal OBRA nursing home reform initiatives, require nursing homes to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. "Highest practicable" is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental or psychosocial needs of the individual. (CFR 483.25 and federal F-tag 309).	treatment or services that are above the level of room and board but that include no more than 3 hours of nursing care per week per resident." "Nursing care" is defined under s.50.01(2m), Stats., as "nursing procedures, other than personal care, that are permitted to be performed by a registered nurse under s.441.01(3) or by a licensed practical nurse under s.441.11(3), directly on or to a resident." Under s.50.035(10), the 3 hour nursing care limit can be exceeded: 1) For not more than 30 days to a resident who does not have a terminal illness but who has a temporary condition that requires the additional care; 2) If the CBRF has obtained or is in the process of obtaining a waiver from the DHFS, for more than 30 days to a resident who does not have a terminal illness but who has a stable or long-term condition that requires the additional care; and 3) For a resident who has a terminal illness and requires the additional care. HFS 83.06((1)(a) 5- May not admit persons needing 24 hour nursing supervision. HFS 83.06((1)(a) 6- May not admit persons with chronic personal care needs that can not be met by facility or community agency. HFS 83.01(2)-Services must be provided to encourage residents "to move toward functional independence in daily living to continue functioning independently to extent possible."	standards and policies. HFS 89.24(2) (b)3 - Facility may not limit amount of hospice service, amount of unpaid services by tenant family or friends, or amount of recuperative care above 28 hours/week for up to 90 days. HFS 89.24(3)(b) - Congregate services (e.g. meals, laundry, housekeeping) not counted as part of 28 hours/week /tenant calculation. HFS 89.13 (2) - Services provided can be either directly or under contract, and must be sufficient to meet needs in service agreement in addition to unscheduled needs and 24-hour emergency services. HFS 89.23 (1)-RCAC may provide or contract for services "sufficient and qualified" to meet care needs in service agreement + unscheduled needs + 24-hour emergency care. HFS 89.23 (2)(a) 2 - Defines minimums for supportive, personal care, & nursing services; option to provide more than minimum "at the option of the facility." **Discussion:** Under Chapter 50, Wis. Stats., and HFS 89, RCACs are prohibited from providing more than 28 hours per resident per week of personal, supportive and nursing services. By the same token, RCACs are not permitted to limit the total hours of care to less than 28 hours per resident per

Subject	Nursing Homes	CBRFs	RCACs
Minimum Required and Defined Services (continued)		HFS 83.03(1)(a) 1-Defines "care, treatment & services" as "supervision and supportive services provided…to persons who have needs which cause them to be unable to live independently in community." HFS 83.04(2)-Defines "activities of daily living," but defines them differently than in HFS 89. HFS 83.04(45)-Defines "palliative care." HFS 83.04(46)-Defines "personal care" as help with ADLs. HFS 83.04(56)-Defines "respite care." HFS 83.04(64)-Defines "supervision." HFS 83.04(65)-Defines "supervision of self-administered medications." HFS 83.04(66)-Defines "supportive services" as those given "during final stages of an individual's terminal illness…." HFS 83.31(1) – CBRFs are required to provide needed "program services" identified in the resident's individualized service plan (ISP), either directly or by written agreement with other agencies or persons. HFS 83.32(1)-Specifies in detail requirements for assessments. HFS 83.32(2)-Specifies in detail requirements for ISP. HFS 83.32(4)-Specifies exceptions and conditions for persons in respite care. HFS 83.33(2)-Specifies requirements for general services to be provided, including supervision, information & referral, leisure activities, community activities, transportation, health monitoring, medical	week but may limit the types of care they provide to the minimum required supportive, personal and nursing services. For instance, a RCAC is only required to provide health monitoring, medication management and medication administration to meet its nursing services requirement. RCACs may discharge tenants whose needs cannot be met with the minimum level of required service or whose condition requires the immediate availability of a nurse 24 hours a day. However, there is no limit on the amount of services a RCAC tenant may arrange for; the 28-hour limit only applies to services provided by the RCAC. The computation of hours of service is only needed to determine whether a tenant should be discharged; facilities are not required to continually document staff time spent in providing services to each tenant. Finally, in computing the 28 hour service limit, only individualized services count toward the 28 hours; congregate services and activities which would typically be available in a hotel or unlicensed housing for the elderly do not.

Subject	Nursing Homes	CBRFs	RCACs
Minimum Required and Defined Services (continued)		services, and advance directives. HFS 83.33(3)- Specifies requirements for medications and resident self-administration. HFS 83.33(4)- Specifies requirements for "specific services" by client group, including personal care, independent living skills, communication, socialization, assistance with self-direction, monitoring symptom status, medications administration instruction, activity programming for dementia residents, transitional services, and nursing care. HFS 83.35-Specifies in considerable detail requirements for food services, including provision of "at least" 3 meals/day + snack. **Discussion:** The key distinction between "nursing care" in a CBRF and "nursing services" in a RCAC is the amount of hands-on nursing that is permitted. The 3-hour per resident per week limit in CBRF nursing care applies to nursing procedures performed by a RN or LPN "directly on or to a resident." It does not apply to consultation, documentation or supervisory functions, only direct, hands-on care. It also excludes care provided by non-professionals (CNAs). "Nursing services" in a RCAC are defined as nursing procedures, excluding personal services, which must be performed by a RN or as a delegated act under the supervision of a RN. This, obviously, is a much broader interpretation	

Subject	Nursing Homes	CBRFs	RCACs
Minimum Required and Defined Services (continued)		of nursing than the CBRF code permits. S.50.01(3) defines a nursing home as "a place where 5 or more persons who are not related to the operator or administrator reside, receive care or treatment and, because of their mental or physical condition, require access to 24-hour nursing services, including limited nursing care, intermediate level nursing care and skilled nursing services." "Nursing services" itself is not defined; the three levels listed are on the basis of those definitions. It is permissible, though not necessarily advisable, for a CBRF to provide significantly more hands-on nursing care under its 3-hour limit than a RCAC could under its 28-hour limit or than virtually all nursing homes currently do provide.	
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Staff Requirements	HFS 132.41 - Requires licensed administrator, and specifies full-time administrator except for small facilities or when overseeing facilities on same campus. HFS 132.42 (3)(a): New employees. Every employee shall be certified in writing by a physician or physician extender as having been screened for tuberculosis infection and… HFS 132.45(1): General. The	HFS 83.12 (1) A CBRF licensee shall have an administrator responsible for the day-to-day operations. HFS 83.15 (1) (c) 2. From 9:00 pm to 7:00 am, requires staff-to-resident ratio of one-to-twenty for every twenty residents that require a Class C licensed facility. HFS 83.15 (2): Written staff schedule. (a) The licensee shall maintain and have available for department review a current written schedule for staffing the facility.	HFS 89.23 (2)(b) – The number, assignment and responsibilities of staff shall be adequate to provide all services identified in tenants' service agreements, including sufficient time to let staff assist tenants with unscheduled care needs. HFS 89.23 (5): Documentation. A RCAC shall document that the requirements for provider qualifications have been met. HFS 89.23 (6): Written Staffing Plan. A

Subject	Nursing Homes	CBRFs	RCACs
Staff Requirements (continued)	administrator or administrator's designee shall provide the department with any information required to document compliance with HFS 132 and Ch.50, Stats., and shall provide reasonable means for examining records and gathering the information. HFS 132.60 (4)-Requires provision of emergency services. HFS 132.60 (7)-Provides for use of oxygen only on order of a physician, except in an emergency. HFS 132.61-Requires full-time or part-time medical director, and specifies medical and physician services including requirement for visit every 30 or 90 days, depending on level of care. HFS 132.62(2)(a)-Requires at least one full-time director of nursing. HFS 132.62(2)(b)-Requires charge nurse on duty, varying by size of facility. HFS 132.62(3)(f)-Requires 1 nursing staff person on duty at all times. HFS 132.62(3)(a), updated by s.50.04 (2)(d)-Provides minimum hours of nursing care for intensive skilled nursing (3.25 hours/resident/day), for skilled nursing level residents (2.5 hours/resident/day), and for intermediate level or limited care residents (2.0 hours/resident/day), with 20% of minimum required to be provided by nurses. HFS 132.63-Requires dietitian supervisor, full-time or part-time depending on size, and specifies dietary services in detail.	HFS 83.13: Personnel. (1) Job descriptions. Written job descriptions shall be available for all employees. HFS 83.13 (7): Employee Personnel Record. (a) A separate personnel record shall be maintained and kept up-to-date for each employee. HFS 83.13 (7)(a) 8: A completed criminal record check form from the department of justice must be maintained. 83.15 (1)(a)-Generally, requires only "adequate" staff/resident ratio 83.15 (1)(c) 1-Requires at least 1 qualified staff on site when any residents in building.	RCAC shall maintain an up-to-date, written staffing plan which describes how the facility is staffed to provide services that are sufficient to meet tenant needs. 89. 23 (4) (b) Service Manager. RCACs shall have a designated Service Manager responsible for day-to-day operations.