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Details:

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2009-10

(session year)

Senate

(Assembly, Senate or Joint)

Committee on ... Public Health, Senior Issues, Long-Term Care, and Job Creation (SC-PHSILTCJC)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Gigi Godwin (LRB) (November/2011)

Senate

Record of Committee Proceedings

Committee on Public Health, Senior Issues, Long-Term Care, and Job Creation

Senate Bill 470

Relating to: dementia specialist certification program and requiring the exercise of rule-making authority.

By Senators Carpenter, Darling, Taylor and Coggs; cosponsored by Representatives Krusick, J. Ott, Berceau, Mason, A. Ott, Pasch, Roys, Smith and Townsend, by request of Alzheimer's and Dementia Alliance of Wisconsin, Coalition of Wisconsin Aging Groups, Wisconsin Board of Aging and Long Term Care, Disability Rights Wisconsin.

January 22, 2010 Referred to Committee on Public Health, Senior Issues, Long-Term Care, and Job Creation.

February 17, 2010 **PUBLIC HEARING HELD**

Present: (5) Senators Carpenter, Coggs, Vinehout, Schultz and Kapanke.
Absent: (0) None.

Appearances For

- Tim Carpenter, Milwaukee — Sen., 3rd Senate District
- Peggy Krusick, Milwaukee — Rep., 7th Assembly District
- Mary Kay Baun, Dodgeville
- Harold Blotner, Madison
- Paul Rusk, Madison — Alzheimers & Dementia Alliance of Wisconsin
- Heather Bruemmer, Madison — Board on Aging and LongTerm Care
- Rob Gundermann, Madison — Wisconsin Alzheimers Alliance

Appearances Against

- Rita Giovannoni, Madison — RSA of Wisconsin
- Forbes McIntosh, Madison — RSA of Wisconsin & WI. Assisted Living Association
- Jim McGinn, Madison — WHIA & WICAL

Appearances for Information Only

- None.

Registrations For

- William Donaldson, Madison — Board on Aging and LongTerm Care
- Robert Forbess, Madison
- Robert Pelletier, Madison
- Robert Trembath, Middleton
- Eugene Knudson, Portage — Alzheimer's & Dementia Alliance
- John Hendrick, Madsion — Coalition of Wisconsin Aging Groups
- Lynn Breedleve, Belkville — Disabilitys Rights of Wisconsin

Registrations Against

- Norell Toso, Janesville — Alzheimers Association

Registrations for Information Only

- None.

March 3, 2010 **EXECUTIVE SESSION HELD**

Present: (5) Senators Carpenter, Coggs, Vinehout, Schultz and Kapanke.
Absent: (0) None.

Moved by Senator Coggs, seconded by Senator Vinehout that **Senate Bill 470** be recommended for passage.

Ayes: (3) Senators Carpenter, Coggs and Vinehout.
Noes: (2) Senators Schultz and Kapanke.

PASSAGE RECOMMENDED, Ayes 3, Noes 2

Russell DeLong
Committee Clerk

Vote Record

Committee on Public Health, Senior Issues, Long-Term Care, and Job Creation

Date: 3-3-10

Moved by: Coggs Seconded by: Vinehout

AB _____ SB 470 Clearinghouse Rule _____

AJR _____ SJR _____ Appointment _____

AR _____ SR _____ Other _____

A/S Amdt _____

A/S Amdt _____ to A/S Amdt _____

A/S Sub Amdt _____

A/S Amdt _____ to A/S Sub Amdt _____

A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

Be recommended for:

☒ Passage ☐ Adoption ☐ Confirmation ☐ Concurrence ☐ Indefinite Postponement

☐ Introduction ☐ Rejection ☐ Tabling ☐ Nonconcurrence

Committee Member	Aye	No	Absent	Not Voting
Senator Tim Carpenter, Chair	☒	☐	☐	☐
Senator Spencer Coggs	☒	☐	☐	☐
Senator Kathleen Vinehout	☒	☐	☐	☐
Senator Dale Schultz	☐	☒	☐	☐
Senator Dan Kapanke	☐	☒	☐	☐
Totals:	3	2	___	___

☒ Motion Carried ☐ Motion Failed

Re: Senate 470
2-16-2010

I would like to speak in favor of this
My name is Hal Blotner, and my wife, Suzanne has Alzheimers disease. She is a resident of the dementia care unit, called the Haven at Attic Angels Place.

I visit my Wife daily, and have gotten to know all of the CNA's and staff very well. I felt comfortable in talking to them and ~~asking~~ their opinion regarding this proposed certification training. Everyone I talked to thought it was a great idea and would prepare them to do a better job than they are already doing. The fact that they would welcome the additional preparation for a job, that is not a good fit for everyone, is a an indication how sincere and motivated these young men and women are. They are providing conscientious care to my wife and uniformly and equally to all the residents.

Coincidentally, in June of this year, the Alliance will be holding a training session to welcome about 50 people, and it will take place at Attic Angels Place.

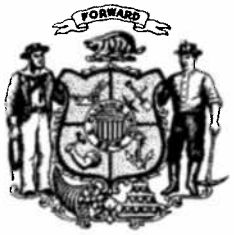
Before I retired, I was a small business man, and was the owner of Dane County Vending. One of the reasons I sold the business, was so that I could devote

more time to being a care giver to my wife. Don't ever under estimate how men can adapt to being the care-giver to their loved ones, I see that demonstrated very dramatically with a group of men that is a support group sponsored by the Alliance. We meet monthly to discuss common problems in a very open and candid way. We come from a broad variety of backgrounds, but there is great spirit & camaraderie and hopefully, we leave the meeting feeling encouraged, knowing we are not alone. There are a number of them here, attending this hearing to show their support for this bill.

In conclusion, I respectfully ask that you approve this proposal.

Hal Blotner
4418 W Lake Lane
Madison, WI 53711
608-233-8401

WISCONSIN STATE LEGISLATURE



STATE OF WISCONSIN
BOARD ON AGING AND LONG TERM CARE
1402 Pankratz Street, Suite 111
Madison, WI 53704-4001
(608) 246-7013
Ombudsman Program (800) 815-0015
Medigap Helpline (800) 242-1060
Fax (608) 246-7001
http://longtermcare.wi.gov

Testimony of
Heather A. Bruemmer, Executive Director of the
Board on Aging and Long Term Care
Before the Senate Committee on
Public Health, Senior Issues, Long-Term Care, and Job Creation
17 Feb 2010

Good Afternoon Chairman Carpenter and members of the Committee. I am Heather Bruemmer, Executive Director of the Board on Aging and Long Term Care and I appear before you today to speak in favor of SB 470.

The Board on Aging and Long Term Care has, for nearly thirty years, been a strong advocate for the rights of elder Wisconsinites who have been diagnosed with Alzheimer's disease and other dementias. Our Long Term Care Ombudsmen have frequently been called in to consult on cases or advocate for residents and their families in situations where they have been inadequately served. In some cases, they have been neglected or ineffectively protected by caregivers who have not received adequate training and education regarding the unique needs of persons with dementia. In many of these cases the resident lives in a facility that claims to specialize in caring for persons with dementia and markets itself as an "expert" or "leader" in the field.

Two case examples include; a confused resident who required extensive assistance with activities of daily living sustained third degree burns when left unsupervised after given a cup of coffee. Apparently improperly trained staff did not check the temperature prior to serving. In another situation, six residents on a 16-bed Alzheimer's unit were identified as having repeatedly abused other residents on the unit, including hitting, grabbing, pushing to the floor, spitting at, throwing objects at, and furniture and on one occasion, punching another resident. The facility management separated the aggressive residents from the rest, but did not work at developing staff skills and proactive approaches for preventing/reducing such incidents. Appropriate training and continued education may have prevented these situations from occurring.

Simply saying that your facility knows how to care for persons with dementia does not provide the same level of dementia-considerate care and success as does having caregivers go through a program of comprehensive and ongoing training provided by experts in this subject. The Board believes that, where

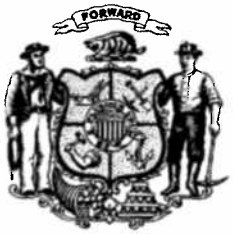
the existing training model available through the Alzheimer's Association has been used in combination with ongoing updates and staff support, the quality of care and the understanding of the disease have been improved over the situation in facilities where staff are not effectively educated about how to care for these residents. The addition of state certification that recognizes this level of training and competency would do much to strengthen the framework of Wisconsin's dementia care system.

It is the position of the Board on Aging and Long Term Care that enactment of SB 470 would offer an obvious significant benefit to facility residents who suffer from the disease and to the families of these residents. Importantly, there could well be a benefit to the facilities. A facility that is staffed by properly trained, supported and motivated caregivers may experience greater success in addressing the challenges experienced by persons with dementia and may be less likely to encounter regulatory difficulties along with developing an enhanced reputation within the community.

There is only one area of SB 470 that the Board would propose to amend. Where the bill discusses re-training of certified dementia specialists, the Board would suggest that the bill clearly identify specific areas to be covered in the re-training session. I would suggest that these sessions be required to focus on the areas of current best practices in effective communication and responding to persons with challenging behaviors. With the addition of this small but important information, this bill would become stronger and would signal the concern of the State of Wisconsin for assuring the best care possible for persons with dementia.

I thank you for this opportunity to express the position of the Board on Aging and Long Term Care and I would again ask for the Committee's favorable consideration of SB 470. I would be happy to answer any questions that you may have.


WISCONSIN STATE LEGISLATURE


FORWARD

Wednesday, February 17, 2010

Senator Tim Carpenter, Chair
Wisconsin State Legislature
Room 306 South
State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Re: Concerns with SB-470 Creating Dementia Specialist Certification

Dear Sen. Carpenter and Members of the Committee:

The Residential Services Association of Wisconsin (RSA) is recommending that the committee take no action on Senate Bill 470 at this time.

Although this legislation has good intentions it is our belief that Wisconsin already has laws that adequately address the aspects of training and testing of long-term caregivers with respect to dementia and other medical conditions prevalent to the geriatric population *(see attached documents: HFS-83 and HFS-129-Subchapter III, IV and VII).*

RSA feels that the creation of a new 40-hour certification and 2-year recertification program devoted entirely to one medical condition fails to recognize that other diseases and health conditions impact the geriatric population to a similar degree.

If the Legislature passes a new law specifically for dementia training and certification, then a policy and process question needs to be posed, "should similar training standards and policies be instituted for other prevalent medical conditions impacting the geriatric population?"

We understand that dementia is a common medical condition found in the geriatric population, however our point is that there are many prevalent medical conditions impacting this population: i.e. cancer, heart disease, respiratory disease, gastrointestinal

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6737 West Washington Street, Suite 1300, Milwaukee, Wisconsin 53214
(414) 276-9273 (Office) / (414) 276-7704 (Fax)

disease, endocrine/metabolic disorders, movement disorders (Parkinson's), diabetes, urinary incontinence, osteoporosis, sleep disorders, etc.

In addition, like the growing number of Alzheimer's and dementia organizations, there are a number of non-profit advocacy organizations that provide focused caregiver training programs for on various medical conditions. Many providers already voluntarily enroll many of their staff in these programs to meet existing requirements and often to provide training beyond what is required.

To that end, RSA members question why a new 40-hour training and certification process needs to be stipulated in law and where did the 40-hour minimum standard come from? Is there a study or an already established program that this number is being based upon?

In addition, RSA members are concerned that although this legislation provides for voluntary certification now, it has been our experience that regulation of this kind is sometimes a two-step lobbying objective - where a "voluntary" regulation that has no fiscal impact is introduced and passed in one legislative session and then the following session a succeeding bill is introduced to make the program a minimum requirement.

RSA-Wisconsin cannot support new regulatory requirements that will increase operational costs, whether voluntary or mandatory, at a time when the legislature and the administration has not only failed to provide much needed reimbursement increases over the past decade - but has and continues to institute cuts to essential Medicaid and Medicaid-Waiver programs (i.e. the Wisconsin 2009-2011 Biennial Budget and the "ForwardHealth Rate Reform Project 1.0 and 2.0).

As most committee members are likely aware, the Wisconsin Department of Health Services recently announced to the healthcare community that a budget shortfall in this current fiscal biennium of approximately $100 million GPR exists in the Medicaid and Medicaid-Waiver programs. This is in addition to the $633 (all funds) budget shortfall the Wisconsin Legislature required the department to manage in the budget process last year. The Department has reconvened the "ForwardHealth Rate Reform Project 2.0" to find ways to deal with the newly recognized $100 million GPR budget shortfall in Medicaid.

In closing, long-term care providers have a limited ability to absorb reimbursement rate cuts, delay of payments and new regulatory requirements – issues that are a problem for long-term care providers today. Many RSA members have a limited ability or no ability (i.e. a "private pay" population) to shift increased regulatory costs to – so these providers are placed in the unsustainable situation of having to find ways to reduce costs.

Keep in mind that direct care comprises approximately 80% of a long-term care provider's operational budget. Creating new regulatory training and certification programs will increase a provider's operational costs and those costs will have to be made up from other cost centers that will likely have an impact on quality care.

Long-term care providers only ask that if the Legislature is going to create new regulatory requirements – the Legislature then pay its fair share up front for the related cost increases.

Sincerely,

Anne L Foerster

Anne Foerster
President, RSA-Wisconsin


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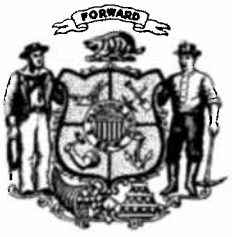
FORWARD

WISCONSIN STATE ASSEMBLY

PEGGY KRUSICK
STATE REPRESENTATIVE

Peggy Krusick's Testimony in Support of SB 470
(Dementia Specialist Certification)

Senate Committee on Public Health, Senior Issues, Long-Term Care, and Job Creation
February 17, 2010

Thank you Chairman Carpenter and Committee members for the opportunity to testify in support of Senate Bill 470.

Right now, almost half of nursing home residents living in 90% of Wisconsin nursing homes have some form of dementia and, according to some estimates, Alzheimer's cases will increase by more than 50% in the next 20 years.

As the number of people with Alzheimer's disease and other dementia continues to increase, there will be a growing demand for caregivers who have the unique skills and knowledge necessary to provide quality care to these individuals.

Many long-term care consumers with Alzheimer's or other dementia receive much of their care from certified nursing assistants.

The problem is Wisconsin only requires these nurses to receive minimal training on providing dementia care, especially when compared to other states like neighboring Illinois, which requires nurse aides to receive at least 12 hours of dementia-specific instruction. In fact, when the number of training hours for CNAs in Wisconsin was increased recently from 75 hours to 120 hours, no new dementia training requirements were added and there's still no minimum number of hours of dementia specific training required.

The other problem is that while dementia specialist certifications are currently available on the private market, the state doesn't regulate this job classification, so the value of the certification can vary tremendously depending on where it's obtained.

For example, some for-profit companies offer dementia specialist certifications on the Internet with very few requirements. Often all you need to do to get certified by one of these online outfits is pay a fee, maybe attend an aging conference and take a test.

The non-profit Alzheimer's and Dementia Alliance, on the other hand, provides a well-regarded 16-hour dementia specialist training program, but even with full-time trainers on staff it doesn't have the resources necessary to meet the growing demand for training.

SB 470 would help eliminate the disparity in the quality of these types of programs by creating a consistent state training standard for those who wish to train and certify dementia specialists in Wisconsin.

-over-

SB 470
Provides interested nurse aides and resident activity coordinators in Wisconsin the opportunity to be state certified as a Dementia Specialist after successfully completing and meeting all of the requirements of a dementia-specific training program approved by the Department of Health Services (DHS).

Directs DHS to establish the standards for approved Dementia Specialist training and competency evaluation programs.

Requires an approved Dementia Specialist training program to include at least 40 hours of instruction in 9 specified areas (*list attached*). The topics covered are intended to expand a caregiver's understanding of dementia and enhance their ability to appropriately handle common behaviors associated with the disease which otherwise can be both frustrating and frightening.

Requires Dementia Specialists to renew their certification every 2 years after completing 4 hours of approved continuing education.

Allows DHS to charge a fee for the certification—which would cover the cost of the program when combined with 50% federal matching funds.

Conclusion
The number of people in Wisconsin who will be diagnosed with Alzheimer's disease or dementia is increasing and will only continue to increase even more in the years to come. Passing SB 470 is an important first step toward ensuring that Wisconsin has enough trained caregivers with the expertise needed to provide the quality care these individuals will require and their families will demand.

Thanks for your consideration. I'd be happy to answer any questions.

Supporters
Alzheimer's and Dementia Alliance of Wisconsin
Wisconsin Federation of Nurses and Health Professionals
Coalition of Wisconsin Aging Groups
Wisconsin Board on Aging and Long-Term Care
Disability Rights Wisconsin

Dementia Specialist Training Topics (SB 470)

1. Understanding the signs and symptoms of the various forms of dementia and the possible variations in care needs among individuals affected by the various forms of dementia.

2. How to approach, observe, listen to, and communicate with, an individual with dementia.

3. Recognizing pain in an individual with dementia.

4. Skills and techniques for encouraging purposeful activities to provide holistic care intended to promote optimal life experiences for persons with dementia.

5. Understanding the needs of an individual with dementia, how to develop a trusting relationship within the challenges of the effects of dementia, and how to avoid and manage behaviors that may be harmful to the individual or others.

6. Communication skills necessary to communicate with coworkers, professionals, and families regarding individuals with dementia.

7. Skills necessary to effectively advocate for the needs and interests of persons with dementia.

8. Developing and using care plans to assist individuals with dementia in experiencing the highest possible quality of life.

9. Techniques for effective problem solving.


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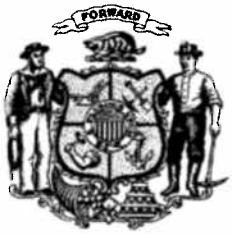
FORWARD

February 17, 2010

Dear Senator Carpenter and members of the Committee:

My name is Mary Kay Baum and I serve on the board of the Alzheimer's Alliance of Wisconsin and as the chair of our public policy committee. I also have Alzheimer's disease. My two sisters also have Alzheimer's disease and my mother had the disease before she died.

I'm here today in support of Senate Bill 470. I know how hard these C.N.A's work and what a good job they do overall as caregivers. I am concerned though about how much they understand my disease. I know they don't get very much training with regard to dementia in their C.N.A. coursework. I'm concerned about what will happen if I or one of my sisters has to go into a nursing home at some point. Will the staff understand me? Will the staff understand my disease? Honestly, I have enough to worry about right now. I want to know that if I go into a nursing home some day I will have people taking care of me who understand my illness and how to help me. If Senate Bill 470 passes I won't worry so much. I'll know there will be dementia specialists to take care of my family members if we get to that point or find ourselves in that situation.

In closing I would just like to read a couple lines from a poem I wrote for my sister that I think sheds some light on my situation.

Sincerely,

Mary Kay Baum

Mary Kay Baum
3819 Evans Quarry Road, #6
Dodgeville, WI 53533

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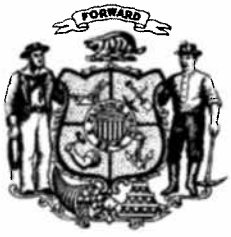

February 17, 2010

Senate Committee on Public Health, Senior Issues, Long Term Care and Job Creation

Dear Senator Carpenter and members of the Committee:

I really wanted to speak at the hearing today in person but I wasn't able to get the time off so I'm submitting my comments in favor of Senate Bill 470 in writing. I work as a certified nursing assistant (C.N.A.) in Lodi where I've worked for 1 1/2 years.

I've gone through the dementia training program offered by the Alzheimer's Alliance and I believe it has helped me become a better C.N.A. In my recent 15 hour training one of the most eye opening, hands on experiences was to write 10 items - whether they be people or objects - that are most nearest and dearest to me on 10 different slips of paper. The next thing I knew, people were coming around and aimlessly taking three or four of these slips of paper at a time until I had none of them left. I had no say in it whatsoever as my son, husband, home and more slipped right through my fingers; it breaks my heart realizing that a person with dementia actually faces this reality.

A problem I recognized in giving care for residents with dementia, before I even took this class, was the pace at which C.N.A.' s move. When we are trained in school we are taught to be fast and efficient. I could tell when I first started working on an Alzheimer's unit that is not what worked - patience was. This class gave me another hands on demonstration by having me put popcorn kernels in my shoes, cotton balls in my ears, glasses with a different prescription and putting on rubber gloves. We then had to walk down a flight of stairs into another room where the music was playing, lights were flashing and the instructor was calling out questions to us that we needed to write answers to on the paper in front of us all the while someone else kept trying to rearrange the groups in which we had seated ourselves...Once again it was very eye opening - showing that the sensory mechanisms are not the same as those residents without dementia and why they may be having a more difficult time with what we consider to be ordinary and easy day-to-day functions. Patience, going slow is the key - something that a lot of C.N.A.'s aren't aware of that needs to be done because it's not taught during your basic C.N.A. course.

If I could present myself as a Certified Dementia Specialist (as well as a C.N.A.) to facilities and families alike I believe it would ease their minds knowing there was special education to back up my word saying I knew how to take care of their loved ones that are struggling with this disease that robs them of all they know little by little. A family might be more inclined to admit a relative with dementia into long-term care knowing that there are Certified Dementia Specialists working there then into a long-term facility without any for the pure simple fact of knowledge. This disease is more complex than most people realize and it takes considerable knowledge not only in being able to care for a person with it, but also to be able to connect with the family.

Sincerely,

Leah Reiter

120 West Mill St

Poynette, WI 53955

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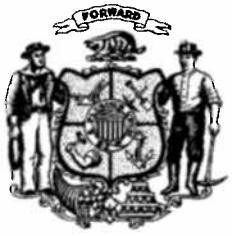

Alzheimer's & Dementia Alliance
OF WISCONSIN

February 17, 2010

Senate Committee on Public Health, Senior Issues, Long Term Care and Job Creation testimony in favor of Senate Bill 470.

By: Rob Gundermann, Public Policy Director Alzheimer's and Dementia Alliance of Wisconsin.

Good morning and thank you for the opportunity to speak today. I'm Rob Gundermann here today on behalf of the Alzheimer's Alliance in support of Senate Bill 470.

This bill simply provides an opportunity for C.N.A's and activity directors to get some additional dementia training without imposing any mandates on anyone. I've included with my testimony as appendix A, a state by state chart showing the additional training requirements other states have imposed. We've looked at what other states have done and I've spoken with my counterparts in other states and we believe we have developed a better approach which is what we have before us today in the form of SB 470, an entirely voluntary certification program that would create true dementia specialists who other staff could go to with questions. One comment I've heard is that at some point we will seek to mandate this training on all C.N.A's. There will never be a need to associate mandates with this training. The demand is there. If we provide the opportunity C.N.A's will take advantage of that opportunity. C.N.A's want more training.

In our Madison office we have dedicated one staff position to training but even with that commitment we can't meet the demand. We train 50 people a month, 600 per year and while we could put more staff hours into training we would then be taking that time away from serving families. We have 115,000 families in Wisconsin coping with dementia and frankly we don't have the resources to meet their needs let alone devote more resources to training facility staff.

We're now seeing for profit businesses filling that void by selling certifications online and advertising to facilities that this is a good way to help with marketing. SB 470 will ensure that there is a baseline of knowledge obtained by anyone calling themselves a dementia specialist and the bill gives the caregivers some recognition for having furthered their education and training.

The primary focus of the training C.N.A's go through to get certified as a C.N.A. is on tasks. Students are taught how to safely transfer patients, how to effectively feed them, how to give bed baths and how to dress someone who has had a stroke. They learn how to take vital signs and how to pass medications, etc.

A dementia specific course of training doesn't focus so much on tasks as on how to build a relationship with a person with dementia. How can you get someone whose mind is

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Columbia/Sauk Regional Office
2825 Hunters Trail
Portage, WI 53901
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support@alzwisc.org
www.alzwisc.org

Alzheimer's & Dementia Alliance
OF WISCONSIN

compromised to trust you enough to not fight the tasks you've been trained to help them with? How can you prevent or disarm the fear and paranoia that is frequently a part of the normal emotional response from a person whose mind can no longer reason? If you don't know how to communicate with someone who no longer understands normal language or abstract concepts, how can you connect them to anything meaningful or purposeful in their day?

The result of in-depth dementia training is that those who have a dementia diagnosis have the best possible chance of a higher quality of life. Creating a State certified dementia specialist classification will give C.N.A's tools that will help the C.N.A. be more confident in their abilities and more successful in their interactions with residents. C.N.A's who feel confident and successful are more likely to continue working as C.N.A's, and will lead to less employee turnover.

I had two C.N.A's who have gone through our dementia training program and had planned to be here today but learned yesterday that they would not be able to take time off of work to come to the hearing. They did however prepare written statements and asked that I distribute to the committee which is also included with my comments.

If you have any questions I would be happy to try to answer.

Thanks you.

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support@alzwisc.org
www.alzwisc.org

Date ?

To members of the Committee on Public Health, Senior Issues, Long Term Care and Job Creation supporting Senate bill 470

Hello Members of the Committee. I wish that I could be there in person today to answer any questions you might have, but due to my work schedule I was not able to attend. I am a CNA and I work primarily with people who have some form of dementia. Let me say that I have a deep affection and respect for my residents and their family members and the 15 hour training program that I went through helped me to further deepen my respect and understanding of what they go through.

In our CNA training we only touch on dementia and it's many forms and the deterioration over time of what happens to the person suffering from it. In our recent 15 hour training one of the most moving exercises was to have us write down 10 things that were most important to us and then people came around and randomly took two or four of these people or things we had written - and then they took more - until we had nothing left. We had no control over it - and neither did those that we had lost. The thought of that being the reality for a person with dementia was devastating for me.

Caring for people with dementia isn't for everyone - it takes time, it takes commitment and it takes a very big heart. Helping someone simply sit on a chair or go to the toilet can be an exercise in patience and frustration on our parts and fear and agitation on the part of the resident.

My Charge Nurse always says she depends on her CNA's so much for input on the residents because we are the ones who have hands on - everyday - and we are the ones who will notice subtle changes that might indicate a headache, depression, or a urinary tract infection. That is why this training is so important!

The class gave us new techniques to handle agitation and difficult situations - we all related to each others situations and I know we all left there with a much better understanding of what we deal with on a day to day basis and we were certainly more equipped to handle all of it.

Dementia isn't just getting old - it is slowly losing the very fabric of who we are - one string at a time. My residents make my day when I get to see that glimmer of them - that they are still in there, despite the hallucinations or the ability to carry on a real conversation anymore. They have taught me to live in the moment - a lesson we could all benefit from - because if you can not live in just this moment, you will not be able to help them or see them as people.

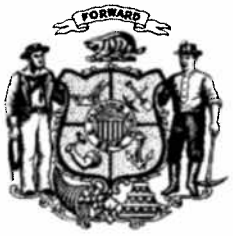
We all have a story to tell and the dementia training helps us to help our residents keep telling their story and continuing to live life - and to help the family through those difficult days, which can be many.

I hope this helps you to understand the importance of training - it is not for every CNA, but for those of us who care for dementia patients it is a Godsend.

Thank you for your time and consideration,

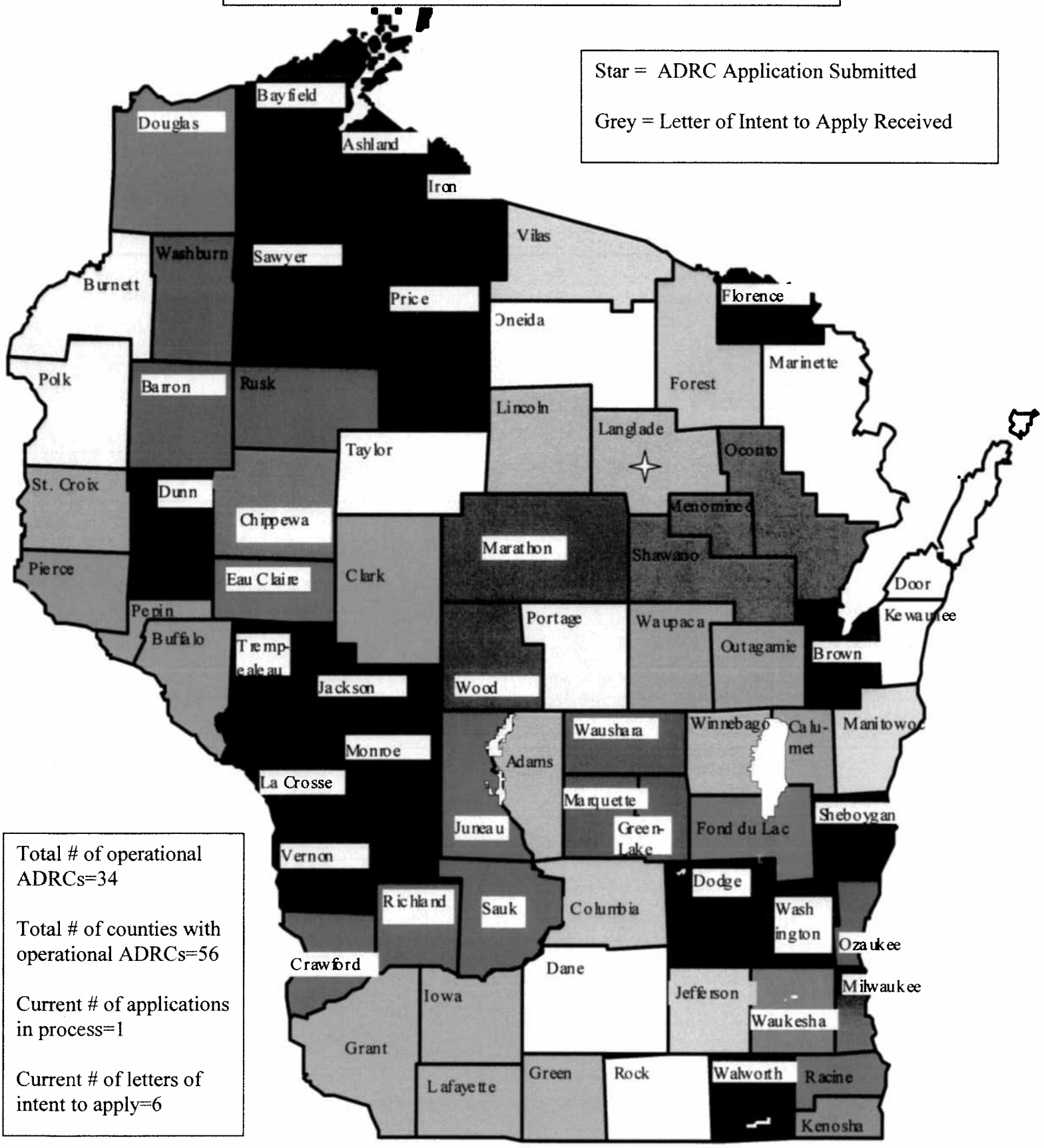
Julie E. Cakanic
122 2nd Street
Lodi, WI


WISCONSIN STATE LEGISLATURE


FORWARD

SB 470?

Current and Proposed Aging and Disability Resource Centers January 1, 2010



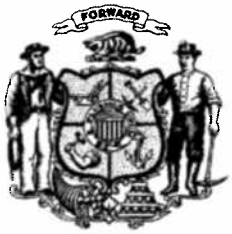
Total # of operational ADRCs=34

Total # of counties with operational ADRCs=56

Current # of applications in process=1

Current # of letters of intent to apply=6

WISCONSIN STATE LEGISLATURE



SB470?

Chapter DHS 129

CERTIFICATION OF PROGRAMS FOR TRAINING AND TESTING NURSE AIDES, MEDICATION AIDES AND FEEDING ASSISTANTS

Note: Chapter HSS 129 was renumbered to chapter HFS 129 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1999, No. 522. Chapter HFS 129 as it existed on November 30, 2008, was repealed and a new chapter DHS 129, as renumbered from chapter HFS 129 under s. 13.92 (4) (b) 1., Stats., was created, Register November 2008 No. 635, effective December 1, 2008.

Subchapter I — General Provisions

DHS 129.01 Authority and purpose. This chapter is promulgated under the authority of ss. 146.40 (2m), (3) and (5) and 227.11 (2) (a), Stats., to provide conditions of approval for training programs and competency evaluation programs for persons who work as nurse aides, medication aides or feeding assistants in hospitals, nursing homes or facilities for the developmentally disabled, home health agencies or hospices certified under 42 USC 1395 to 1395ccc, and conditions for including persons in the department's registry of nurse aides.

History: CR 08–042: cr. register November 2008 No. 635, eff. 12–1–08; correction made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.

DHS 129.02 Applicability. This chapter applies to any facility, agency or other organization that proposes to maintain a registry of nurse aides, train or administer competency evaluation testing of nurse aides, feeding assistants, or medication aides under a program approved by or under contract with the department under this chapter, and to all persons automatically included or eligible for inclusion and requesting inclusion in the department's registry of nurse aides.

History: CR 08–042: cr. register November 2008 No. 635, eff. 12–1–08.

DHS 129.03 Definitions. In this chapter:

(1) "Abuse" has the meaning specified in s. DHS 13.03 (1).

(2) "Basic nursing course" means a course or combination of courses that contain the basic nursing skills, competencies and knowledge that the department is satisfied are generally equivalent in content to the skills contained in s. DHS 129.07 (1).

(3) "Body mechanics" means the use of the muscle and skeletal systems during activity and when positioning the body for work tasks, given that the task is within the limits of worker capability when assisting in the movement, positioning and transfer of clients.

(4) "Caregiver misconduct registry" has the meaning specified in s. DHS 13.03 (4).

(5) "Client" means a person receiving care, treatment or diagnostic services from a health care provider.

(6) "Client care ergonomics" means a multifaceted, standardized approach for client mobility tasks, which incorporates the evaluation of client characteristics to assure proper selection and use of equipment by caregivers according to algorithms for client transfer and mobility activities.

(7) "Client related services" means care, treatment or diagnostic services provided to a client.

(8) "Clinical setting" means one of the following:

(a) A practice setting where care and treatment of clients occur.

(b) A health care–related setting, where care and treatment of clients occurs.

(9) "Competency evaluation program" means a testing program for nurse aides that is approved under this chapter and consists of all of the following components:

(a) A written or oral examination.

(b) A skills demonstration examination.

(10) "Complicated feeding problems" means difficulty in swallowing, recurrent lung aspiration, or tube or parenteral or IV feedings.

(11) "Department" means the Wisconsin department of health services.

(12) "Developmental tasks" means those functions normally associated with the aging process, including acceptance of and adjustment to psychosocial and physiological processes, transition throughout adulthood, retirement development, and life review.

(13) "Direct supervision" means that an RN or LPN is immediately available on the same unit, floor or wing as the nurse aide while the nurse aide is performing client–related services.

(14) "Employment" means working for another for compensation on a full–time, part–time, temporary, per diem, contractual or other basis.

(15) "Facility for the developmentally disabled" means a place or a distinct part of a place where five or more unrelated persons reside and who, because of their developmental disabilities, require access to 24–hour nursing care or treatment for developmental disabilities as defined under rules promulgated by the department for facilities for the developmentally disabled. "Facility for the developmentally disabled" does not include any of the following:

(a) A convent or facility owned or operated exclusively by and for members of a religious order that provides reception and care or treatment of an individual.

(b) A hospice that directly provides inpatient care.

(c) An assisted living facility, as defined in s. 50.034, Stats.

(d) A nursing home.

(16) "Feeding assistant" means a person at least 16 years old who has completed a state–approved feeding assistant training program and who is paid by a nursing home, or a person who is used under an arrangement with another agency or organization to assist clients who have no feeding complications with the activities of eating and drinking. "Feeding assistant" does not mean an individual who is a licensed health professional or registered dietician; volunteers without money compensation; or a nurse aide.

(17) "General supervision" means at least intermittent face–to–face contact between supervisor and nurse aide, but does not require the continuous presence of the supervisor in the same area during client–related services.

(18) "Handicapping condition" means a physical or mental impairment that makes ability to care for oneself unusually difficult or limits one's capacity to work.

(19) "Health care provider" means any of the following:

(a) A nursing home.

(b) A facility for the developmentally disabled.

(c) An intermediate care facility for the mentally retarded.

(d) A hospital.

(e) A home health agency.

(f) A hospice.

(g) A rural medical center that provides one or more of the services listed in pars. (a) to (f).

(20) "Home health agency" has the meaning specified in s. 50.49 (1), Stats.

(21) "Hospice" means an organization, program or place as defined in s. 50.90 (1), Stats., and ch. DHS 131, and is certified as a provider of services under 42 USC 1395 to 1395ccc.

(22) "Hospice medication aide" means a nurse aide who is able to administer medications in a hospice after passing a department–approved medication course.

(23) "Hospital" has the meaning specified in s. 50.33 (2), Stats.

(24) "Licensed health care professional" means a physician, physician's assistant, nurse practitioner, physical, speech or occupational therapist, an occupational therapy assistant, a registered nurse, a licensed practical nurse or any other health or health service professional subject to the jurisdiction of the Wisconsin department of regulation and licensing.

(25) "Licensed practical nurse (LPN)" means an individual who is licensed under s. 441.10 (3) (a) to (d), Stats., or who has a temporary permit under s. 441.10 (3) (e), Stats.

(26) "Mechanical support" means any article, device or garment that is used only to achieve the proper position or balance of the client.

(27) "Misappropriation" has the meaning specified in s. DHS 13.03 (12).

(28) "Misconduct" means abuse or neglect of a client or misappropriation of a client's property as specified in s. DHS 13.03 (1), (12) and (14).

(29) "Neglect" has the meaning specified in s. DHS 13.03 (14).

(30) (a) "Nurse aide" means a person, regardless of the person's title, who provides routine client–related services under the supervision of a registered nurse or licensed practical nurse. "Nurse aide" includes any of the following:

1. Any person on the registry.

2. Any person providing nursing or nursing–related services to clients, regardless of the title under which the person is employed, except individuals in sub. (31).

3. Any person who has successfully completed a training program under s. DHS 129.07 and a competency evaluation program under s. DHS 129.08.

4. Any person employed to provide nursing or nursing–related services, or employed within the last 24 months as a nurse aide by a health care provider.

5. Any person eligible to be included on the registry under s. 146.40, Stats.

6. Any student nurse on assignment for greater than 120 days.

(b) "Nurse aide" does not mean a person who is licensed, receives a permit, is certified or is registered under chs. 441, 448, 449, 450, 451, 455 or 459, Stats.

(c) "Nurse aide" does not mean a person whose duties primarily involve skills that are different from those taught in training and competency evaluation programs approved under s. DHS 129.07 and s. DHS 129.08. A volunteer is not a "nurse aide".

(31) "Nurse technician" means a nursing student who either is enrolled in a nursing program leading to registered nurse or practical nurse licensure, has graduated from such program and does not hold a temporary permit or who has been unsuccessful on the nursing licensure exam and is retaking the exam.

(32) "Nursing home" has the meaning specified in s. 50.01 (3), Stats.

(33) "Nursing home medication aide" means a nurse aide who is able to administer medications in a nursing home or a facility for the developmentally disabled after passing a department–approved medication course.

(34) "Onsite review" means an evaluation of a training program conducted at the physical location of the training program to verify the program is in compliance with the terms of the approval issued.

(35) "Plan of correction" means the training program's plan to correct all areas identified as deficient during an onsite review.

(36) "Preliminary approval" means the initial 3 month approval issued by the department following the completed review and verification of all aspects of the application.

(37) "Primary instructor" means a registered nurse licensed to practice in Wisconsin who has a minimum of 2 years of nursing experience working as a registered nurse, at least one year of which must be in the provision of long–term care facility services, and who has completed a course in adult education or supervising nurse aides.

(38) "PRN medications" means medications administered as necessary based on the resident's or patient's condition.

(39) "Program" means the facility, agency or other entity or individual who operates an approved training program.

(40) "Program trainer" means an individual from a health related field who provides specialized training about that field to nurse aides under the general supervision of the primary instructor.

(41) "Qualified clinical setting" means a clinical setting unencumbered by restrictions imposed under 42 CFR 483.151.

(42) "Qualified medication consultant" means one of the following:

(a) A pharmacist licensed in Wisconsin.

(b) An advanced practice nurse prescriber as defined in s. N 8.02 (2).

(c) A masters–prepared registered nurse, teaching medication administration to RN or LPN students.

(43) "Registered nurse (RN)" means an individual who is licensed as a registered nurse under s. 441.06, Stats., or who has

(d) *Enforcement.* 1. The department may deny or withdraw approval of a new or existing program for any of the following reasons:

a. The program cannot provide satisfactory evidence that the program meets the standards for program approval.

b. The program did not conduct any training classes within the previous 24 consecutive months.

c. The program fails to allow the department to conduct an on–site visit of the training program.

2. The department may withdraw program approval immediately or prescribe the time within which the deficiencies identified during an onsite review shall be corrected. All notices of deficiency shall be given in writing to the program contact, identified in DHS 129.05 (1) (c). The program contact may submit a plan of correction to the department. If the program fails to correct the deficiency within the specified time, the approval may be withdrawn.

3. When program approval is withdrawn, the program shall do all of the following:

a. Submit a plan to the department within 10 business days after the withdrawal of the program's approval for the completion of the program of the enrolled students with another program in good standing with the department.

b. Allow students who have started that program to complete the course with another program that is in good standing with the department.

c. Provide for custody of the training records for a 3 year time period as required in DHS 129.07 (2) (f).

4. Denial or withdrawal of facility–based training is subject to the requirements of applicable federal law.

5. If the approval is withdrawn, the program may request a hearing under in s. DHS 129.10.

6. If approval of the program is denied or withdrawn under subd. 1., the program may not reapply for program approval for 6 months from the date of the denial or withdrawal of the program approval.

History: CR 08–042: cr. register November 2008 No. 635, eff. 12–1–08; correction in (2) (d) 6. made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.

DHS 129.06 Standards for instructors of nurse aide trainIng programs. (1) PRIMARY INSTRUCTOR. (a) The primary instructor for a training program shall be a registered nurse licensed to practice in Wisconsin, who has at least 2 years of experience working as a registered nurse, of which at least one year of experience shall be actual work experience in providing care in a nursing home that meets the requirements of sections 1919(a), (b), (c) and (d) of the Social Security Act.

(b) Notwithstanding par. (a), the primary instructor for a training program conducted by a hospital shall have at least one of the 2 years experience working as a registered nurse in a hospital.

(c) Notwithstanding par. (a), for a primary instructor in a training program in a home health agency–based program, shall have at least one of the 2 years experience working as a registered nurse in the provision of home health care.

(d) A primary instructor shall provide to the program a resume documenting the instructor's education and clinical experience in meeting clients' psychosocial, behavioral, cognitive and physical needs, and the program shall maintain the instructor's resume on file and shall include a copy of the instructor's resume with the program's application for program approval.

(e) The primary instructor shall attend a training course for instructors approved by the department under sub. (3). The department may waive this requirement for an instructor who has taken a substantially equivalent course or who has substantially equivalent training or clinical experience.

(f) A primary instructor is considered active as long as the instructor remains affiliated with an approved course. If the primary instructor leaves the program and does not become affiliated with another program the instructor's approval as a primary instructor is inactivated as of the date the instructor leaves the approved program.

(g) The department may revoke approval of a primary instructor if the department determines the primary instructor failed to comply with any requirement of this chapter.

(2) PROGRAM TRAINER. (a) Only persons licensed in health care and public health fields may serve as program trainers to meet specialized training needs. This may include licensed registered nurses, licensed practical nurses, pharmacists, dietitians, social workers, registered sanitarians, fire safety experts, health care administrators, gerontologists, psychologists, physical and occupational therapists, activity therapists, speech and language pathologists, audiologists, and high school instructors who are approved by the administration in their respective districts to teach health occupation courses.

(b) A program trainer shall have at least one year of work experience in the area the program trainer will provide training.

(c) A program trainer shall work under the general supervision of the primary instructor.

(3) TRAINING COURSE FOR PRIMARY INSTRUCTORS. Application for approval of a training course for primary instructors shall be made on a form provided by the department. The department shall review an application for approval of a training course for primary instructors and shall approve or deny the application within 90 days after receiving the application. The application shall include documentation of all of the following:

(a) The instructor shall be a registered nurse licensed to practice in Wisconsin and have at least 2 years of experience as an instructor of nursing practice or nurse aides.

(b) The course shall be a minimum of 16 hours in length.

(c) The training course shall include the following areas:

1. The principles of adult learning and training techniques.

2. Formulating training objectives, including behavior objectives which state measurable performance criteria to provide a basis for competency evaluation.

3. Designing the curriculum to provide a logical organization of the material to be covered.

4. Developing lesson plans.

5. Choosing appropriate teaching strategies and methodologies.

6. Developing learning materials.

7. Applying methods for evaluating trainee learning.

8. Effectively supervising trainees' clinical practice.

9. Defining criteria for successful achievement of training program objectives, including development of oral and written examinations and development of methods for demonstrating skills based on behaviorally stated course objectives; and

10. Developing a recordkeeping system.

History: CR 08–042: cr. register November 2008 No. 635, eff. 12–1–08.

DHS 129.07 Standards for nurse aide training programs. (1) CURRICULUM. A training program shall include theory and practice in all of the following care areas:

(a) *Interpersonal communication and social interaction.* The program shall include the theory of and practice in communicating and interacting on a one–to–one basis with a client; serving as part of a team implementing client care objectives; demonstrating sensitivity to a client's emotional; social and psychological needs through directed interactions; and skills that enable expressions of age–appropriate behavior by allowing a client to make personal choices and by reinforcing behavior that supports a client's sense of dignity. After completion of this portion of the training program, a nurse aide shall do all of the following:

1. Identify the components of a caregiver–client relationship and be able to recognize and demonstrate understanding of all of the following:

a. The uniqueness of each client, in terms of that person's age, disability, family status, financial status, gender, marital status, race, and sexual orientation, and cultural, generational, social, ethnic, religious or other background, values or characteristics.

b. The needs of a client with Alzheimer's disease, dementia, mental illness, mental retardation or other cognitive disabilities or impairments.

c. Ways both nurse aides and clients can cope with stress.

d. What constitutes caregiver misconduct.

e. The messages conveyed by body language, speech and facial expressions.

2. Demonstrate an ability to establish effective relationships with clients and be able to do all of the following:

a. Communicate with clients in a respectful manner that affords clients dignity.

b. Explain procedures and activities to clients before carrying out those procedures or beginning those activities.

c. Demonstrate concern for clients who have long–term or disabling illnesses or who are dying.

d. Identify developmental tasks associated with the aging process.

3. Demonstrate an ability to use appropriate verbal and nonverbal communication skills with clients and be able to do all of the following:

a. Recognize effective listening techniques.

b. Distinguish assertive from aggressive responses.

c. Identify the difference between non–acceptable and acceptable touching during job performance.

d. Identify therapeutic interventions and specialized techniques for responding to client's wandering and confusion.

4. Recognize common barriers to communication, including language, vision changes, hearing loss, speech problems, memory loss, disorientation and pain.

5. Demonstrate an ability to promote the independence of clients within the limitations of their physical, mental and intellectual impairments by fostering self–help skills through appropriate responses to clients' attempts to provide self care, including recognizing clients' level of ability in self care activities.

6. Identify the role of the family and other persons of importance to the client in the client's care and as resources for client emotional support.

(b) *Basic nursing skills.* The program shall include the theory of and practice in basic nursing skills, including bed making, taking vital signs, measuring height and weight, caring for the client's environment, measuring fluid and nutrient intake and output, assisting in the provision of proper nutritional care, walking or transferring the client using body mechanics and appropriately selected equipment with regard to principles of client care ergonomics, and maintaining infection control and safety standards. A nurse aide shall do all of the following:

1. Use acceptable personal hygiene.

2. Recognize the components of working relationships.

3. Identify how and when to seek guidance, using the supervisory channels of communication within the facility or agency.

4. Use proper body mechanics.

5. Demonstrate an understanding of the meaning of common medical terms and abbreviations.

6. Observe and report changes in client behavior and physical status, including signs and symptoms of common diseases and conditions.

7. Recognize when a client may be choking and respond appropriately.

8. Recognize the normal physical and psychological changes associated with aging.

9. Identify the basic principles of nutrition and hydration.

10. Recognize and report deviations from a client's normal food and fluid intake and output.

11. Recognize the basic requirements of commonly prescribed therapeutic diets.

12. Use common measures to promote a client's skin integrity, considering the client's ethnicity, race and age.

13. Demonstrate appropriate techniques in walking, transferring, positioning and transporting clients.

14. Recognize and respond appropriately to unsafe environmental conditions, including damp floors, frayed electrical cords and loose hand rails.

15. Recognize and respond appropriately to emergency situations including following emergency evacuation procedures.

16. Demonstrate appropriate hand washing techniques.

17. Understand and use commonly used alternatives to restraints in accordance with current professional standards.

18. Maintain the safety and cleanliness of client care areas.

19. Make use of proper isolation technique.

20. Perform commonly accepted infection control practices, including proper gloving technique and proper disposal of blood and body fluids and secretions.

21. Make occupied and unoccupied beds.

22. Measure temperature, pulse and respiration.

23. Measure a client's weight and height.

24. Record objective information.

25. Apply nonprescription ointments to unbroken skin areas.

26. Recognize the general effects of prescribed routine medications.

27. Recognize therapeutic interventions and specialized non–pharmacological pain control interventions.

28. Assist with care of clients when death is imminent.

29. Assist with post–mortem care.

30. Maintain the safety and cleanliness of areas where food is stored.

(c) *Personal care skills.* The program shall include the theory of and practice in basic personal care skills, including bathing, mouth care, grooming, dressing, toileting, and assistance with eating, hydration and skin care. A nurse aide shall demonstrate the ability to do all of the following:

1. Give a complete or partial bed bath to a client and assist a client in taking a bath or a shower.

2. Provide care of the client's perineal area.

3. Apply appropriate oral hygiene practices when assisting a client with oral hygiene, including caring for the client's dentures.

4. Care for a client's nails, hair and skin.

5. Shave and shampoo a client, including applying nonprescription medicated shampoos.

6. Dress and undress a client.

7. Prepare a client for meals.

8. Assist in feeding a client, including helping a client use adaptive devices and feeding utensils and encouraging a client to eat nutritionally balanced meals.

9. Assist a client with bowel and bladder elimination.

(d) *Basic restorative services.* The program shall include the theory of and practice in providing restorative services. Basic restorative services include the application of assistive devices for ambulation; eating and dressing; maintenance of range of motion through appropriate exercises; proper turning and positioning both in bed and chair; proper transferring techniques; bowel and bladder training; and care and use of prosthetic devices such as hearing aids, artificial eyes and artificial limbs. A nurse aide shall demonstrate the ability to do all of the following:

1. Recognize the importance of bowel and bladder programs.

2. Recognize the method for maintaining and improving musculoskeletal functioning by promoting joint mobility, body align-

ment and movement, including being able to do all of the following:

a. Position clients by use of pillows, towel rolls, padding and footboards.

b. Perform simple range of motion exercises.

c. Assist clients in the use of crutches, walkers, wheelchairs, canes, prostheses and appliances.

3. Transfer clients safely and according to principles of patient care ergonomics and with proficiency in use of available equipment that is used to transfer clients.

Note: Equipment used to transfer clients includes, but is not limited to, mechanical lifts, friction reducing devices; wheelchairs and gait belts.

4. Reinforce breathing exercises, including coughing and deep breathing.

5. Help clients use hearing aids and visual aids.

(e) *Rights of clients.* 1. The program shall provide instruction on the principles of and requirements relating to clients' rights. The nurse aide shall demonstrate an understanding of all of the following obligations:

a. Providing privacy for clients in treatment, living arrangements and personal care needs.

b. Maintaining the confidentiality of client health and personal records.

c. Allowing clients to make personal choices to accommodate the clients' needs.

d. Providing help clients need in getting to and participating in activities, including client and family group meetings.

e. Maintaining the personal possessions of clients in good and secure condition.

f. Interacting with clients without abusing or neglecting the clients.

g. Interacting with clients without misappropriating the clients' property.

h. Immediately reporting to appropriate facility or agency staff every instance of abuse or neglect of a client or misappropriation of a client's property as defined in s. DHS 13.03 (1), (12), and (14).

2. The nurse aide shall demonstrate behavior that recognizes that clients have rights and that the aide respects those rights. The nurse aide shall do all of the following:

a. Demonstrate respect and concern for each client's rights, preferences and awareness of age, color, disability, family status, financial status, gender, marital status, race, sexual orientation, and ethnic, cultural, social, generational and religious differences.

b. Show respect for cultural, ethnic and religious food preferences.

c. Recognize what constitutes abuse of clients and demonstrate an understanding of how to interact with clients without abusing them or without appearing to abuse them.

d. Demonstrate prevention and intervention skills with combative clients that balance appropriate client care with a need to minimize the potential for injury to the aide and others.

e. Recognize the role of state and federal regulatory agencies in licensing or otherwise approving providers and in investigating complaints of abuse of client property.

f. Demonstrate an understanding of the process by which a client or staff member may file a complaint on behalf of a client and seek redress for a perceived violation of client rights.

g. Recognize the role of client advocacy groups as client resources.

h. Demonstrate awareness of how to file a complaint with the department regarding operations within the provider setting.

(f) *Dementias.* The program shall include instruction about dementia and specific techniques for meeting the basic needs of clients with dementia. The nurse aide shall demonstrate an understanding of all of the following:

1. The nature of dementia, including the cause, course and symptoms of the impairment. The effects that brain changes have on the person's moods, abilities and functioning.

2. The effects on the client of staff verbal and nonverbal communication with the client and means of modifying these communications and approaches to facilitate effective interaction between clients and staff.

3. The feeding and fluid intake problems associated with dementia and the specialized techniques for addressing those problems.

4. The effect of the environment on clients with dementia and the appropriate environmental stimuli to use with those clients to reduce stress and maximize normal functioning and how to incorporate strategies that preserve function and prevent excess disability.

5. Possible causes of dementia related symptomatic behavior changes, specifically focusing on understanding behavior as an attempt to communicate unmet needs and then how to address the unmet need including an understanding of how pain impacts behavior.

6. Ways to help the person with dementia continue meaningful involvement in his or her day, the importance of structure and routine and the incorporation of the person's life story and past interests, routines, tastes, values and background.

7. The stress involved for the client, family and nurse aide in caring for a client with dementia and techniques for coping with this stress and ways to address the person with dementia's core needs of having self-esteem boosted, being useful, giving and receiving love, and caring for self and others.

(2) PROGRAM OPERATION. (a) *Class setting.* 1. Programs shall ensure that classrooms and lab facilities are adequate to meet the needs of the program, based on the number of students enrolled and how the classroom space is used. Programs shall ensure that classroom and skills labs have adequate temperature controls, clean and safe conditions, adequate space to accommodate students, adequate lighting, and all training equipment needed, including audiovisual equipment and any equipment needed for simulating resident care. Lab equipment shall be in the skill lab at all times necessary for demonstration, practice, and student demonstration. Any area designated as a classroom or lab in a facility-based program shall be an area that is not designated for resident care.

2. The program shall have qualified faculty members for both the classroom and the skills portion of the program.

3. The program shall have reasonable accommodations for students and prospective students with handicapping conditions.

(b) *Program standards.* 1. A training program shall be a minimum of 120 hours in length. This requirement includes at least 32 hours of clinical experience in a clinical setting approved by the department. The first 16 hours of training shall be provided in a classroom setting before a student has direct contact with clients. Tours of a facility including observations of clients and day-to-day facility activities may be incorporated into the classroom hours. Competency evaluation and provider orientation may not be counted toward meeting the 120-hour minimum requirement.

2. The program shall cover all of the following during the first 16 hours of classroom training:

a. Communication and interpersonal skills.

b. Infection control.

c. Safety and emergency procedures.

d. Promoting residents' independence.

e. Residents' rights.

3. A health care provider may employ a student as a nurse aide after the student has completed 16 hours of classroom training in the topics in subd. 2., and if the student is a full-time permanent employee, and is enrolled in an approved training program. The training program shall provide the health care provider with veri-

fication that the program has provided the instruction specified in subd. 2.

4. The program shall provide notification to students sponsored by Medicaid–certified nursing facilities that the students are not responsible for any costs associated with training, including deposits for textbooks or supplies used.

(c) *Clinical setting.* Before a student performs any client–related services, the RN primary instructor shall determine that the student has been trained and found proficient in providing those services. The training program shall ensure all of the following:

1. Access to a clinical setting approved by the department that is adequate to meet the needs of the program.

a. Clinical settings shall be in compliance with state and federal law. The program designee or primary instructor and the health care provider with whom the program has contracted are responsible for verifying that the clinical facility is in compliance with state and federal law. This verification shall be documented in the program's files and shall be available during the evaluation process.

b. The agreement between the program and the clinical setting shall be reviewed and renewed annually by the department and upon any change of facility or school administration. A copy of the agreement shall be submitted to the department.

c. During classroom and lab instructions, students shall be oriented to the various forms used to document resident information. Instructors shall supervise documentation on the appropriate flow sheets and forms during the clinical rotation.

d. Before a student begins a clinical rotation, the primary instructor shall evaluate and document that the student successfully demonstrated the ability to perform a skill.

e. Students may not give hands–on care to a resident who is not assigned to the student unless the student is under the direct supervision of the primary instructor.

f. Students who are under the general supervision of the primary instructor may be paired, during the student's clinical rotation, with nurse aides who are employed by the health care provider.

g. Students shall maintain safe practices, infection control and respect resident rights at all times.

h. Students shall demonstrate knowledge regarding their assigned residents' diagnoses and identified needs.

i. Students and instructors shall wear clothing that is in compliance with program policy and that is appropriate for performing resident care. The clothing shall include a nametag that designates the name of the nurse aide training program and the person's status as a student or instructor.

j. The scheduled clinical hours shall provide experiences that meet expected outcomes outlined in the program curriculum.

k. The length of the clinical day may not exceed 8 hours.

L. A health care facility may serve as the site of clinical instruction for up to 2 nurse aide training programs at the same time, except that the department may decide to allow more than 2 programs at a single health care facility on a case–by–case basis in conjunction with the facility's administrative staff.

m. The program shall not be used as a substitute for staff orientation or staff education programs.

2. An adequate number of primary instructors in the clinical setting to provide safe and effective supervision and assistance of students.

a. Primary instructors shall not function in another role while supervising students in the clinical setting.

b. A ratio of 6 to 8 students per instructor is considered to be adequate in most circumstances.

c. The primary instructor shall evaluate and document that a student demonstrated successfully the ability to perform a skill before the student begins a clinical rotation.

d. The primary instructor shall make all student clinical assignments with the approval of the health care provider. The instructor shall complete a review of each resident's chart to retrieve pertinent information needed by the students to provide the required cares. Care plan information shall be reviewed at the beginning of each clinical experience and shall include new orders or changes in each resident's status.

e. A student's assignment shall be shared with the clinical setting to which the student is assigned before the student arrives at the clinical setting.

f. Each student shall be given an individual assignment. More than 2 students shall not be assigned to the same resident at the same time.

g. Clinical assignments shall include all of the following:

i. Care of clients with varied levels of care needs.

ii. The opportunity to be evaluated on organizational skills and time management.

h. The RN primary instructor is responsible for supervising the clinical performance of each LPN program trainer.

(d) *Nursing home–based program.* Training of nurse aides may be performed under the general supervision of the director of nursing for a facility; however, the director of nursing may not act as the primary instructor or as a program trainer. Instructors shall not be involved in more than one role while supervising students in the clinical area.

(e) *Expectations and records.* 1. The training program shall maintain a list of the skills and a summary of the knowledge that a student will complete by the end of the training program.

2. On the list of skills, the primary instructor shall verify, by initialing and dating each individual skill, that the student has satisfactorily performed that skill. When a student has satisfactorily completed all required skills and competencies and attained the necessary knowledge, as well as achieved the stated course completion criteria, the trainee qualifies to enter a competency evaluation program.

3. The primary instructor shall provide a copy of the student's performance record to the student at the conclusion of the student's training.

(f) *Record retention.* The training program shall retain all records required by this section for a period of at least 3 years after a student completes the training program.

History: CR 08–042: cr. register November 2008 No. 635, eff. 12–1–08; correction in (1) (e) 1. h. made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; renumbering in (2) (c) 2. g. made under s. 13.92 (4) (b) 1., Stats., Register November 2008 No. 635.

DHS 129.08 Standards for nurse aide competency evaluation programs. (1) EXAMINER QUALIFICATIONS. The examiner conducting the clinical competency program of a student shall be an RN with at least one year experience caring for the elderly or chronically ill of any age.

(2) WRITTEN OR ORAL EVALUATION COMPONENT. (a) The RN examiner will give each student instructions for the written or oral evaluation component. After the student's written or oral evaluation has begun, the RN may designate another person to proctor the written or oral evaluation.

(b) The competency evaluation program shall develop a pool of test questions that addresses all 6 content areas and their components under s. DHS 129.07 (1). The test questions shall include enough questions to form 3 separate and complete examinations.

(c) The competency evaluation program shall develop written and oral examinations from the pool of test questions. The content of the written and oral examinations shall reflect the content and emphasis of the training program approved by the department.

(d) The competency evaluation program shall provide students with written and oral examinations in English. If the student will be working in a provider setting in which the predominant lan-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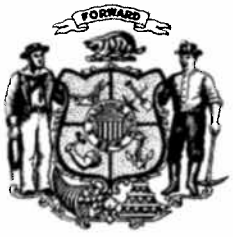
FORWARD

SB470?

Chapter DHS 83

COMMUNITY–BASED RESIDENTIAL FACILITIES

Note: Chapter HSS 3 as it existed on June 30, 1996 was repealed and a new chapter HFS 83 was created effective July 1, 1996 and corrections were made under s. 13.93 (2m) (b) 1., 6. and 7., Stats., Register, July, 1996, No. 487. Corrections made under s. 13.93 (2m) (b) 6., 7. and 14., Stats., Register, November, 1996, No. 491. Corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, October, 1999, No. 526. Chapter HFS 83 was renumbered to chapter DHS 83 under s. 13.92 (4) (b) 1., Stats., and corrections made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635. **Chapter DHS 83 as it existed on March 31, 2009 was repealed and a new chapter DHS 83 was created effective April 1, 2009, and corrections made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.**

Subchapter I — General Provisions

DHS 83.01 Authority and purpose. (1) This chapter is promulgated under the authority of s. 50.02 (2), Stats., to develop and establish regulations and standards for the care, treatment or services, and health, safety, rights, welfare, and comfort of residents in CBRFs.

(2) The chapter is intended to ensure all CBRFs provide a living environment for residents that is as homelike as possible and is the least restrictive of each resident's freedom; and that care and services a resident needs are provided in a manner that protects the rights and dignity of the resident and that encourages the resident to move toward functional independence in daily living or to maintain independent functioning to the highest possible extent.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.02 Definitions. In this chapter:

(1) "Abuse" has the meaning given in s. 46.90 (1), Stats.

(2) "Accessible" means barriers are not present that prevent a person from entering, leaving or functioning within a CBRF without physical help.

(3) "Activities of daily living" means bathing, eating, oral hygiene, dressing, toileting and incontinence care, mobility and transferring from one surface to another such as from a bed to a chair.

(4) "Administrator" means an employee, including the licensee, or an employee designated by the licensee, who is responsible for the management and day–to–day operation of the CBRF.

(5) "Adult" means an individual who is at least 18 years of age.

(6) "Ambulatory" means the ability to walk without difficulty or help.

(7) "Apartment" means a living space with separate living, toileting and sleeping areas.

(8) "Applicant" means the person seeking licensure of a CBRF.

(9) "Area of refuge" means a room or stairwell landing for residents who cannot negotiate stairs, used for safe, temporary refuge in a fire or other emergency to await instruction or assistance.

(10) "Assessment" means gathering and analyzing information about a prospective or existing resident's needs and abilities.

(11) "Basement" means that portion of a building that is partly or completely below grade.

(12) "Care, treatment or services" means the provision of personal care, supervision, supervision of medication administration, management, or assistance to a resident by the CBRF, an employee, or by a person, agency or corporation affiliated with or under contract to the operator that is above the level of room and board.

(13) "Caregiver" has the meaning given in s. 50.065 (1) (ag), Stats.

(14) "Case manager" means a person who plans, coordinates and oversees the care of a resident.

(15) "Chemical restraint" means a psychotropic medication used for discipline or convenience, and not required to treat medical symptoms.

(16) "Client group" means individuals who need similar services because of a common disability, condition or status. Client groups include individuals:

(a) With functional impairments that commonly accompany advanced age.

(b) With irreversible dementia, such as Alzheimer's disease.

(c) Who have a developmental disability as given in s. 51.01 (5), Stats.

(d) Who are emotionally disturbed or who have a mental illness as given in s. 51.01 (13) (a), Stats.

(e) Who are alcoholic as given in s. 51.01 (1), Stats., or who are drug dependent as defined in s. 51.01 (8), Stats.

(f) With physical disabilities.

(g) Who are pregnant and in need of counseling services.

(h) Under the legal custody of a government correctional agency or under the legal jurisdiction of a criminal court.

(i) Diagnosed as terminally ill.

(j) With traumatic brain injury.

(k) With acquired immunodeficiency syndrome (AIDS).

(17) "Common dining and living space" means areas of the CBRF that are available to all residents for living and dining.

(18) "Community–based residential facility" or "CBRF" has the meaning given in s. 50.01 (1g), Stats.

(19) "Department" means the Wisconsin department of health services.

(20) "Dietary supplement" means a product taken by mouth that contains a dietary ingredient such as vitamins, minerals, herbs or other botanicals, amino acids, and substances such as enzymes, organ tissues, glandulars, and metabolites.

(21) "Dietitian" means a person certified under subch. V of 448, Stats.

(22) "Employee" means any person who works for a CBRF or for an entity that is affiliated with the CBRF or that is under contract to the CBRF, who is under direct control of the CBRF or corporation affiliated with the CBRF and who receives compensation subject to state and federal employee withholding taxes.

(23) "Habitable floor" means any floor level used by residents or other occupants of the CBRF, for sleeping, living, cooking or dining, including a basement.

(24) "Habitable room" means any room used for sleeping, living, cooking or dining, excluding enclosed places such as closets, pantries, hallways, laundries, storage spaces, utility rooms and administrative offices.

(25) "Horizontal evacuation" means egress travel from one building to an area in another building on approximately the same level, or egress travel through or around a wall or partition which affords safety from fire and smoke to an area on approximately the same level in the same building.

(26) "Intermediate level nursing care" means care that is required by a person who has a long–term illness or disability who has reached a relatively stable condition.

(27) "Involuntary administration of psychotropic medication" means any one of the following:

(a) Placing psychotropic medication in an individual's food or drink with knowledge that the individual protests receipt of the psychotropic medication.

(b) Forcibly restraining an individual to enable administration of psychotropic medication.

(c) Requiring an individual to take psychotropic medication as a condition of receiving privileges or benefits.

(28) "Legal representative" means a person who is any of the following:

(a) The health care agent under an activated power of attorney for health care under ch. 155, Stats.

(b) A person appointed as a durable power of attorney under s. 243.07, Stats.

(c) A guardian as given in s. 54.01 (10) to (12), Stats.

(29) "Medication administration" means the direct injection, ingestion or other application of a prescription or over–the–counter drug or device to a resident by a practitioner, the practitioner's authorized agent, CBRF employees or the resident, at the direction of the practitioner. Medication administration does not include reminders to take medication.

(30) "Misappropriation of property" has the meaning as given in s. DHS 13.03 (12).

(31) "Neglect" has the meaning as given in s. 46.90 (1) (f), Stats.

(32) "New construction" means construction for the first time of any building or addition to an existing building on or after the effective date of this chapter.

(33) "NFPA" means the National Fire Protection Association.

(34) "Non–ambulatory" means a person who is unable to walk, but who may be mobile with the help of a wheelchair or other mobility devices.

(35) "Nursing care" means nursing procedures, other than personal care, that a registered nurse or a licensed practical nurse performs directly on or to a resident.

(36) "Other occupant" means any person who lives and sleeps in the CBRF, but who is not a resident of the CBRF.

(37) "Personal care" means assistance with activities of daily living, but does not include nursing care.

(38) "Pharmacist" means an individual licensed under ch. 450, Stats.

(39) "Physical restraint" means any manual method, article, device, or garment interfering with the free movement of the resident or the normal functioning of a portion of the resident's body or normal access to a portion of the resident's body, and which the resident is unable to remove easily, or confinement of a resident in a locked room.

(40) "Practitioner" means a person licensed in Wisconsin to prescribe and administer drugs or licensed in another state and recognized by this state as a person authorized to prescribe and administer drugs.

(41) "Psychotropic medication" means a prescription drug, as given in s. 450.01 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior.

(42) "Qualified resident care staff" means an employee who has successfully completed all of the applicable training and orientation under subch. IV.

(43) "Relative" means a spouse, parent, stepparent, child, stepchild, sibling, grandchild, grandparent, aunt, uncle, niece, or nephew.

(44) "Remodeling" means to make over or rebuild a portion of a building, structure or room, thereby modifying its structural strength, fire hazard character, exiting, heating and ventilating systems, electrical system, fire alarm, and fire protection systems, call system, internal circulation or use as previously approved by

the department. Construction of interior walls shall be considered remodeling. Remodeling does not include minor repairs necessary for the maintenance of a building such as replacing like components of existing systems, redecorating existing walls or replacing floor finishes.

(45) "Reside" means the intent to remain in the CBRF permanently or continuously for more than 28 consecutive days.

(46) "Resident" means a person unrelated to the licensee or administrator who resides in the CBRF and who receives care, treatment or services in addition to room and board.

(47) "Resident care staff" means the licensee and all employees who have one or more of the following responsibilities for residents: supervising a resident's activities or whereabouts, managing or administering a resident's medications, providing personal care or treatments for a resident, planning or conducting training or activity programming for a resident. Resident care staff does not include volunteers and employees who work exclusively in the food service, maintenance, laundry service, housekeeping, transportation, or security or clerical areas, and employees that do not work on the premises of the CBRF.

(48) "Respite care" means a person's temporary placement in a CBRF for no more than 28 consecutive days for care, treatment or services as established by the primary care provider.

(49) "Room" means a space that is completely enclosed by walls and a ceiling.

(50) "Seclusion" means physical or social separation of a resident from others by actions of employees, but does not include separation to prevent the spread of communicable disease or voluntary cool–down periods in an unlocked room.

(51) "Semi–ambulatory" means a person is able to walk with difficulty or only with the assistance of an aid such as crutches, cane or a walker.

(52) "Significant change in a resident's physical or mental condition" means one or more of the following:

(a) Decline in a resident's medical condition that results in further impairment of a long term nature.

(b) Decline in 2 or more activities of daily living.

(c) A pronounced decline in communication or cognitive abilities.

(d) Decline in behavior or mood to the point where relationships have become problematic.

(e) Significant improvement in any of the conditions in pars. (a) to (d).

(53) "Standard precautions" means measures taken to reduce the risk of transmission of infection from contact with blood, body fluids or other moist body substances including all mucous membranes, non–intact skin, blood, all body fluids, secretions, and excretions except sweat, whether or not they contain visible blood.

(54) "Supervision" means oversight of a resident's daily functioning, keeping track of a resident's whereabouts and providing guidance and intervention when needed by a resident.

(55) "Terminal illness" means a medical prognosis issued in writing by a physician or other qualified medical professional that an individual's life expectancy is less than 12 months.

(56) "Therapeutic diet" means a food regimen ordered by a physician or other medical professional directed by the physician.

(57) "Unit dose" means medications packaged by a pharmacist in blister cards, punch cards, strip packaging, medication reminder boxes or other similar packaging where the medication dose is packaged in a pre–selected dose.

(58) "Utensils" means dishes, silverware and pots and pans used for preparing, serving or consuming food.

(59) "Volunteer" means any person who provides services for residents without compensation, except for reimbursement of expenses related to services provided at the CBRF.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09; correction in (30) made under 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

DHS 83.03 Variance and waiver. (1) In this section:

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

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

(2) EXCEPTION TO A REQUIREMENT. (a) The department may grant a waiver or variance if the department determines that the proposed waiver or variance will not jeopardize the health, safety, welfare or rights of any resident.

(b) A written request for a waiver or variance shall be sent to the department and include justification that the waiver or variance will not adversely affect the health, safety or welfare of any resident for the requested action.

(c) A written request for a variance shall include a description of an alternative means planned to meet the intent of the requirement.

Note: Send a request for a waiver or variance of a requirement of this chapter to the appropriate regional office of the Department's Division of Quality Assurance listed in Appendix A. Information about the Division of Quality Assurance can be found at: http://dhs.wi.gov/rl_dsl/bqainternet.htm

(3) The department may rescind a waiver or variance if any of the following occurs:

(a) The department determines the waiver or variance has adversely affected the health, safety or welfare of the residents.

(b) The CBRF fails to comply with any of the conditions of the waiver or variance as granted.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

Subchapter II — Licensing

DHS 83.04 Licensing categories. The department shall license each CBRF as follows:

(1) SIZE. (a) A CBRF for 5 to 8 residents is a small CBRF.

(b) A CBRF for 9 to 20 residents is a medium CBRF.

(c) A CBRF for 21 or more residents is a large CBRF.

(2) CLASSIFICATION. (a) *Class A ambulatory.* A class A ambulatory CBRF serves only residents who are ambulatory and who are mentally and physically capable of responding to a fire alarm by exiting the CBRF without any help or verbal or physical prompting.

(b) *Class A semi–ambulatory (AS).* A class A semi–ambulatory CBRF serves only residents who are ambulatory or semi–ambulatory and who are mentally and physically capable of responding to a fire alarm by exiting the CBRF without any help or verbal or physical prompting.

(c) *Class A non–ambulatory (ANA).* A class A non–ambulatory CBRF serves residents who are ambulatory, semi–ambulatory or non–ambulatory and who are mentally and physically capable of responding to a fire alarm by exiting the CBRF without any help or verbal or physical prompting.

(d) *Class C ambulatory (CA).* A class C ambulatory CBRF serves only residents who are ambulatory but one or more of whom are not mentally capable of responding to a fire alarm by exiting the CBRF without any help or verbal or physical prompting.

(e) *Class C semi–ambulatory (CS).* A class C semi–ambulatory CBRF serves only residents who are ambulatory or semi–ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting.

(f) *Class C non–ambulatory (CNA).* A class C non–ambulatory CBRF serves residents who are ambulatory, semi–ambulatory or non–ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.05 Application requirements. (1) No person may conduct, maintain, operate or permit to be maintained or operated a CBRF unless the CBRF is licensed by the department. A person who assumes ownership interest in a CBRF, regardless of whether the transfer includes title to the real estate, or changes the location of the CBRF shall complete an application as required under sub. (2).

(2) An application for initial licensure shall be on a form provided by the department and shall be accompanied by all of the following:

(a) A program statement as specified under s. DHS 83.06 (1).

(b) A floor plan specifying dimensions of the CBRF, exits and planned room usage.

(c) A fire inspection form.

(d) All required fees.

(e) A balance sheet.

(f) Evidence that the applicant has 60 days of projected operating funds in reserve.

(g) Any additional information requested by the department.

Note: A copy of the application form can be obtained at http://dhs.wisconsin.gov/rl_dsl/CBRF/CBRFinqResp.htm or by contacting the Division of Quality Assurance Regional Office listed in Appendix A.

(3) The applicant shall provide evidence to the department that the license applicant has made a good faith effort to establish a community advisory committee under s. 50.03 (4) (g), Stats.

(4) A CBRF may not be located on a parcel of land zoned for commercial, industrial or manufacturing use.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.06 Program statement. (1) CONTENT. The program statement shall accurately include all of the following:

(a) The name of the licensee, the administrator and the staff position in charge when the licensee or administrator is away from the CBRF.

(b) Employee availability, including 24 hour staffing patterns and the availability of a licensed nurse, if any.

(c) The resident capacity of the CBRF.

(d) The class of the CBRF under s. DHS 83.04 (2).

(e) The client group to be served. If serving more than one client group, the program statement shall include an explanation acceptable to the department of how the client groups are compatible with one another.

(f) A complete description of the program goals and services consistent with the needs of residents.

(g) Limitations of services, including the criteria for determining who may reside in the CBRF.

(h) Respite care services, if provided.

(2) AVAILABILITY. (a) Before finalizing an agreement to provide care, the CBRF shall provide its program statement to each person seeking placement or to the person's legal representative. CBRFs serving only clients of a government correctional agency are exempt from paragraph (a).

(b) The program statement shall be available to employees, to residents and to any other person upon request.

(3) CHANGE IN PROGRAM STATEMENT. Any change in the program statement content under sub. (1) shall be submitted to the department at least 30 days before its effective date.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.07 Fit and qualified. (1) ELIGIBILITY. An applicant may not be licensed unless the department determines the applicant is fit and qualified to operate a CBRF.

(2) STANDARDS. In determining whether a person is fit and qualified, the department shall consider all of the following:

(a) *Compliance history.* Compliance history with Wisconsin or any other state's licensing requirements and with any federal certification requirements, including any license revocation or denial.

(b) *Criminal history.* Arrest and criminal records, including any of the following:

1. Crimes or acts involving abuse, neglect or mistreatment of a person or misappropriation of property of the person.

2. Crimes or acts subject to elder abuse reporting under s. 46.90, Stats.

3. Crimes or acts related to the manufacture, distribution, prescription, use, or dispensing of a controlled substance.

4. Fraud or substantial or repeated violations of applicable laws and rules in the operation of any health care facility or in the care of dependent persons.

5. A conviction or pending criminal charge which substantially relates to the care of adults or minors, to the funds or property of adults or minors, or to the operation of a residential or health care facility.

(c) *Financial history.* Financial stability, including

1. Financial history and financial viability of the owner or related organization.

2. Outstanding debts or amounts due to the department or other government agencies, including unpaid forfeitures and fines.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.08 Department action. (1) INITIAL LICENSE. (a) Within 70 days after receipt of a complete application, the department shall either approve or deny the license. The initial license issued by the department to an applicant may be a probationary license.

(b) A probationary or regular license issued by the department shall be only for the premises and persons named in the application. A license may not be transferred or assigned.

(c) A probationary license may be valid for up to 12 months, unless sooner revoked.

(d) A regular license is valid until suspended or revoked by the department.

(2) LICENSE DENIAL. The department shall deny a probationary or regular license to any applicant who does not substantially comply with any provision of this chapter or ch. 50, Stats., or who is not fit and qualified as specified in s. DHS 83.07 or who has failed to pay any fee or any outstanding amounts due to the department. The department shall provide the reasons for denial and the process for appeal of the denial in a written notice to the applicant.

(3) LICENSE REVOCATION. The department may revoke a license for any of the reasons and under the conditions specified under s. 50.03 (5g) (d) to (g), Stats.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.09 Biennial report and fees. Every 24 months, on a date determined by the department, the licensee shall submit a biennial report on the form provided by department, and shall submit payment of the license continuation fees.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.10 Change of ownership. (1) DUTIES OF THE TRANSFEROR. (a) The transferor shall notify the department within 30 days before the final change of ownership of a CBRF and shall include the name and contact information of the transferee.

(e) A valid nursing home administrator's license issued by the department of regulation and licensing.

(2) Persons who are the qualified administrator of record with the department of a CBRF on April 1, 2009, shall be exempt from the qualification requirements specified under sub. (1).

(3) RESPONSIBILITIES. (a) The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.

(b) The administrator shall be responsible for the training and competency of all employees.

(c) A qualified resident care staff shall be designated as in charge whenever the administrator is absent from the CBRF.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.16 Employee. (1) Each employee shall have the skills, education, experience and ability to fulfill the employee's job requirements.

(2) Resident care staff shall be at least 18 years old.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.17 Hiring and employment. (1) CAREGIVER BACKGROUND CHECK. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department's rehabilitation process as defined in ch. DHS 12.

(2) EMPLOYEE HEALTH COMMUNICABLE DISEASE CONTROL. (a) The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.

(b) Employees shall be re–screened for clinically apparent communicable disease as described in par. (a) based on the likelihood of exposure to communicable disease, including tuberculosis.

(c) A person who has a communicable disease shall not be permitted to work or be present in the CBRF if the disease would present a risk to the health or safety of residents.

Note: For information from the center for disease control and prevention regarding screening for tuberculosis go to http://www.cdc.gov/

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09; corrections in (1) made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

DHS 83.18 Employee records. (1) A separate record for each employee shall be maintained, kept current, and at a minimum, include:

(a) A written job description including duties, responsibilities and qualifications required for the employee.

(b) Beginning date of employment.

(c) Educational qualifications for administrators.

(d) A completed caregiver background check following procedures under s. 50.065, Stats., and ch. DHS 12.

(e) Documentation of training, or exemption verification.

(2) Employee records shall be available upon request at the CBRF for review by the department.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09; correction in (1) (d) made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

Subchapter IV — Orientation and Training

DHS 83.19 Orientation. Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following:

(1) Job responsibilities.

(2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property.

(3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible.

(4) Emergency and disaster plan and evacuation procedures under s. DHS 83.47 (2).

(5) CBRF policies and procedures.

(6) Recognizing and responding to resident changes of condition.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.20 Department–approved training. (1) APPROVED TRAINING. (a) Training for standard precautions, fire safety, first aid and choking, and medication administration and management shall be approved by the department or designee and shall be provided by trainers approved by the department or designee. Approvals for training plans and trainers for standard precautions, fire safety, first aid and choking, and medication administration and management issued before April 1, 2009, shall expire April 1, 2010.

(b) The CBRF shall maintain documentation of the training in par. (a), including the trainer approval number, the name of the employee, training topic and the date training was completed.

(2) APPROVED COURSES. (a) *Standard precautions.* All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non–intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material.

(b) *Fire safety.* Within 90 days after starting employment, all employees shall successfully complete training in fire safety.

(c) *First aid and choking.* Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking.

(d) *Medication administration and management.* Any employee who manages, administers or assists residents with prescribed or over–the–counter medications shall complete training in medication administration and management prior to assuming these job duties.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.21 All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following:

(1) RESIDENT RIGHTS. Training shall include general rights of residents including rights as specified under s. DHS 83.32 (3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self–determination, and the CBRF's complaint and grievance procedures. Residents' rights training shall be completed within 90 days after starting employment.

(2) CLIENT GROUP. (a) Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment.

(b) In a CBRF serving more than one client group, employees shall receive training for each client group.

(3) RECOGNIZING, PREVENTING, MANAGING AND RESPONDING TO CHALLENGING BEHAVIORS. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self–injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09; correction in (1) made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

DHS 83.22 Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following:

(1) ASSESSMENT OF RESIDENTS. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment.

(2) INDIVIDUAL SERVICE PLAN DEVELOPMENT. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident's needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress.

(3) PROVISION OF PERSONAL CARE. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring.

(4) DIETARY TRAINING. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.23 Employee supervision. Until an employee has completed all required training, the employee shall be directly supervised by the administrator or by qualified resident care staff.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.24 Exemptions. (1) EXEMPTIONS FOR COMPLETED TRAINING. Employees who have completed department–approved training in standard precautions, fire safety, first aid and choking, and medication administration and management prior to or on April 1, 2009, or who receive such training within one year after April 1, 2009, shall be exempt from the training specified under s. DHS 83.20 (2).

(2) GENERAL EXEMPTIONS. A practitioner, licensed pharmacist, registered nurse or licensed practical nurse is exempt from training specified in ss. DHS 83.20 (2) (a), (c) and (d), 83.21 and 83.22.

(3) EXEMPTIONS FROM STANDARD PRECAUTIONS TRAINING. Except as stated in subs. (1) and (2), the following individuals are exempt from training in standard precautions:

(a) Emergency medical technicians.

(b) Employees who can provide documentation that they have had training from a regulated health care entity in the practice of standard precautions within the previous year.

(c) A nurse aide certified after 1999 and in good standing on the Wisconsin Nurse Aide Registry.

(4) EXEMPTIONS FROM FIRE SAFETY TRAINING. Except as stated under sub. (1), firefighters are exempt from training in fire safety.

(5) EXEMPTIONS FROM FIRST AID AND CHOKING TRAINING. Except as stated in subs. (1) and (2), the following individuals are exempt from training in first aid and choking:

(a) Emergency medical technicians.

(b) Student nurses who have successfully completed related training.

(6) EXEMPTIONS FROM MEDICATION ADMINISTRATION AND MANAGEMENT TRAINING. Except as stated under subs. (1) and (2), the following individuals are exempt from medication administration and management training:

(a) Nurse aides who have completed a medication aide training program and are in good standing on the Wisconsin Nurse Aide Registry.

(b) Student nurses currently enrolled in a nursing program that has successfully completed a medication administration course.

(c) Other licensed health care persons whose licensure and scope of practice allows medication administration.

Note: See ch. DHS 129 for medication aide training standards.

(7) EXEMPTIONS FROM CLIENT GROUP TRAINING, RESIDENT RIGHTS TRAINING, AND CHALLENGING BEHAVIOR TRAINING. Except as specified under subs. (1) and (2), all of the following individuals are exempt from client group training, resident rights training and challenging behavior training:

(a) Licensed nursing home administrators.

(b) Substance abuse counselors as defined under s. RL 160.02 (26).

(c) Employees with a degree in social work, psychology or a similar human services field.

(d) Student nurses who have successfully completed related courses.

(e) A nurse aide in good standing on the Wisconsin Nurse Aide Registry.

(8) EXEMPTION FROM PROVISION OF PERSONAL CARE TRAINING. A nurse aide in good standing on the Wisconsin Nurse Aide Registry is exempt from provision of personal care training.

(9) EXEMPTIONS FROM ASSESSMENT AND INDIVIDUAL SERVICE PLAN DEVELOPMENT TRAINING. Except under subs. (1) and (2), the following individuals are exempt from assessment and individual service plan development training:

(a) Licensed nursing home administrators

(b) Substance abuse counselors as defined under s. RL 160.02 (26).

(c) Employees with a degree in social work, psychology or a similar human services field.

(d) Student nurses who have successfully completed related courses.

(10) EXEMPTIONS FROM DIETARY TRAINING. Except under subs. (1) and (2), the following individuals are exempt from training in determining dietary needs, menu planning, food preparation and sanitation:

(a) Registered dietitians.

(b) Employees whose only responsibility is delivering meals.

(c) Employees who have completed an associate in applied science degree in culinary arts.

(d) A certified dietary manager.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.25 Continuing education. The administrator and resident care staff shall receive at least 15 hours per calendar

year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following:

(1) Standard precautions.

(2) Client group related training.

(3) Medications.

(4) Resident rights.

(5) Prevention and reporting of abuse, neglect and misappropriation.

(6) Fire safety and emergency procedures, including first aid.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

DHS 83.26 Documentation. (1) The CBRF shall maintain documentation of all employee training under s. DHS 83.21 and task specific training under s. DHS 83.22 and shall include the name of the employee, the name of the instructor, the dates of training, a description of the course content, and the length of the training.

(2) Employee orientation and hours of continuing education shall be documented in the employee's file.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09.

Subchapter V — Admission, Retention and Discharge

DHS 83.27 Limitations on admissions and retentions. (1) LICENSE CAPACITY. (a) No CBRF may have more residents, including respite care residents, than the maximum bed capacity on its license.

(b) The CBRF may not have more than 4 residents, or 10% of the licensed capacity, whichever is greater, who need more than 3 hours of nursing care per week or care above intermediate level nursing care for not more than 30 days unless the facility has obtained a waiver from the department or the department has received a request for a waiver from the CBRF and the department's decision is pending.

(2) ADMISSION AND RETENTION LIMITATIONS. A CBRF may not admit or retain any of the following persons:

(a) A person who has an ambulatory or cognitive status that is not compatible with the license classification under s. DHS 83.04 (2).

(b) A person who is destructive of property or self, or who is physically or mentally abusive to others, unless the CBRF has sufficient resources to care for such an individual and is able to protect the resident and others.

(c) A person who has physical, mental, psychiatric or social needs that are not compatible with the client group as described in the CBRF's program statement.

(d) A person who needs more than 3 hours of nursing care per week except for a temporary condition needing more than 3 hours of nursing care per week for no more than 30 days. If the CBRF requests a waiver or variance, the department may grant a waiver or variance to this requirement, as described under s. DHS 83.03, if the following conditions are met:

1. The resident's clinical condition is stable and predictable, does not change rapidly, and medical orders are unlikely to involve frequent changes or complex modifications and the resident's clinical condition is one that may be treatable, or the resident has a long–term condition needing more than 3 hours of nursing care per week for more than 30 days.

2. The resident is otherwise appropriate for the level of care provided in the CBRF.

3. The services needed to treat the resident's condition are available in the CBRF.

(e) A person whose condition requires 24–hour supervision by a registered nurse or licensed practical nurse.

(f) A person whose condition requires care above intermediate level nursing care.

(g) A person who requires a chemical or physical restraint except as authorized under s. 50.09 (1) (k), Stats.

(h) A person who is incapacitated, as defined under s. 50.06 (1), Stats., unless the person has a health care agent under a valid and properly activated power of attorney for health care under ch. 155, Stats., or a court appointed guardian under ch. 54, Stats., except for the admission of an incapacitated individual who does not have such a legal representative, and who is admitted directly from the hospital according to the provision of s. 50.06, Stats.

(i) A person who resides in a CBRF licensed for 16 or more residents, and has been found incompetent under ch. 54, Stats., and does not have a court–ordered protective placement under s. 55.12, Stats.

(3) ADMISSION OF MINORS. The CBRF may not admit a person under 18 years of age without written approval of the department and only if any of the following apply:

(a) The CBRF is also licensed under ch. DCF 57 as a group foster care home or under ch. DCF 52 as a residential care center for children and youth.

(b) The minor has been waived to an adult court under s. 938.18, Stats.

(c) The minor is the child of an adult resident. When the minor child of an adult resident resides in a CBRF, all of the following shall apply:

1. The adult resident retains custody and control of the child.

2. The CBRF shall have written policies related to the presence of minors in the CBRF, including policies on parental responsibility, school attendance and any care, treatment or services provided to the minors by the CBRF.

History: CR 07–095: cr. Register January 2009 No. 637, eff. 4–1–09; corrections in (3) (a) made under 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

DHS 83.28 Admission procedures. (1) ASSESSMENT. The CBRF shall assess each resident before admission as required under s. DHS 83.35 (1).

(2) SERVICES AND CHARGES. Before or at the time of admission, the CBRF shall provide written information regarding services available and charges for those services as required in s. DHS 83.29 (1).

(3) ADMISSION AGREEMENT. Before or at the time of admission, the CBRF shall provide the admission agreement as required under s. DHS 83.29 (2).

(4) HEALTH SCREENING. (a) *Resident health screening.* 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening.

2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards.

3. The CBRF shall maintain the screening documentation in each resident's record.

(b) *Respite care health screening.* 1. Within 90 days before or 7 days after admission for persons in respite care who will reside in the CBRF for more than 7 days, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each respite care person for clinically apparent communicable disease, including tuberculosis, and document the results of the screening.

2. If the person did not provide evidence of health screening required under subd. 1., prior to the second admission in a calendar year of a person in respite care, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each respite care person for clinically apparent communi-

cable disease, including tuberculosis, and document the results of the screening.

3. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards.

4. The CBRF shall maintain the screening documentation for each respite care person.

(5) TEMPORARY SERVICE PLAN. Upon admission, the CBRF shall develop a temporary service plan as required under s. DHS 83.35 (2).

(6) RESIDENT RIGHTS, GRIEVANCE PROCEDURE AND HOUSE RULES. Before or at the time of admission, the CBRF shall provide and explain resident rights, the house rules of the CBRF as required under s. DHS 83.32 (2), and the grievance procedure, including written information regarding the names, addresses and telephone numbers of all resident advocacy groups serving the client groups in the facility, including the long term care ombudsman program and the protection and advocacy services of Disability Rights Wisconsin, Inc.

(7) ADVANCED DIRECTIVES. At the time of admission, the CBRF shall determine if the resident has executed an advanced directive. An advanced directive describes, in writing, the choices about treatments the resident may or may not want and about how health care decisions should be made for the resident if the resident becomes incapacitated and cannot express their wishes. A copy of the document shall be maintained in the resident record as required under s. DHS 83.42 (1) (p). A CBRF may not require an advanced directive as a condition of admission or as a condition of receiving any health care service. An advanced directive may be a living will, power of attorney for health care, or a do-not-resuscitate order under chs. 154 or 155, Stats., or other authority as recognized by the courts of this state.

History: CR 07-095: cr. Register January 2009 No. 637, eff. 4-1-09.

DHS 83.29 Admission agreement. (1) SERVICES AND CHARGES. (a) *Definition.* In this section, "entrance fee" means a payment required for admission to the CBRF that is in addition to the fees for services and security deposit.

(b) *Written information regarding services and charges.* Before or at the time of admission, the CBRF shall provide written information regarding services available and the charges for those services to each resident, including persons admitted for respite care, or the resident's legal representative. This information shall include any charges for services not covered by the daily or monthly rate, any entrance fees, assessment fees and security deposit.

(c) *Written notice of any change in services or in charges.* The CBRF shall give the resident or the resident's legal representative a 30-day written notice of any change in services available or in charges for services that will be in effect for more than 30 days.

(2) ADMISSION AGREEMENT REQUIREMENTS. The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person's legal representative signing and dating an admission agreement. The admission agreement shall include all of the following:

(a) An accurate description of the basic services provided, the rate charged for those services and the method of payment.

(b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services.

(c) The method for notifying residents of a change in charges for services.

(d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency.

(e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge.

(f) A statement that the amount of the security deposit may not exceed one month's fees for services, if a security deposit is collected.

(g) Terms for holding and charging for a resident's room during a resident's temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency.

(h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency.

(3) REFUNDS. (a) The CBRF shall return all refunds due a resident under the terms of the admission agreement within 30 days after the date of discharge.

(b) During the first 6 months following the date of initial admission, the CBRF shall refund the entire entrance fee when the resident is discharged or when the resident meets the terms for notification to the CBRF of voluntary discharge as contained in the CBRF's admission agreement.

(4) CONFLICT WITH THIS CHAPTER. No statement of the admission agreement may be in conflict with any part of this chapter, unless the department has granted a waiver or variance of a provision of this chapter.

History: CR 07-095: cr. Register January 2009 No. 637, eff. 4-1-09.

DHS 83.30 Family care information and referral. If the secretary of the department has certified that a resource center, as defined under s. DHS 10.13 (42), is available for the facility under s. DHS 10.71, the CBRF shall provide information to prospective residents and refer residents and prospective residents to an aging and disability resource center as required under s. 50.035 (4m) to (4p), Stats., and s. DHS 10.73.

History: CR 07-095: cr. Register January 2009 No. 637, eff. 4-1-09; corrections made under 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

DHS 83.31 Discharge or transfer. (1) APPLICABILITY. This section applies to all resident discharges except for persons in respite care.

(2) EMERGENCY OR TEMPORARY TRANSFERS. If a condition or action of a resident requires the emergency transfer of the resident to a hospital, nursing home or other facility for treatment not available from the CBRF, the CBRF may not involuntarily discharge the resident unless the requirements under sub. (4) are met.

(3) DISCHARGE OR TRANSFER INITIATED BY RESIDENT. (a) Any competent resident may initiate transfer or discharge at any time in accordance with the terms of the admission agreement if the resident is not in the custody of a government correctional agency, committed under s. 51.20, Stats., or under a court-ordered protective placement under s. 55.12, Stats.

(b) If a resident found incompetent under ch. 54, Stats., protests the resident's admission or continued stay, the licensee or designee shall immediately notify the legal representative and the county protective services agency to obtain a determination about whether to discharge the resident under s. 55.055 (3), Stats.

(4) DISCHARGE OR TRANSFER INITIATED BY CBRF. (a) *Notice and discharge requirements.* 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section.

2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident.


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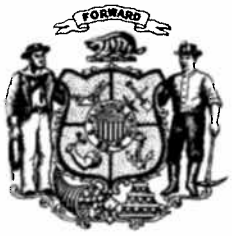
FORWARD

SB 470?

APPENDIX A

State-by-State Chart

The following chart provides an overview of dementia training requirements among the states. A check in the ALF (assisted living facility) or SNF (skilled nursing facility) columns indicates that some form of dementia-specific training beyond the state's CNA training standard is mandated. Some states have different training requirement for special care units (SCU) than for traditional ALFs or SNFs. Thus, a check in the SCU column indicates that a separate requirement exists for those facilities. For more information on your state's specific dementia training laws and regulations, please contact Laura Boone, laura.boone@alz.org.

State	ALF	SNF	SCU
Alabama	X		X (ALF)
Alaska			
Arizona	X		
Arkansas	X		X
California	X		X (ALF)
Colorado			
Connecticut			X
Delaware	X (Feeding assts)	X (Feeding assts)	
District of Columbia	X		
Florida	X	X	
Georgia	X		
Hawaii			
Idaho			X
Illinois			X
Indiana	X	X	
Iowa			X (ALF)
Kansas	X		
Kentucky	X		X (SNF)
Louisiana	X	X	X
Maine			X
Maryland	X	X	
Massachusetts	X		
Michigan			
Minnesota	X	X	
Mississippi	X	X	
Missouri	X	X	
Montana			X (ALF)
Nebraska	X		X (ALF)
Nevada	X	X	
New Hampshire			
New Jersey	X	X	X (ALF)
New Mexico			
New York			X (ALF)
North Carolina			X (ALF)
North Dakota			
Ohio			X (ALF)
Oklahoma			X (ALF)
Oregon	X	X	X (ALF)
Pennsylvania	X		
Rhode Island			X
South Carolina			X (ALF)
South Dakota			X (ALF)
Tennessee			X
Texas			X
Utah	X		X (ALF)
Vermont	X		X (ALF)
Virginia	X		X (ALF)
Washington	X	X	
West Virginia	X	X	X
Wisconsin			
Wyoming			X (ALF)