Chapter DHS 132

NURSING HOMES

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Note: Chapter H 32 as it existed on July 31, 1982 was repealed and a new chapter HFS 132 was created effective August 1, 1982. Chapter HSS 132 was renumbered chapter HFS 132 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, December, 1996, No. 492. Chapter HFS 132 was renumbered chapter DHS 132 under s. 13.92 (4) (b) 1., Stats., and corrections made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

Subchapter I — General

DHS 132.11 Statutory authority. This chapter is promulgated under the authority of ss. 49.498 (14), 49.499 (2m), 50.02, 50.03, 50.095, and 50.098, Stats., to provide conditions of licensure for nursing homes.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; CR 06−053: am. Register August 2007 No. 620, eff. 9−1−07.

DHS 132.12 Scope. All nursing homes licensed under s. 50.03, Stats., are subject to all the provisions of this chapter, except for those provisions that apply only to particular licensure categories, and except for those nursing homes regulated by ch. DHS 134. Nursing homes include those owned and operated by the state, counties, municipalities, or other public bodies. Nursing homes are also subject to the provisions in ch. 50, Stats., and chs. SPS 361 to 365, except s. SPS 361.31 (3). Federally certified nursing homes are also subject to the provisions contained in 42 CFR 483.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; CR 06−053: am. Register August 2007 No. 620, eff. 9−1−07; correction made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637; correction made under s. 13.92 (4) (b) 7., Stats., Register January 2012 No. 673.

DHS 132.13 Definitions. In this chapter:

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

(1m) "Advanced practice nurse prescriber" means a person who has been granted a certificate to issue prescription orders under s. 441.16 (2), Stats.

(2m) "Authorized prescriber" means a person licensed in this state to prescribe medications, treatments or rehabilitative therapies, or licensed in another state and recognized by this state as a person authorized to prescribe medications, treatments or rehabilitative therapies.

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

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

(a) Manifested before the individual reaches age 22;

(b) Likely to continue indefinitely; and

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

1. Self−care;
2. Understanding and use of language;
3. Learning;
4. Mobility;
5. Self−direction; and
6. Capacity for independent living.

(5) "Dietitian" means a person who is any of the following:

(a) Certified under s. 448.78, Stats.

(b) Licensed or certified as a dietitian in another state.

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

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

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

(8r) "Intensive skilled nursing care" means care requiring specialized nursing assessment skills and the performance of specific services and procedures that are complex because of the resident's condition or the type or number of procedures that are necessary, including any of the following:

(a) Direct patient observation or monitoring or performance of complex nursing procedures by registered nurses or licensed practical nurses on a continuing basis.

(b) Repeated application of complex nursing procedures or services every 24 hours.

(c) Frequent monitoring and documentation of the resident's condition and response to therapeutic measures.

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

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

(10m) "Involuntary administration of psychotropic medication" means any 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.

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

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

(13m) "Neglect" has the meaning specified under s. DHS 13.03 (14).

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

(17) "Nurse practitioner" means a registered professional nurse who meets the requirements of s. DHS 105.20 (1).

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

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

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

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

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

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

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

(25g) "Protest" means make more than one discernible negative response, other than mere silence, to the offer of, recommendation for, or other proffering of voluntary receipt of psychotropic medication. "Protest" does not mean a discernible negative response to a proposed method of administration of the psychotropic medication.

(25r) "Psychotropic medication" means a prescription drug, as defined in s. 450.01 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior.

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

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

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

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

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

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

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

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

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

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

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

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

3. A service that is generally unskilled would be considered skilled where, because of special medical complications, its performance or supervision or the observation of the resident necessitates the use of skilled nursing personnel.

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

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

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; emerg. renum. (3) to (24) to be (4) to (25), cr. (3), eff. 9−15−86; r. and recr. Register, January, 1987, No. 373, eff. 2−1−87; emerg. cr. (8m), eff. 7−1−88; am. (4), Register, February, 1989, No. 398, eff. 3−1−89; cr. (8m), Register, October, 1989, No. 406, eff. 11−1−89; correction made to (17) under s. 13.93 (2m) (b) 7., Stats., Register December 2003 No. 576; CR 04−053: r. and recr. (1), cr. (1m), (2m), (8r) and (13m), am. (2) and (5) Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. (2), (6), (13), (14), (15), (19) and (33), Register August 2007 No. 620, eff. 9−1−07; CR 07−042: cr. (10m), (25g) and (25r) Register October 2007 No. 622, eff. 11−1−07; corrections in (1), (3), (13m) and (17) made under s. 13.92 (4) (b) 6. and 7., Stats., Register January 2009 No. 637.

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

(a) Skilled nursing facility; or

(b) Intermediate care facility.

(1m) LICENSURE AS AN INSTITUTION FOR MENTAL DISEASES. (a) *Requirements.* The department may grant a facility a license to

operate as an institution for mental diseases if the following conditions are met:

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

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

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

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

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

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

Note: To obtain a copy of the application form for a license to operate a nursing home, write: Division of Quality Assurance, P.O. Box 2969, Madison, Wisconsin 53701−2969.

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

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

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

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

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

5. Disclosure of any financial failures directly or indirectly involving any person or business entity identified in the application concerning the operation of a residential or health care facility that resulted in any debt consolidation or restructuring, insolvency proceeding or mortgage foreclosure, or in the closing of a residential or health care facility or the moving of its residents. In this subdivision "insolvency" means bankruptcies, receiverships, assignments for the benefit of creditors, and similar court−supervised proceedings.

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

(bm) The applicant shall provide information to demonstrate that any person having the authority to directly manage the operation of the facility has the education, training or experience to operate and manage a health care facility to provide for the health, safety, and welfare of its residents in substantial compliance with state and federal requirements.

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

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

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

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

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

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

3. Any adverse action against the applicant or any person or business entity named in the application based upon noncompliance with federal statutes or regulations in the applicant's or any person or business entity named in the application's operation of a residential or health care facility in this or any other state. In this subdivision, "adverse action" means an action by a state or federal agency which resulted in the imposition of Category 3 remedies pursuant to 42 CFR sec. 488.408 (e), placement of a state monitor or the appointment of a receiver, transfer of residents, or the denial, non−renewal, cancellation or termination of certification of a residential or health care facility operated by the applicant;

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

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

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

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

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

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

10. Any prior financial failures of the applicant and any person and related business entity identified in the application concerning the operation of a residential or health care facility that resulted in any debt consolidation or restructuring, insolvency proceeding or mortgage foreclosure or in the closing of residential or health care facility or the moving of its residents. "Insolvency" has the meaning provided in s. DHS 132.14 (3) (a) 5.

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

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

(b) *Regular license.* If the applicant has been previously licensed, the department shall issue a regular license if the applicant is found to be in substantial compliance with this chapter. A regular license is valid indefinitely unless suspended or revoked.

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

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

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

(8) REPORTING. Every 12 months, on a schedule determined by the department, a nursing home licensee shall submit a report to the department in the form and containing the information that the department requires, including payment of the fee required under s. 50.135 (2) (a), Stats. If a complete report is not timely filed, the department shall issue a warning to the licensee. If a nursing home licensee who has not filed a timely report fails to submit a complete report to the department within 60 days after the date established under the schedule determined by the department, the department may revoke the license.

(9) REPORTING INVOLUNTARY ADMINISTRATION OF PSYCHOTROPIC MEDICATION. The licensee shall provide, in a format approved by the department, information required by the department to assess the facility's compliance with s. 55.14, Stats., relating to involuntary administration of psychotropic medication to a resident.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; cr. (5), Register, November, 1985, No. 359, eff. 12−1−85; r. and recr., Register, January, 1987, No. 373, eff. 2−1−87; emerg. cr. (1m), eff. 7−1−88; am. (3) (c), renum. (4) to (6) to be (5) to (7) and am. (5) and (6) (a), cr. (4), Register, February, 1989, No. 398, eff. 3−1−89; cr. (1m), Register, October, 1989, No. 406, eff. 11−1−89; am. (6), cr. (8), Register, August, 2000, No. 536, eff. 9−1−00; CR 06−053: cr. (3) (a) 5. and (bm), am. (4) (b) 2., 3. and 10., Register August 2007 No. 620, eff. 9−1−07; CR 07−042: cr. (9) Register October 2007 No. 622, eff. 11−1−07.

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; correction made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

DHS 132.16 Quality assurance and improvement projects. (1) FUNDS. Pursuant to ss. 49.499 (2m) and 50.04 (8), Stats., the department may, from the appropriation under s. 20.435 (6) (g), Stats., distribute funds for innovative projects designed to protect the property and the health, safety, and welfare of residents in a facility and to improve the efficiency and cost effectiveness of the operation of a facility so as to improve the quality of life, care, and treatment of its residents.

(2) QUALITY ASSURANCE AND IMPROVEMENT COMMITTEE. (a) The department shall establish and maintain a quality assurance and improvement committee to review proposals and award funds to facilities for innovative projects approved by the committee under sub. (3).

(b) 1. Committee members shall be appointed by the secretary for a term of up to 12 months and include, at the secretary's discretion, one or more representatives from the department, the board on aging and long term care, disability, aging and long term care advocates, facilities, and other persons with an interest or expertise in quality improvement or delivery of long term care services. Facility members shall comprise at least half of the committee membership.

2. A representative's term may be extended at the secretary's discretion.

(3) COMMITTEE RESPONSIBILITIES. The quality assurance and improvement committee shall do all of the following:

(a) Meet at least annually.

(b) Develop and propose for the secretary's approval criteria for review and approval of projects proposed under this section.

(c) Considering the criteria approved by the secretary under par. (b), review proposals submitted by facilities under this section and approve submitted proposals, defer a determination pending additional information, or deny approval of proposals submitted.

(d) Identify areas of need within a facility or corporation, the state or regions as projects to be addressed.

(e) Develop opportunities and strategies for general improvement concerning licensed facilities.

(f) Encourage proposals that develop innovative cost−effective methods for improving the operation and maintenance of facilities and that protect residents' rights, health, safety and welfare and improve residents' quality of life.

(g) Disseminate within the department and to facilities and other interested individuals and organizations the information learned from approved projects.

(h) Prepare an annual report to the secretary.

(4) A decision under sub. (3) (c) to defer or deny approval of or award funds for a proposal may not be appealed.

History: CR 06−053: cr. Register August 2007 No. 620, eff. 9−1−07; CR 13−028: am. (1) Register December 2013 No. 696, eff. 1−1−14.

Subchapter II — Enforcement

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

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

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

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

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

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

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

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

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

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

d. The reasons for the request; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Required by a change in law.

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

Subchapter III — Residents' Rights and Protections

DHS 132.31 Rights of residents. (1) RESIDENTS' RIGHTS. Every resident shall have the right to all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) NOTIFICATION. (a) *Serving notice.* Facility staff shall verbally explain to each new resident and to that person's guardian, if any, prior to or at the time of the person's admission to the facility, these rights and the facility's policies and regulations governing resident conduct and responsibilities.

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

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; r. and recr. (1) (c), (d), (j), (m), (2) to (4), renum. (5) to (6), cr. (1) (p) and (5), Register, January, 1987, No. 373, eff. 2−1−87; am. (1) (d) 1. intro., (k) and (4) (b), Register, February, 1989, No. 398, eff. 3−1−89; am. (6) (e), Register, August, 2000, No. 536, eff. 9−1−00; CR 04−053: am. (1) (k) Register October 2004 No. 586, eff. 11−1−04; correction in (2) made under s. 13.93 (2m) (b) 7., Stats., Register August 2007, No. 620; CR 06−053: renum. (6) (a) to be (6), r. (1) (a) to (c), (e) to (o), (2), (3), (4) (c), (5) and (6) (b) to (e), am. (1) (intro.) and (4) (a), Register August 2007 No. 620, eff. 9−1−07; correction in (1) (p) 3. made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

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

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

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

(2) RESTRICTION. Except as otherwise provided by this section, no resident may be housed in a locked unit. Physical or

chemical restraints or repeated use of emergency restraint under sub. (5) may not be used to circumvent this restriction. Placement in a locked unit shall be based on the determination that this placement is the least restrictive environment consistent with the needs of the person.

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

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

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

2. The court that protectively placed the resident under s. 55.15, Stats., made a specific finding of the need for a locked unit;

3. The resident has been transferred to a locked unit pursuant to s. 55.15, Stats., and the medical record contains documentation of the notice provided to the guardian, the court and the agency designated under s. 55.02, Stats.; or

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

(b) A facility may transfer a resident from a locked unit to an unlocked unit without court approval pursuant to s. 55.15, Stats., if it determines that the needs of the resident can be met on an unlocked unit. Notice of the transfer shall be provided as required under s. 55.15, Stats., and shall be documented in the resident's medical record.

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

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

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

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; am. (1) (a) and (2), r. and recr. (3), Register, January, 1987, No. 373, eff. 2−1−87; corrections in (3) (a) 2., 3. and (b) made under s. 13.93 (2m) (b) 7., Stats., Register October 2007 No. 622.

Subchapter IV — Management

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

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

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

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

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

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

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

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

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; CR 06−053: r. (3) Register August 2007 No. 620, eff. 9−1−07.

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

(3) PHYSICAL HEALTH CERTIFICATIONS. (a) *New employees.* Every employee shall be certified in writing by a physician, physician assistant or an advanced practice nurse prescriber as having been screened for the presence of clinically apparent communicable disease that could be transmitted to residents during the normal performance of the employee's duties. This certification shall include screening for tuberculosis within 90 days prior to employment.

(b) *Continuing employees.* Employees shall be rescreened for clinically apparent communicable disease as described in par. (a) based on the likelihood of exposure to a communicable disease, including tuberculosis. Exposure to a communicable disease may be in the facility, in the community or as a result of travel or other exposure.

(c) *Non−employees.* Persons who reside in the facility but are not residents or employees, such as relatives of the facility's owners shall be certified in writing as required in pars. (a) and (b).

(4) DISEASE SURVEILLANCE AND CONTROL. When an employee or prospective employee has a communicable disease that may result in the transmission of the communicable disease, he or she may not perform employment duties in the facility until the facility makes safe accommodations to prevent the transmission of the communicable disease.

Note: The Americans with Disabilities Act and Rehabilitation Act of 1973 prohibits the termination or non−hiring of an employee based solely on an employee having an infectious disease, illness or condition.

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; am. (3) (a) and (4), Register, January, 1987, No. 373, eff. 2−1−87; CR 03−033: am. (3) (a), r. and recr. (4) Register December 2003 No. 576, eff. 1−1−04; CR 04−053: am. (3) and (4) Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. (2) Register August 2007 No. 620, eff. 9−1−07.

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

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

(2) CONTINUING EDUCATION. (a) *Nursing inservice.* The facility shall require employees who provide direct care to residents to attend educational programs designed to develop and improve the skill and knowledge of the employees with respect to the needs of the facility's residents, including rehabilitative therapy, oral health care, and special programming for developmentally disabled residents if the facility admits developmentally disabled

persons. These programs shall be conducted as often as is necessary to enable staff to acquire the skills and techniques necessary to implement the individual program plans for each resident under their care.

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

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; r. and recr. (2) (a) and am. (4), Register, January, 1987, No. 373, eff. 2−1−87; CR 04−053: renum. (1) (c) to be (1) (b) Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. (3) Register August 2007 No. 620, eff. 9−1−07.

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

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

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

(4) MEDICAL RECORDS — GENERAL. (c) *Unit record.* A unit record shall be maintained for each resident and day care client.

(f) *Retention and destruction.* 1. An original medical record and legible copy or copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of this resident shall be retained for a period of at least 5 years following a resident's discharge or death when there is no requirement in state law. All other records required by this chapter shall be retained for a period of at least 2 years.

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

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

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

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

a. The stamp or electronic representation is used only by the person who makes the entry; and

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

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

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

(a) *Identification and summary sheet.*

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

a. A summary of prior treatment;

b. Current medical findings;

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

d. The resident's rehabilitation potential;

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

f. Level of care;

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

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

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

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

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

e. Limitations on activities;

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

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

3. Physician progress notes following each visit.

4. Annual physical examination, if required; and

5. Alternate visit schedule, and justification for such alternate visits.

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

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

3. Nursing notes are required as follows:

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

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

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

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

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

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

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

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

f. Summary of restorative nursing measures which are provided;

g. Summary of the use of physical and chemical restraints.

h. Other non−routine nursing care given;

i. The condition of a resident upon discharge; and

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

(d) *Social service records.* Notes regarding pertinent social data and action taken.

(e) *Activities records.* Documentation of activities programming, a summary of attendance, and quarterly progress notes.

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

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

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

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

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

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

sent form shall in this case be maintained as required under sub. (6) (i). The summary shall include:

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

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

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

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

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

1. Current medical findings and condition;

2. Final diagnoses;

3. Rehabilitation potential;

4. A summary of the course of treatment;

5. Nursing and dietary information;

6. Ambulation status;

7. Administrative and social information; and

8. Needed continued care and instructions.

(6) OTHER RECORDS. The facility shall retain:

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

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

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

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

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

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

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

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

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

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

(h) *Funds and property statement.* The statement prepared upon a resident's discharge or transfer from the facility that accounts for all funds and property held by the facility for the resident.

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; am. (1) (3) (c) (5) (intro.), (b) 1. intro. and e., 2. a. and d., 3., (c) 1. and 2., (d) 1., (e), (f) 1. and (g), (6) (g), renum. (4) (a) to (e), (5) (e) and (6) (h) to be (4) (c) to (g), (5) (L) and (6) (i) and am. (5) (L), cr. (4) (a) and (b), (5) (e) and (6) (h), Register, January, 1987, No. 373, eff. 2−1−87; CR 04−053: r. and recr. (3) and (5) (d), am. (4) (g) 2. and (5) (e), r. (5) (g) Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. (4) (a), (b) and (d), (e) and (f) 1. and 3., am. (4) (f) 2. (g) 1., (5) (b) 3. and 5., (c) 4. g., and (6) (h), renum. (4) (f) 2., 4. and 5. to be (4) (f) 1., 2. and 3., Register August 2007 No. 620, eff. 9−1−07.

DHS 132.46 Quality assessment and assurance. (1) COMMITTEE MAINTENANCE AND COMPOSITION. A facility shall maintain a quality assessment and assurance committee for the purpose of identifying and addressing quality of care issues. The committee shall be comprised of at least all of the following individuals:

(a) The director of nursing services.

(b) The medical director or a physician designated by the facility.

(c) At least 3 other members of the facility's staff.

(2) COMMITTEE RESPONSIBILITIES. The quality assessment and assurance committee shall do all of the following:

(a) Meet at least quarterly to identify quality of care issues with respect to which quality assessment and assurance activities are necessary.

(b) Identify, develop and implement appropriate plans of action to correct identified quality deficiencies.

(3) CONFIDENTIALITY. The department may not require disclosure of the records of the quality assessment and assurance committee except to determine compliance with the requirements of this section. This paragraph does not apply to any record otherwise specified in this chapter or s. 50.04 (3), 50.07 (1) (c) or 146.82 (2) (a) 5., Stats.

History: CR 04−053: cr. Register October 2004 No. 586, eff. 11−1−04.

Subchapter V — Admissions, Retentions and Removals

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

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

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

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

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

(b) *Communicable diseases.* 1. 'Communicable disease management.' The nursing home shall have the ability to appropriately manage persons with communicable disease the nursing home admits or retains based on currently recognized standards of practice.

2. 'Reportable diseases.' Facilities shall report suspected communicable diseases that are reportable under ch. DHS 145 to the local public health officer or to the department's bureau of communicable disease.

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

(c) *Abusive or destructive residents.* 1. Notwithstanding s. DHS 132.13 (1), in this paragraph, "abusive" describes a resident whose behavior involves any single or repeated act of force, violence, harassment, deprivation or mental pressure which does or reasonably could cause physical pain or injury to another resident, or mental anguish or fear in another resident.

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

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

2. Except in an emergency, no person who has a developmental disability may be admitted to a facility unless the county

department under s. 46.23, 51.42, or 51.437, Stats., of the individual's county of residence has recommended the admission.

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

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

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

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

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

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

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

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

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

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

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

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

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; emerg. r. and recr. (2) (d) and (3), eff. 9−15−86; r. and recr. (2) (d) am. (1) (b) 1., (2) (e) 1. and 2. intro., (3) (a) and (b), (4) (c), Register, January, 1987, No. 373, eff. 2−1−87; am. (2) (b) 2. and 3. (d) 2., r. (2) (d) 3. and (3), renum. (2) (e), (f) and (4) to be (2) (f), (g) and (3), cr. (2) (e), Register, February, 1989, No. 398, eff. 3−1−89; correction in (2) (b) 3. made under s. 13.93 (2m) (b) 7., Stats., Register, August, 2000, No. 536; CR 03−033: r. and recr. (2) (b) 1. Register December 2003 No. 576, eff. 1−1−04: CR 04−053: r. and recr. (2) (b) and am. (2) (c) Register October 2004 No. 586, eff. 11−1−04**;** correction in (2) (b) 2. made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

DHS 132.52 Procedures for admission. (2) PHYSICIAN'S ORDERS. No person may be admitted as a resident except upon:

(a) Order of a physician;

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

(c) Receipt of certification in writing from a physician, physician assistant or advanced practice nurse prescriber that the individual has been screened for the presence of clinically apparent communicable disease that could be transmitted to other residents or employees, including screening for tuberculosis within 90 days prior to admission, or a physician, physician assistant or advanced practice nurse prescriber has ordered procedures to treat and limit the spread of any communicable diseases the individual may be found to have.

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

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

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

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

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

(7) FAMILY CARE INFORMATION AND REFERRAL. If the secretary of the department has certified that a resource center, as defined in s. DHS 10.13 (42), is available for the facility under s. DHS 10.71, the facility shall provide information to prospective residents and refer residents and prospective residents to the aging and disability resource center as required under s. 50.04 (2g) to (2i), Stats., and s. DHS 10.73.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; renum. (1) to (5) to be (2) to (6) and am. (2) and (3), cr. (1), Register, January, 1987, No. 373, eff. 2−1−87; cr. (7), Register, October, 2000, No. 538, eff. 11−1−00; CR 03−033: am. (2) (c) Register December 2003 No. 576, eff. 1−1−04; CR 04−053: am. (2) (c) and (4) and r. (5) and (6) Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. (1), Register August 2007 No. 620, eff. 9−1−07**;** corrections in (7) made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

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

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

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

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

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

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

5. For medical reasons as ordered by a physician;

6. In case of a medical emergency or disaster;

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

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

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

10. As otherwise permitted by law.

(b) *Alternate placement.* 1. Except for transfers or discharges under par. (a) 2. and 6., for nonpayment or in a medical emergency, no resident may be involuntarily transferred or discharged unless an alternative placement is arranged for the resident. The resident shall be given reasonable advance notice of any planned transfer or discharge and an explanation of the need for and alternatives to the transfer or discharge except when there is a medical emergency. The facility, agency, program or person to which the resident is transferred shall have accepted the resident for transfer in advance of the transfer, except in a medical emergency.

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

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

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

(3) PROCEDURES. (a) *Notice.* The facility shall provide a resident, the resident's physician and, if known, an immediate family

member or legal counsel, guardian, relative or other responsible person at least 30 days notice of transfer or discharge under sub. (2) (a) 2. to 10., and the reasons for the transfer or discharge, unless the continued presence of the resident endangers the health, safety or welfare of the resident or other residents. The notice shall also contain the name, address and telephone number of the board on aging and long−term care. For a resident with developmental disability or mental illness, the notice shall contain the mailing address and telephone number of the protection and advocacy agency designated under s. 51.62 (2) (a), Stats.

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

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

3. Transfer and discharge activities shall include:

a. Counseling regarding the impending transfer or discharge;

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

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

d. Provisions for needed medications and treatments during relocation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. A resident or a facility may appeal the decision of the department's bureau of quality assurance in writing to the department of administration's division of hearings and appeals within 5 days after receipt of the decision.

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

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

Note: The bureau of quality assurance was renamed the division of quality assurance.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; cr. (2) (b) 8. and 9., am. (2) (c), (3) (b) 2. and (c), Register, January, 1987, No. 373, eff. 2−1−87; renum. (2) (c) to be (2) (c) 1. and am., cr. (2) (c) 2., Register, February, 1989, No. 398, eff. 3−1−89; am. (2) (c) 2. b., Register, October, 1989, No. 406, eff. 11−1−89; r. and recr. (1) to (3), cr. (4) (d) and (6), Register, June, 1991, No. 426, eff. 7−1−91; CR 06−053: am. (2) (b) 1., r. (4) (c), Register August 2007 No. 620, eff. 9−1−07.

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

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

Subchapter VI — Services

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

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

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

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

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

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

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

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

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

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

d. Consideration and implementation, as appropriate, of nonpharmacological interventions to control pain.

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

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

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

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

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

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

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

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

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

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

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

(d) *Administration of medications.* 1. 'Personnel who may administer medications.' In a nursing home, medication may be administered only by a nurse, a practitioner, as defined in s. 450.01 (17), Stats., or a person who has completed training in a drug administration course approved by the department.

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

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

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

(6) PHYSICAL AND CHEMICAL RESTRAINTS. (b) *Orders required.* Physical or chemical restraints shall be applied or administered only on the written order of a physician which shall

indicate the resident's name, the reason for restraint, and the period during which the restraint is to be applied.

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

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

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

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

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

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

Note: The department encourages and promotes the principles of resident self−determination and person directed care.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; r. and recr. (5) (d) 1., Register, February, 1983, No. 326, eff. 3−1−83; am. (1) (d), (2) (d), (3) (5) (a) 1. to 3., (6) (c) and (8) (a), r. and recr. (1) (b) and (6) (f), Register, January, 1987, No. 373, eff. 2−1−87; am. (6) (a) 1. Register, February, 1989, No. 398, eff. 3−1−89; cr. (8) (d), Register, November, 1990, No. 419, eff. 12−1−90; correction in (5) (d) made under s. 13.93 (2m) (b) 7., Stats., Register, August, 2000, No. 536; CR 04−053: cr. (1) (c) 5., am. (5) (a) 1. and 2., (5) (d) 2., and (6) (b), r. (5) (a) 3. and (c) Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. (1) (a) 2. and 3., (c) 1., and (e), (2) (c), (4), (5) (a) 4., (b), (d) 3., 4., 6. and (e), (6) (a), (c), (d), (g), (7), and (8) (a) 1., and 2., and (d), am. (5) (a) 1., (6) (b), and (8) (a) (intro.), Register August 2007 No. 620, eff. 9−1−07.

DHS 132.61 Medical services. Every skilled care facility shall retain, pursuant to a written agreement, a physician to serve as medical director on a part−time or full−time basis as is appropriate for the needs of the residents and the facility. Medical direction and coordination of medical care in the facility shall be provided by the medical director.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; r. and recr. (2) (b), Register, January, 1987, No. 373, eff. 2−1−87; correction in (2) (b) made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1996, No. 492; CR 06−053: r. (1) (c), (2), cons., renum. and am. (1) (a) and (b) to be DHS 132.61, Register August 2007 No. 620, eff. 9−1−07.

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

(2) NURSING ADMINISTRATION. (a) *Director of nursing services in skilled care and intermediate care facilities.* 1. 'Staffing requirement.' Every skilled care facility and every intermediate care facility shall employ a full−time director of nursing services who may also serve as a charge nurse in accordance with par. (b).

2. 'Qualifications.' The director of nursing services shall be a registered nurse.

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

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

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

c. Coordinating nursing services with other resident services;

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

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

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

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

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

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

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

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

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

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

b. The charge nurse, if a licensed practical nurse, shall manage and direct the nursing and other activities of other licensed practical nurses and less skilled assistants and shall arrange for the provision of direct care to specific residents, including administration of medications, by nursing personnel based upon individual resident needs, the facility's physical arrangement, and the staff capability. A licensed practical nurse who serves as a charge nurse shall be under the supervision and direction of a registered nurse who is either in the facility or on call.

(3) NURSE STAFFING. In addition to the requirements of sub. (2), there shall be adequate nursing service personnel assigned to care for the specific needs of each resident on each tour of duty. Those personnel shall be briefed on the condition and appropriate care of each resident.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; am. (2) (b) 2. and (c), r. (2) (d), Register, January, 1987, No 373, eff. 2−1−87; am. (3) (a), Register, February, 1989, No. 398, eff. 3−1−89; CR 04−053: am. (2) (a) 1. and r. and recr. (3) (a) Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. (1) (b), (2) (a) 2. b., (b) 2. and (c), (3) (a) and (c) to (h), renum. (1) (a) to be (1), cons., renum. and am. (2) (a) 2. (intro.) and a. to be (2) (a) 2., cons., renum. and am. (3) (intro.) and (b) to be (3), Register August 2007 No. 620, eff. 9−1−07.

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

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

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

a. Is a dietitian.

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

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

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

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

(4) MENUS. (a) *General.* The facility shall make reasonable adjustments to accommodate each resident's preferences, habits, customs, appetite, and physical condition.

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

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

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

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

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

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; am. (2) (a), (4) (a) 3., (5) (d) and (f) and (7) (a) 4., Register, January, 1987, No. 373, eff. 2−1−87; r. and recr. (5) (c), Register, February, 1989, No. 398, eff. 3−1−89; CR 04−053: am. (1), r. and recr. (2), r. (6) (c) and (7) (a) 4. Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. (2) (c), (3) (4) (a) 1. to 3., and 5., (b) 2. and 3., (5) (a), (b), (d) to (f), (6), (7) (a), (b) 1. and (c), and (8), renum. (4) (a) 4., (b) 1., and (7) (b) 2. to be (4) (a) and (b), (7), Register August 2007 No. 620, eff. 9−1−07.

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

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

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

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

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

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

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

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

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

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; CR 06−053: r. (2) (a), Register August 2007 No. 620, eff. 9−1−07.

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

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

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

(c) "Schedule II drug" means any medication listed in s. 961.16, Stats.

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

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

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

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

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

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

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

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

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

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

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

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

3. 'Controlled substances.' Separately locked and securely fastened boxes or drawers, or permanently affixed compartments, within the locked medication area shall be provided for storage of schedule II drugs, subject to 21 USC ch. 13, and Wisconsin's uniform controlled substance act, ch. 961, Stats.

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

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

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

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

8. 'Labeling medications.' Prescription medications shall be labeled with the expiration date and as required by s. 450.11 (4),

Stats. Non−prescription medications shall be labeled with the name of the medication, directions for use, the expiration date and the name of the resident taking the medication.

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

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

(d) *Control of medications.* 1. 'Receipt of medications.' The administrator or a physician, nurse, pharmacist, or the designee of any of these may be an agent of the resident for the receipt of medications.

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

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

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

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

(f) *Resident control and use of medications.* Medications which, if ingested or brought into contact with the nasal or eye mucosa, would produce toxic or irritant effects shall be stored and used only in accordance with the health, safety, and welfare of all residents.

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

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

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

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

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

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

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

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; r. and recr. (3) (b), am. (6) (a), (b) 6. and (c), Register, January, 1987, No. 373, eff. 2−1−87; am. (3) (b) 2., (6) (b) 8. and (c) 1. and 3., Register, February, 1989, No. 398, eff. 3−1−89; correction in (1) (c) made under s. 13.93 (2m) (b) 7., Stats., Register, August, 2000, No. 536; correction made to (6) (d) 1. under s. 13.93 (2m) (b) 7., Stats., Register December 2003 No. 576; CR 04−053: am. (2) and (5) (d), r. (3) (a), renum. and am. (3) (b) 1. and 2., r. (6) (c) 3. Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. (3) and (6) (a) and (f) 1. and 2., renum. (6) (f) 2. to be (6) (f), Register August 2007 No. 620, eff. 9−1−07.

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

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

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; am. (3), Register, January, 1987, No. 373, eff. 2−1−87; CR 06−053: r. (2) and (4), Register August 2007 No. 620, eff. 9−1−07.

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

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

(3) ADMISSION HISTORY. The facility shall prepare a social history of each resident.

(4) CARE PLANNING. A social services component of the plan of care, including potential for discharge, if appropriate, shall be developed and included in the plan of care required by s. DHS 132.60 (8) (a).

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

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

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

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

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

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

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; am. (3) (a), (4) (a) and (5) (a), Register, January, 1987, No. 373, eff. 2−1−87; CR 04−053: r. and recr. (3) and (4) Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. (2) (b) and (4) (b), renum. (2) (a) to be (2), renum. (4) (a) to be (4) and am., Register August 2007 No. 620, eff. 9−1−07.

DHS 132.69 Activities. Each facility shall have an activity program designed to meet the needs and interests of each resident.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; am. (2) (a), r. and recr. (2) (c), r. (2) (d) and (f), renum. (2) (e) to be (2) (d), Register, January, 1987, No. 373, eff. 2−1−87; CR 04−053: r. (2) (a) 1. a. Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. and recr. (1) to be DHS 132.69, r. (2), Register August 2007 No. 620. eff. 9−1−07.

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

(2) DEFINITIONS. In this section:

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

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

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

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

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

2. A physician;

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

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

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

6. A registered nurse;

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

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

(3) ACTIVE TREATMENT PROGRAMMING. All residents who are developmentally disabled shall receive active treatment. Active treatment shall include the resident's regular participation, in accordance with the IPP, in professionally developed and supervised activities, experiences and therapies.

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

2. The IPP shall include:

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

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

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

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

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

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

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

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

History: Cr. Register, January, 1987, No. 373, eff. 2−1−87; am. (2) (a), (b), (3), (4) (a), (b), (c) 1., 2. intro. and a. and (d), renum. (2) (c) to (d) and am. (intro.) and 3., cr. (2) (c), Register, February, 1989, No. 398, eff. 3−1−89; correction in (2) (d) 4. made under s. 13.93 (2m) (b) 7., Stats., Register, August, 2000, No. 536; CR 06−053: cons., renum. and am. (3) (a) (intro.) and 1. (intro.) to be (3), r. (3) (a) 1. a. and b., 2., and (b), (4) (a), (b) 2. a. to c. and (c) 1., 2. and 3., renum. (4) (b) 2. d. and e. and (c) 1. a. to d. to be (4) (b) 2. a. and b. and (c) 1. to 4., Register August 2007 No. 620, eff. 9−1−07; corrections in (2) (d) 4. and 5. made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

DHS 132.70 Special requirements when persons are admitted for short−term care. (1) SCOPE. A facility may admit persons for short−term care. A facility that admits persons for short−term care may use the procedures included in this section rather than the procedures included in ss. DHS 132.52 and 132.60 (8). Short−term care is for either respite or recuperative purposes. The requirements in this section apply to all facilities that admit persons for short−term care when they admit, evaluate or provide care for these persons. Except as specified in this section, all requirements of this chapter, including s. DHS 132.51, apply to all facilities that admit persons for short−term care.

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

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

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

2. The attending physician's plans for discharge.

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

(c) The facility shall send a copy of the comprehensive resident assessment, the physician's orders and the plan of care under par. (b) to the person's attending physician. The attending physician shall sign the assessment and the plan of care within 48 hours after the person is admitted.

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

(b) No person may be admitted to a facility for respite care or recuperative care without signing or the person's guardian or designated representative signing an acknowledgement of having received a statement before or on the day of admission that indicates the expected length of stay, with a note that the responsibility for care of the resident reverts to the resident or other responsible party following expiration of the designated length of stay.

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

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

1. The resident care plan prepared under sub. (2) (b).

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

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

4. Physicians' orders;

5. A record of medications;

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

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

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

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

History: Cr. Register, January, 1987, No. 373, eff. 2−1−87; am. (1), (2) (a) (intro.) and (b) (intro.), Register, February, 1989, No. 398, eff. 3−1−89; CR 06−053: r. (2) (a) 1. b., (b), (3) (b) 2. to 9., (4) (a) and (b), (5) and (6), renum. (2) (a) (intro.), 1. (intro.), 2. and 3. to be (2) (intro.), (a) (intro.), (b) and (c), am. (2) (a) (intro.) and (b) and (7) (a) 1., cons., renum., and am. (3) (b) (intro.) and 1. to be (3) (b), Register August 2007 No. 620, eff. 9−1−07; correction in (2) (c) made under s. 13.93 (2m) (b) 7., Stats., Register August 2007 No. 620.

Subchapter VII — Physical Environment

DHS 132.71 Furniture, equipment and supplies. (1) FURNITURE IN RESIDENT CARE AREAS. (b) *Bedding.* 1. Each resident shall be provided at least one clean, comfortable pillow. Additional pillows shall be provided if requested by the resident or required by the resident's condition.

2. Each bed shall have a mattress pad.

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

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

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

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

(c) *Other furnishings.* 2. a. At least one chair shall be in each room for each bed. A folding chair shall not be used. If requested by the resident or guardian, a wheel−chair or geri−chair may be substituted.

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) When in use at the resident's bedside, cannulas, hoses, and humidifier bottles shall be maintained and used in accordance with current standards of practice and manufacturers' recommendations.

(e) Disposable inhalation equipment shall be maintained and used in accordance with current standards of practice and manufacturers' recommendations.

(f) With other inhalation equipment such as intermittent positive pressure breathing equipment, the entire resident breathing circuit, including nebulizers and humidifiers, shall be maintained and used in accordance with current standards of practice and manufacturers' recommendations.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; am. (1) (e), (2) (a) and (3), Register, January, 1987, No. 373, eff. 2−1−87; CR 06−053: r. (1) (a), (b) 5., (c) 1. and 3., (2) (b) and (3) to (6), Register August 2007 No. 620, eff. 9−1−07; **2015 Wis. Act 107: am. (7) (d) to (f) Register November 2015 No. 719, eff. 12−1−15.**

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

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

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

(3) POISONS. All poisonous compounds shall be clearly labeled as poisonous and, when not in use, shall be stored in a locked area separate from food, kitchenware, and medications.

(4) GARBAGE. *Storage containers.* All garbage and rubbish shall be stored in leakproof, nonabsorbent containers with close−fitting covers, and in areas separate from those used for the preparation and storage of food. Containers shall be cleaned regularly. Paperboard containers shall not be used.

(6) PEST CONTROL. (b) *Provision of service.* Pest control services shall be provided in accordance with the requirements of s. 94.705, Stats.

(c) *Screening of windows and doors.* All windows and doors used for ventilation purposes shall be provided with wire screening of not less than number 16 mesh or its equivalent and shall be properly installed and maintained to prevent entry of insects. Screen doors shall be self−closing and shall not interfere with exiting. Properly installed airflow curtains or fans may be used in lieu of screens.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; am. (2) (b), (c) and (e), (6) (c), Register, January, 1987, No. 373, eff. 2−1−87; CR 06−053: r. (2) (a) to (d), (4) (b), (5) and (6) (a), renum. (4) (a) to be (4), Register August 2007 No. 620, eff. 9−1−07.

Subchapter VIII — Life Safety, Design and Construction

DHS 132.81 Scope and definitions. (1) APPLICATION. This subchapter applies to all facilities except where noted. Wherever the rules in ss. DHS 132.83 and 132.84 modify the applicable life safety code under s. DHS 132.82, these rules shall take precedence.

(2) DEFINITIONS. The definitions in the applicable life safety code required under s. DHS 132.82 apply to this subchapter. In addition, in this subchapter:

(a) "Life safety code" means the National Fire Protection Association's standard 101.

(b) "Period A facility" means a facility or a portion of a facility which before July 1, 1964, was either licensed as a nursing home or had the plans approved by the department; a county home or county mental hospital approved under former ch. PW 1 or 2 before July 1, 1964, which is to be converted to nursing home use; a hospital approved under ch. DHS 124 before July 1, 1964, which is to be converted to nursing home use; or any other recognized inpatient care facility in operation before July 1, 1964, to be converted to nursing home use.

(c) "Period B facility" means a facility or a portion of a facility the plans for which were approved by the department on or after July 1, 1964, but no later than December 1, 1974; a county home or county mental hospital approved under former ch. PW 1 or 2, on or after July 1, 1964, but no later than December 1, 1974, which is to be converted for nursing home use; or any other recognized inpatient care facility in operation on or after July 1, 1964, but no later than December 1, 1974, which is to be converted to nursing home use.

(d) "Period C facility" means a facility, the plans for which were approved by the department after December 1, 1974, including new additions to existing licensed facilities and major remodeling and alterations.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; r. and recr. (2), Register, January, 1987, No. 373, eff. 2−1−87; reprinted to restore dropped copy in (2) (b), Register, May, 1987, No. 377; correction in (2) (b) made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637.

DHS 132.812 Review for compliance with this chapter and the state building code. (1) The department shall review nursing home construction and remodeling plans for compliance with this chapter and for compliance with the state commercial building code, chs. SPS 361 to 365, with the exception of s. SPS 361.31 (3). Where chs. SPS 361 to 365 refer to the department of safety and professional services, those rules shall be deemed for purposes of review under this chapter to refer to the department of health services.

(2) The department shall have 45 working days from receipt of an application for plan review and all required forms, fees, plans and documents to complete the review and approve, approve with conditions or deny approval for the plan.

History: Emerg. cr., eff. 7−1−96; cr. Register, December, 1996, No. 492, eff. 7−1−96; corrections in (1) made under s. 13.93 (2m) (b) 7., Stats., Register, August, 2000, No. 536; corrections in (1) made under s. 13.93 (2m) (b) 7., Stats., Register December 2003 No. 576; correction in (1) made under s. 13.92 (4) (b) 6., Stats., Register January 2009 No. 637; correction in (1) made under s. 13.92 (4) (b) 6., 7., Stats., Register January 2012 No. 673.

DHS 132.815 Fees for plan reviews. (1) REQUIREMENT. Before the start of any construction or remodeling project for a nursing home, the plans for the construction or remodeling shall be submitted to the department, pursuant to s. DHS 132.84 (17), for review and approval by the department. The fees established in this section shall be paid to the department for providing plan review services.

(2) FEE SCHEDULE. (a) *General.* The department shall charge a fee for the review under s. DHS 132.812 of plans for a nursing home capital construction or remodeling project. The fee shall be based in part on the dollar value of the project, according to the schedule under par. (b), and in part on the total gross floor area in the plans, as found in par. (c). The total fee for plan review is determined under par. (d). Fees for review of partial plans, for revision of plans, for extensions of plan approval, and for handling and copying, and provisions for the collection and refund of fees are found in par. (e).

(b) *Fee part based on project dollar value.* The part of the fee based on project dollar value shall be as follows:

1. For projects with an estimated dollar value of less than $5,000, $100;

2. For projects with an estimated dollar value of at least $5,000 but less than $25,000, $300;

3. For projects with an estimated dollar value of at least $25,000 but less than $100,000, $500;

4. For projects with an estimated dollar value of at least $100,000 but less than $500,000, $750;

5. For projects with an estimated dollar value of at least $500,000 but less than $1 million, $1,500;

6. For projects with an estimated dollar value of at least $1 million but less than $5 million, $2,500; and

7. For projects with an estimated dollar value of $5 million or more, $5,000.

(c) *Fee part based on total gross floor area.* 1. 'General.' The part of the fee based on total gross floor area shall be as provided in Table 132.815 subject to the conditions set out in this paragraph.

2. 'Building, heating and ventilation.' The fees in Table 132.815 apply to the submittal of all building and heating, ventilation and air conditioning (HVAC) plans. A fee for review of plans shall be computed on the basis of the total gross floor area of each building.

TABLE 132.815
Fee Part Based on Total Gross Floor Area

	FEE		
Area (Sq. Feet)	Bldg. & HVAC	Bldg. Area Only	HVAC Area Only
Up to 2,500	$320	$270	$190
2,501 − 5,000	430	320	240
5,001 − 10,000	580	480	270
10,001 − 20,000	900	630	370
20,001 − 30,000	1,280	900	480
30,001 − 40,000	1,690	1,220	690
40,001 − 50,000	2,280	1,590	900
50,001 − 75,000	3,080	2,120	1,220
75,001 − 100,000	3,880	2,600	1,690
100,001 − 200,000	5,940	4,240	2,120
200,001 − 300,000	12,200	7,430	4,770
300,001 − 400,000	17,190	11,140	6,900
400,001 − 500,000	21,220	13,790	9,020
Over 500,000	22,810	14,850	10,080

3. 'Scope of fee.' The fees indicated in Table 132.815, relating to building and heating, ventilation and air conditioning plans, include the plan review and inspection fee for all components, whether submitted with the original submittal or at a later date. Components covered by that fee are:

a. Building plans;

b. Heating, ventilation and air conditioning plans;

c. Bleacher plans for interior bleachers only;

d. Fire escape plans;

e. Footing and foundation plans; and

f. Structural component plans, such as plans for floor and roof trusses, precast concrete, laminated wood, metal buildings, solariums and other similar parts of the building.

4. 'Building alteration.' a. The examination fee for review of plans for alteration of existing buildings and structures undergoing remodeling or review of tenant space layouts shall be determined in accordance with Table 132.815 on the basis of the gross floor area undergoing remodeling.

b. The fee specified in subd. 4. a. shall be based on the actual gross square footage of the area being remodeled. When remodeling of an individual building component affects building code compliance for a larger area, the fee shall be computed on the basis of the total square footage of the affected area.

(d) *Total fee for review of plans.* To determine the total fee for review of plans, the department shall:

1. Add the fee parts from pars. (b) and (c); and

2. Multiply the sum obtained in subd. 1. by 0.95.

(e) *Other fee provisions related to review of plans.* 1. 'Fee for miscellaneous plans.' Miscellaneous plans are plans that have no building or heating, ventilation and air conditioning plan submissions and for which there may not be an associated area. The fee for a miscellaneous plan shall be $250. This fee is for plan review and inspection. Miscellaneous plans include:

a. Footing and foundation plans submitted prior to the submission of the building plans;

b. Plans for industrial exhaust systems for dust, fumes, vapors and gases, for government−owned buildings only;

c. Spray booth plans, for government−owned buildings only;

d. Stadium, grandstand and bleacher plans, and interior bleacher plans submitted as independent projects;

e. Structural plans submitted as independent projects, such as docks, piers, antennae, outdoor movie screens and observation towers; and

f. Plans for any building component, other than building and heating, ventilation and air conditioning, submitted following the final inspection by the department.

2. 'Fee for permission to start construction.' The fee for permission to start construction shall be $80. This fee shall apply to those applicants proposing to start construction prior to the approval of the plans by the department.

3. 'Fee for plan revision.' The fee for revision of previously approved plans shall be $100. This paragraph applies when plans are revised for reasons other than those that were requested by the department. The department may not charge a fee for revisions requested by the department as a condition of original plan approval.

4. 'Fee for extension of plan approval.' The examination fee for a plan previously approved by the department for which an approval extension [was requested] beyond the time limit specified in this chapter shall be $75 per plan.

5. 'Collection of fees.' Fees shall be remitted at the time the plans are submitted. No plan examinations, approvals or inspections may be made until fees are received.

6. 'Handling and copying fees.' a. The department shall charge a handling fee of $50 per plan to the submitting party for any plan that is submitted to the department, entered into the department's system and subsequently requested by the submitting party to be returned prior to departmental review.

b. The department may charge a photocopying fee of 25 cents per page to anyone who requests copies of construction or remodeling plans, except that a fee of $5 per plan sheet shall be charged for reproduction of plan sheets larger than legal size.

(3) HANDLING AND COPYING FEES. (a) The department shall charge a handling fee of $50 per plan to the submitting party for any plan which is submitted to the department, entered into the department's system and then the submitting party requests that it be returned prior to review.

(b) The department may charge a photocopying fee of 25 cents per page to anyone who requests copies of construction or remodeling plans, except that a fee of $5 per plan sheet shall be charged for reproduction of plan sheets larger than legal size.

History: Emerg. cr. eff. 1−1−94; cr. Register, August, 1994, No. 464, eff. 9−1−94; emerg. r. and recr. (2), eff. 7−1−96; r. and recr. (2), Register, December, 1996, No. 492, eff. 1−1−97.

DHS 132.82 Life safety code. (1) APPLICABILITY. Facilities shall meet the applicable provisions of the 2000 edition of the Life Safety Code.

Note: Copies of the 2000 Life Safety Code and related codes are on file in the Department's Division of Quality Assurance and the Legislative Reference Bureau, and may be obtained from the National Fire Protection Association, Batterymarch Park, Quincy, MA 02269.

(2) FIRE SAFETY EVALUATION SYSTEM. A proposed or existing facility not meeting all requirements of the applicable life safety code shall be considered in compliance if it achieves a passing score on the Fire Safety Evaluation System (FSES), developed by the United States department of commerce, national bureau of standards, to establish safety equivalencies under the life safety code.

(3) RESIDENT SAFETY AND DISASTER PLAN. (a) *Disaster plan.* 1. Each facility shall have a written procedure which shall be followed in case of fire or other disasters, and which shall specify persons to be notified, locations of alarm signals and fire extinguishers, evacuation routes, procedures for evacuating helpless residents, frequency of fire drills, and assignment of specific tasks and responsibilities to the personnel of each shift and each discipline.

2. The plan shall be developed with the assistance of qualified fire and safety experts, including the local fire authority.

3. All employees shall be oriented to this plan and trained to perform assigned tasks.

4. The plan shall be available at each nursing station.

5. The plan shall include a diagram of the immediate floor area showing the exits, fire alarm stations, evacuation routes, and locations of fire extinguishers. The diagram shall be posted in conspicuous locations in the corridor throughout the facility.

(b) *Drills.* Fire drills shall be held at irregular intervals at least 4 times a year on each shift and the plan shall be reviewed and modified as necessary. Records of drills and dates of drills shall be maintained.

(c) *Fire inspections.* The administrator of the facility shall arrange for fire protection as follows:

1. At least semiannual inspection of the facility shall be made by the local fire inspection authorities. Signed certificates of such inspections shall be kept on file in the facility.

2. Certification by the local fire authority as to the fire safety of the facility and to the adequacy of a written fire plan for orderly evacuation of residents shall be obtained and kept on file in the facility.

3. Where the facility is located in a city, village, or township that does not have an official established fire department, the licensee shall obtain and maintain a continuing contract for fire protection service with the nearest municipality providing such

service. A certification of the existence of such contract shall be kept on file in the facility.

Note: See NFPA 10, 1973 edition.

(e) *Fire report.* All incidents of fire in a facility shall be reported to the department within 72 hours.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; r. and recr. (1) and (2), r. (4), renum. (3) and (5) to be (4) and (6), cr. (3) and (5), Register, January, 1987, No. 373, eff. 2−1−87; emerg. am. (3), cr. (3m), r. and recr. (5) and Table, eff. 7−1−94; am. (3), cr. (3m), r. and recr. (5) and Table, Register, January, 1995, No. 469, eff. 2−1−95; CR 04−053: r. and recr. (1) to (5), renum. (6) to be (3) Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. (3) (d) and (f) to (i), Register August 2007 No. 620, eff. 9−1−07.

DHS 132.83 Safety and systems. (1) MAINTENANCE. The building shall be maintained in good repair and kept free of hazards such as those created by any damaged or defective building equipment.

(3) DOORS. (d) *Toilet room doors.* In period B and C facilities, resident toilet room doors shall be not less than 3 feet 0 inches by 6 feet 8 inches, and shall not swing into the toilet room unless they are provided with two−way hardware.

(e) *Thresholds.* In period B and C facilities, raised thresholds which cannot be traversed easily by a bed on wheels, a wheelchair, a drug cart, or other equipment on wheels shall not be used.

(4) EMERGENCY POWER. Emergency electrical service with an independent power source which covers lighting at nursing stations, telephone switchboards, exit and corridor lights, boiler room, fire alarm systems, and medical records when solely electronically based, shall be provided. The service may be battery operated if effective for at least 4 hours.

(7) MECHANICAL SYSTEMS. (a) *Water supply.* 1. A potable water supply shall be maintained at all times. If a public water supply is available, it shall be used. If a public water supply is not available, the well or wells shall comply with ch. NR 812.

2. An adequate supply of hot water shall be available at all times. The temperature of hot water at plumbing fixtures used by residents may not exceed the range of 110−115°F.

(d) *Heating and air conditioning.* The heating and air conditioning systems shall be capable of maintaining adequate temperatures and providing freedom from drafts.

(g) *General lighting.* Period C facilities shall have night lighting.

(h) 5. *Ventilation.* In period C facilities all rooms in which food is stored, prepared or served, or in which utensils are washed shall be well−ventilated. Refrigerated storage rooms need not be ventilated.

(i) *Elevators.* 1. In period B facilities, at least one elevator shall be provided when residents' beds are located on one or more floors above or below the dining or service floor. The platform size of the elevator shall be large enough to hold a resident bed and attendant.

2. In period C facilities, at least one elevator shall be provided in the facility if resident beds or activities are located on more than one floor. The platform size of the elevator shall be large enough to hold a resident bed and an attendant.

(j) 2. *Electrical.* In period B and C facilities at least one duplex−type outlet shall be provided for every resident's bed.

3. In new construction begun after the effective date of this chapter, at least 2 duplex−type outlets shall be provided for each bed.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; am. (3) (c) 1., (5) (e) and (f) (intro), (6) (b), (7) (a), (f), (g) 1., (j) 2., Register, January, 1987, No. 373, eff. 2−1−87; emerg. am. (6) (a), r. and recr. (6) (b), eff. 7−1−94; am. (6) (a), r. and recr. (6) (b), Register, January, 1995, No. 469, eff. 2−1−95; CR 04−053: am. (4) and (7) (a) 2., r. (5) (b), (c) and (d), Register October 2004 No. 586, eff. 11−1−04; CR 06−053: r. (2) (3) (a) to (c), (5), (6), (7) (b), (c), (d) 2., (e), (f), (g) 1., (h) 1. to 4. and 5. a., and (j) 1. and 2. b., renum. (7) (d) 1. and (g) 2. to be (7) (d) and (g), cons., renum. and am. (7) (h) 5. (intro.) and b. to be &(7) (h) 5., cons., renum. and am. (7) (j) 2. (intro.) and a. to be (7) (j) 2., Register August 2007 No. 620, eff. 9−1−07.

DHS 132.84 Design. (1) RESIDENTS' ROOMS. (a) *Assignment of residents.* Sexes shall be separated by means of separate wings, floors, or rooms, except in accordance with s. 50.09 (1) (f) 1, Stats.

(b) *Location.* No bedroom housing a resident shall open directly to a kitchen or laundry.

(g) *Bed arrangement.* The beds shall be arranged so that the beds shall be at least 3 feet apart and a clear aisle space of at least 3 feet from the entrance to the room to each bed shall be provided.

(h) *Closet space.* A closet or locker shall be provided for each resident in each bedroom. Closets or lockers shall afford a space of not less than 15 inches wide by 18 inches deep by 5 feet in height for each resident bed.

(i) *Cubicle curtains.* 1. In period A and B facilities, each bed in a multiple−bed room shall have a flameproof cubicle curtain or an equivalent divider that will assure resident privacy.

2. In period C facilities, each bed in a multiple−bed room shall be provided with a flameproof cubicle curtain to enclose each bed and to assure privacy.

(2) TOILET AND BATHING FACILITIES. (a) *General.* All lavatories required by this subsection shall have hot and cold running water. Toilets shall be water flushed and equipped with open front seats without lids.

(e) *Period A and B.* In period A and B facilities separate toilet and bath facilities shall be provided for male and female residents.

(f) *Period C.* In period C facilities every tub, shower, or toilet shall be separated in such a manner that it can be used independently and afford privacy.

(3) STAFF WORK STATIONS AND OTHER REQUIRED FACILITIES. Each resident living area shall have all of the following:

(a) A staff work station whose location allows staff to provide services to all living areas, resident bedrooms and resident use spaces. The facility shall contain adequate storage space for records and charts and shall contain a desk or work counter for staff, a functional telephone for emergency calls and a resident communication system as required under sub. (4). Staff work stations shall be located to meet the needs of the resident population being served.

(b) Space for storage of linen, equipment and supplies, unless a central space for storage is provided.

(c) 1. Except as provided in subds. 2. and 3., a well−lit, secure medicine preparation, storage and handling room or area available to each staff work station with a work counter, refrigerator, sink with hot and cold running water, and a medicine storage cabinet with lock or space for drug carts. The room shall be mechanically ventilated.

2. In period A nursing homes, a well−lit medicine preparation, storage and handling area equipped with a sink and hot and cold running water may continue to be used. Mechanical ventilation is not required.

3. In period B nursing homes, cart storage space and mechanical ventilation within the medicine preparation room are not required.

(d) 1. Except as provided in subds. 2., 3. and 4., a soiled utility room central to each resident sleeping room wing or module that is equipped with a flush−rim siphon jet service sink, a facility for sanitizing bedpans, urinals, emesis basins, thermometers and related nursing care equipment, appropriate cabinet and counter space, and sink with hot and cold running water. The room shall be mechanically ventilated and under negative pressure.

2. Period A nursing homes shall have a utility room that shall be located, designed and equipped to provide areas for the separate handling of clean and soiled linen, equipment, and supplies.

3. Period B nursing homes shall have a ventilated utility room with a flush−rim service sink.

4. Central location of soiled utility rooms is not required in existing nursing homes.

(e) 1. Except as provided in subd. 2., a clean utility area or room central to each resident sleeping room wing or module that

is equipped with a sink with hot and cold running water, counter, and cabinets for storage of clean utensils and equipment.

2. Period A and B nursing homes shall have a utility room located, designed and equipped to provide areas for the separate handling of clean and soiled linen, equipment and supplies.

(f) Period C nursing homes shall have staff toilet and hand−washing facilities separate from those used by residents.

(g) Period C nursing homes shall have a nourishment station with sink, hot and cold running water, refrigerator and storage for serving between−meal nourishment if a kitchen is not open at all times. Nourishment stations may serve more than one nursing area but not more than a single floor.

(4) RESIDENT AND STAFF COMMUNICATION. (a) Except as provided in pars. (b) and (c), the nursing home shall have a department−approved resident and staff communication system comprised of components listed by an independent testing laboratory to permit each resident to activate the call from resident rooms, toilet area, bathing areas, and activity areas. Nurse calls shall be visible from corridor or access aisles within each resident living area and an audible sounder shall annunciate upon failure of staff response. The communication signal emanating from the toilet, bath and shower areas shall be that of a distinctive emergency call. The activation device shall be reachable by the residents from each toilet, bath or shower location.

Note: Underwriter's Laboratory (UL) is an example of an independent testing laboratory.

(b) Nursing homes in existence November 1, 2004, may continue using a nurse call system that registers calls from each resident bed, resident toilet room and each tub and shower area. In addition, in period B and C nursing homes, the resident staff signal may register in the corridor directly outside the room and at the staff work station.

(c) In all nursing homes in existence November 1, 2004, the nursing home may retain use of non−source signal canceling equipment until any remodeling is undertaken within the smoke compartment where the equipment is located.

(d) Communication systems shall be functioning at all times.

(6) FOOD SERVICE. (a) *General.* The facility shall have a kitchen or dietary area which shall be adequate to meet food service needs and shall be arranged and equipped for the refrigeration, storage, preparation, and serving of food, as well as for dish and utensil cleaning and refuse storage and removal. Dietary areas shall comply with the local health or food handling codes. Food preparation space shall be arranged for the separation of functions and shall be located to permit efficient services to residents and shall not be used for nondietary functions.

Note: The department encourages and supports gerontological design principles that promote innovation and a diversity of approaches.

(15) MIXED OCCUPANCY. Rooms or areas within the facility may be used for occupancy by individuals other than residents and facility staff if the following conditions are met:

(a) The use of these rooms does not interfere with the services provided to the residents; and

(b) The administrator takes reasonable steps to ensure that the health, safety and rights of the residents are protected.

(17) SUBMISSION OF PLANS AND SPECIFICATIONS. For all new construction:

(a) One copy of schematic and preliminary plans shall be submitted to the department for review and approval of the functional layout.

(b) One copy of working plans and specifications shall be submitted to and approved by the department before construction is begun. The department shall notify the facility in writing of any divergence in the plans and specifications, as submitted, from the prevailing rules.

(c) The plans specified in pars. (a) and (b) shall show the general arrangement of the buildings, including a room schedule and fixed equipment for each room and a listing of room numbers, together with other pertinent information. Plans submitted shall be drawn to scale.

(d) Any changes in the approved working plans affecting the application of the requirements herein established shall be shown on the approved working plans and shall be submitted to the department for approval before construction is undertaken. The department shall notify the facility in writing of any divergence in the plans and specifications, as submitted, from the prevailing rules.

(e) If on−site construction above the foundation is not started within 6 months of the date of approval of the working plans and specifications under par. (b), the approval shall be void and the plans and specifications shall be resubmitted for reconsideration of approval.

(f) If there are no divergences from the prevailing rules, the department shall provide the facility with written approval of the plans as submitted.

History: Cr. Register, July, 1982, No. 319, eff. 8−1−82; am. (3) (b) 2. and (13) (c), renum. (15) and (16) to be (16) and (17), cr. (15), Register, January, 1987, No. 373, eff. 2−1−87; am. (1) (b) 2., (2) (e) 1. c. and (5) (a); CR 04−053: r. and recr. (3) and (4) and am. (6) (d) 12. Register October 2004 No. 586, eff. 11−1−04; CR 06−053: am. (1) (a), r. (1) (b) 2. and 3., (c), (d), (e), (f), (j), (k), (2) (b) to (d), (e) 1. a. to d. and 2., (f) 1. to 3., 5., (g), (5) (6) (b) to (d), (7) to (14) and (16), cons., renum. and am. (1) (b) (intro.) and 1. to be (1) (b), cons., renum., and am. (2) (e) (intro.) and 1. (intro.) to be (2) (e), cons., renum. and am. (2) (f) (intro.) and 4. to be (2) (f), Register August 2007 No. 2007, eff. 9−1−07.