order sheet, and shall be countersigned by the physician or dentist within 72 hours, and filed in the resident's clinical record within 10 days of the order.

3. 'Oral orders without nurses.' If the home does not have nurse coverage, an oral order for medications shall be telephoned to a registered pharmacist by the physician or dentist. When the medication is received by the home, the administrator or designee shall copy into the resident's clinical record the information from the prescription label, sign, and date the entry, which shall be countersigned and dated by the physician within 10 days of the order.

4. 'Review of medications.' Each resident's medication shall be reviewed by a registered nurse at the time of the review of the plan of care.

(b) *Stop orders.* 1. 'Compliance with stop order policies.' Medications not specifically limited as to time or number of doses when ordered shall be automatically stopped in accordance with the stop order policy required by s. HSS 132.65 (3) (a) 3. b.

2. 'Notice to physicians or dentists.' Each resident's attending physician or dentist shall be notified of stop order policies and contacted promptly for renewal of orders which are subject to automatic termination.

(c) *Release of medications to residents.* Medications shall be released to residents who are on leave or have been discharged only on order of the physician or dentist.

(d) *Administration of medications.* 1. 'Personnel who may administer medications.' In a nursing home which is licensed only as an intermediate care facility, medication may be administered only by a nurse, a practitioner, as defined in s. 450.07 (1) (d), Stats., or a person who has completed training in a drug administration course approved by the department. In all other nursing homes, medication may be administered only by a nurse or a practitioner, as defined in s. 450.07 (1) (d), Stats., or, if a registered nurse is present in the nursing home when the medication is administered, by a person who has completed training in a drug administration course approved by the department.

Note: On March 1, 1983, s. HSS 132.60 (5) (d) 1. will be repealed and recreated to read: In a nursing home, medication may be administered only by a nurse, a practitioner, as defined in s. 450.07 (1) (d), Stats., or a person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 administration of medications shall be developed by the facility and shall be followed by personnel assigned to prepare and administer medications and to record their administration. The same person shall prepare, administer, and immediately record in the resident's clinical record the administration of medications, except when a single unit dose package distribution system is used.

3. 'Omitted doses in unit dose system.' If, for any reason, a medication is not administered as ordered in a unit dose system, an "unadministered dose slip" with an explanation of the omission shall be placed in the resident's medication container and a notation shall be made in the clinical record.

4. 'Self-administration.' Self-administration of medications by residents shall be permitted on order of the resident's physician or dentist or in a predischarge program under the supervision of a registered nurse or designee.

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

6. 'Day care.' The handling and administration of medications for day care clients shall comply with the requirements of this subsection.

(e) *Reference sources.* Up-to-date medication reference texts and sources of information shall be available to the nurse in charge or on call.

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

(6) PHYSICAL AND CHEMICAL RESTRAINTS. (a) *Definitions.* As used in this subsection, the following definitions apply:

1. "Physical restraint" means any article, device, or garment which is used primarily to modify resident behavior by interfering with the free movement of the resident, and which the resident is unable to remove easily, or confinement in a locked room. Mechanical supports shall not be considered physical restraints.

Note: For rules governing locked units, see s. HSS 132.33.

2. "Mechanical support" means any article, device, or garment which is used only to achieve the proper position or balance of the resident, which may include but is not limited to a geri chair, posey belt, jacket, or a bedside rail.

3. "Chemical restraint" means a medication used primarily to modify behavior by interfering with the resident's freedom of movement or mental alertness.

(b) *Orders required.* Physical or chemical restraints shall be applied or administered only on the written order of a physician which shall indicate the resident's name, the reason for restraint, and the period during which the restraint is to be applied.

(c) *Emergencies.* In an emergency, a physical restraint may be applied temporarily without an order when necessary to protect the resident or others from injury or to protect property, provided the physician is notified immediately and authorization for continued use is obtained from the physician within 12 hours.

(d) *Restriction.* If the mobility of a resident is required to be restrained and can be appropriately restrained either by a physical or chemical restraint or by a locked unit, the provisions of s. HSS 132.33 shall apply.

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

(f) *Periodic care.* While physically restrained, residents shall have their positions changed and personal needs met as necessary, but at least every 2 hours.

(g) *Records.* Any use of restraints shall be noted, dated, and signed in the resident's clinical record on each tour of duty during which the restraints are in use.

Note: See s. HSS 132.45 (5) (c) 4. g., records.

(7) USE OF OXYGEN. (a) *Orders for oxygen.* Except in an emergency, oxygen shall be administered only on order of a physician.

(b) *Person administering.* Oxygen shall be administered to residents only by a capable person trained in its administration and use.

(c) *Signs.* "No smoking" signs shall be posted in the room and at the entrance of the room in which oxygen is in use.

(d) *Flammable goods.* Prior to administering oxygen, all matches and other smoking material shall be removed from the room.

(8) RESIDENT CARE PLANNING. (a) *Development and content of care plans.* 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. HSS 132.52, and shall include:

1. Realistic goals, with specific time limits for attainment; and

2. The methods for delivering needed care, and indication of which professional disciplines are responsible for delivering such care.

Note: For requirements upon admission, see s. HSS 132.52.

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

Note: For concurrent review of medications, see sub. (5) (a) 4.

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

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

HSS 132.61 Medical services. (1) MEDICAL DIRECTION IN SKILLED CARE FACILITIES. (a) *Medical director.* Every skilled care facility shall retain, pursuant to a written agreement, a physician to serve as medical director on a part-time or full-time basis as is appropriate for the needs of the residents and the facility. If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the licensee.

(b) *Coordination of medical care.* Medical direction and coordination of medical care in the facility shall be provided by the medical director. The medical director shall develop written rules and regulations which shall be approved by the licensee and include delineation of the responsibilities of attending physicians. If there is an organized medical staff, by-laws also shall be developed by the medical director and approved by the licensee. Coordination of medical care shall include liaison with attending physicians to provide that physicians' orders are written promptly upon admission of a resident, that periodic evaluations of the adequacy and appropriateness of health professional and supportive staff and services are conducted, and that the medical needs of the residents are met.

(c) *Responsibilities to the facility.* The medical director shall monitor the health status of the facility's employes. Incidents and accidents that occur on the premises shall be reviewed by the medical director to identify hazards to health and safety.

(2) PHYSICIAN SERVICES IN ALL FACILITIES. The facility shall assure that the following services are provided:

(a) *Attending physicians.* Each resident shall be under the supervision of a physician of the resident's or guardian's choice who evaluates and monitors the resident's immediate and long-term needs and prescribes measures necessary for the health, safety, and welfare of the resident. Each attending physician shall make arrangements for the medical care of a physician's residents in the physician's absence.

Note: For medical examinations and assessments required for admission, see s. HSS 132.52.

(b) *Physicians' visits.* Every resident shall be seen by his or her attending physician at least annually, subject to the following:

1. 'Residents requiring skilled care.' Residents requiring skilled nursing care shall be seen by a physician at least every 30 days, unless the physician specifies and justifies in writing an alternate schedule of visits.

2. 'Residents not requiring skilled care.' Residents not requiring skilled nursing care shall be seen by a physician at least every 90 days, unless the physician specifies and justifies in writing an alternate schedule of visits.

3. 'Physician's plan of care.' The physician shall review the plan of care required by s. HSS 132.52 (1) (b) at the time of each visit.

4. 'Review of medications and other orders.' A resident's medications and other orders shall be reviewed by the physician at least at the time of each visit.

Note: For review by an RN, see s. HSS 132.60 (5) (a) 4.

5. 'Progress notes.' A progress note shall be written, dated, and signed by the physician at the time of each visit.

(c) *Availability of physicians for emergency patient care.* The facility shall have written procedures, available at each nurse's station, for procuring a physician to furnish necessary medical care in emergencies and for providing care pending arrival of a physician. The names and telephone numbers of the physicians or medical service personnel available for emergency calls shall be posted at each nursing station.

Note: For reporting requirements, see s. HSS 132.45 (5) (c) 4; for requirements to notify others, see s. HSS 132.60 (3) (a).

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

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

(b) "Ward clerk" means an employe who performs clerical duties of the nursing personnel.

(2) NURSING ADMINISTRATION. (a) *Director of nursing services in skilled care and intermediate care facilities.* 1. 'Staffing requirement.'