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Chapter DHS 124

HOSPITALS

Note: Chapter H 24 as it existed on January 31, 1988 was repealed and a new chapter HSS 124 was created effective February 1, 1988. Chapter HSS 124 was renumbered chapter HFS 124 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 7., Stats., Register, August, 1996, No. 488. Chapter HFS 124 was renumbered chapter DHS 124 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 124.01 Authority, purpose and applicability. This chapter establishes standards for the construction, maintenance and operation of hospitals. The chapter is promulgated under the authority of s. 50.36 (1), Stats., to ensure that hospital patients receive safe and adequate care and treatment and that the health and safety of patients and hospital employees are protected. The provisions of this chapter apply to all facilities meeting the definition of hospital in s. 50.33 (2), Stats., that are not specifically exempt under s. 50.39, Stats., except for those provisions that apply only to particular types of hospitals.

Note: Among facilities that are specifically exempt under s. 50.39, Stats., from being treated as hospitals for purposes of regulation under ss. 50.32 to 50.39 and this chapter are physicians' clinics and offices, nursing homes, the Milwaukee County Mental Health Center and correctional institutions operated by the Wisconsin department of corrections.

History: Cr. Register, January, 1988, No. 385, eff. 2–1–88.

DHS 124.02 Definitions. In this chapter:

(1m) "Critical access hospital" means a hospital that is designated by the department as meeting the requirements of 42 USC 1395i–4 (c) (2) (B) and is federally certified as meeting the requirements of 42 USC 1395i–4 (e).

(2) "Dentist" means a person licensed to practice dentistry under ch. 447, Stats.

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

(5) "Health physicist" means a person holding a masters degree or doctorate in an appropriate discipline of radiologic physics or who has equivalent education and experience.

(6) (a) "Hospital" means any building, structure, institution or place that does all of the following:

1. Offers inpatient, overnight care on a 24–hour–a–day basis, or on an as–needed basis in the case of a critical access hospital.

2. Devotes itself primarily to the maintenance and operation of facilities for the diagnosis and treatment of, and medical or surgical care for, 3 or more nonrelated individuals, designated "patients" in this chapter, suffering from illness, disease, injury or disability, whether physical or mental, or who are pregnant.

3. Regularly makes available at least clinical laboratory services, diagnostic x–ray services and treatment facilities for surgery, obstetrical care or other definitive medical treatment, except as otherwise provided for critical access hospitals in this chapter.

(b) "Hospital" may include, but is not limited to, related facilities such as outpatient facilities, nurses', interns' and residents' quarters, training facilities and central service facilities operated in connection with the hospital.

(c) "Hospital" includes a special hospital.

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

(10) "Medical staff" means the hospital's organized component of physicians, podiatrists, dentists, and other practitioners eligible to be on the medical staff pursuant to the medical staff bylaws who are granted specific clinical privileges for the purposes of providing adequate medical, podiatric, dental care or other health care services for the patients of the hospital.

(10m) "Medicare" means the health insurance program operated by the U.S. department of health and human services under 42 USC 1395 to 1395 ccc and 42 CFR ch. IV, subch. B.

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

(12) "Physician assistant" means a person certified under ch. 448, Stats., to perform patient services under the supervision and direction of a licensed physician.

(13) "Podiatrist" means a person licensed to practice podiatry or podiatric medicine and surgery under ch. 448, Stats.

(14) "Practitioners" means physicians, dentists, podiatrists or other professions permitted by Wisconsin law to distribute, dispense and administer medications in the course of professional practice, admit patients to a hospital, or provide any other health care service that is within that profession's scope of practice and for which the governing body grants clinical privileges.

(19) "Registered nurse" means a person who is licensed as a registered nurse under ch. 441, Stats.

(22) "Tissue" means a substance consisting of cells and intercellular material that is removed from a patient's body during a surgical procedure.

History: Cr. Register, January, 1988, No. 385, eff. 2–1–88; correction in (3) made under s. 13.93 (2m) (b) 6., Stats., Register, August, 1996, No. 488; emerg. cr. (1m), am. (6), (12 and (19), r. and recr. (21), eff. 9–12–98; cr. (1m) and (10m), am. (6), (12) and (19) and r. and recr. (21), Register, January, 1999, No. 517, eff. 2–1–99; correction in (3) made under s. 13.92 (4) (b) 6., Stats., Register January 2009 No. 637; CR 19–135: r. (1), (4), (7), (8), r. and recr. (10), (14), r. (15) to (18), (20), (21) Register June 2020 No. 774, eff. 7–1–20; correction in (14) made under s. 35.17, Stats., Register June 2020.

DHS 124.03 Approval by the department. **(1)** No hospital may operate in Wisconsin unless it is approved by the department.

(2) To be approved by the department, a hospital shall comply with this chapter and with all other applicable state laws and local ordinances, including all state laws and local ordinances relating

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to fire protection and safety, reporting of communicable disease, cancer reporting and post−mortem examination, and professional staff of the hospital shall be licensed or registered, as appropriate, in accordance with applicable laws.

(3) An application for approval shall be submitted to the department on a form prescribed by the department.

Note: For a copy of the hospital approval application form, write Division of Quality Assurance, P.O. Box 2969, Madison, Wisconsin 53701−2969.

(4) The department shall review and make a determination on a complete application for approval within 90 working days after receiving the application.

(5) Approval by the department applies only to the owner of a hospital who may not transfer or assign the approval to anyone else. When there is a change in the ownership of the hospital, the new owner shall submit a new application to the department.

(6) If at any time the department determines that there has been a failure to comply with a requirement of this chapter, it may withhold, suspend or revoke the certificate of approval consistent with s. 50.35, Stats.

(7) Every 12 months, on a schedule determined by the department, a hospital shall submit to the department an annual report 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 annual report is not timely filed, the department shall issue a warning to the holder of the certificate of approval. If a hospital that 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 approval of the hospital.

History: Cr. Register, January, 1988, No. 385, eff. 2−1−88; cr. (7), Register, August, 2000, No. 536, eff. 9−1−00.

DHS 124.04 Waivers and variances. (1) DEFINITIONS. In this section:

(a) "Variance" means an alternative requirement in place of a requirement of this chapter.

(b) "Waiver" means an exception from a requirement of this chapter.

(2) REQUIREMENTS FOR WAIVERS AND VARIANCES. A hospital may submit a request in writing to the department to grant a waiver or variance. The department may grant the waiver or variance if the department determines that the waiver or variance is necessary to protect the public health, safety, or welfare or to support the efficient and economic operation of the hospital. A waiver or variance supports the efficient and economic operation of the hospital in circumstances such as the following:

(a) Strict enforcement of a requirement would result in unreasonable hardship on the hospital or on a patient.

(b) An alternative to a rule, which may involve a new concept, method, procedure or technique, new equipment, new personnel qualifications or the conduct of a pilot project, is in the interests of better care or management.

(3) PROCEDURES. (a) *Applications.* 1. All applications for the grant of a waiver or variance 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 hospital 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 a denial shall contain the reasons for denial.

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

3. The department may impose whatever conditions on the granting of a waiver or variance it considers necessary.

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

(c) *Hearings.* 1. A hospital may contest the department's action on the hospital's application for a waiver or variance by requesting a hearing as provided by ch. 227, Stats.

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

(d) *Revocation.* The department may revoke a waiver or variance, subject to the hearing requirement in par. (c), if:

1. The department determines that the waiver or variance is adversely affecting the health, safety or welfare of the patients;

2. The hospital has failed to comply with the variance as granted or with a condition of the waiver or variance;

3. The person who has received the certificate of approval notifies the department in writing that the hospital wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied; or

4. The revocation is required by a change in state law.

History: Cr. Register, January, 1988, No. 385, eff. 2−1−88; CR 19−135: r. and recr. (2) Register June 2020 No. 774, eff. 7−1−20; correction in numbering in (2) made under s. 13.92 (4) (b) 1., Stats., Register June 2020 No. 774.

Subchapter II — Requirements

DHS 124.05 Statements of deficiency and plans of correction. (1) Based upon an inspection and investigation by the department under s. 50.36 (4), Stats., the department may issue a statement of deficiency notifying the hospital of noncompliance with a requirement of ch. 50, Stats., or department rules.

(2) The hospital shall submit a plan of correction to the department within 10 calendar days, including holidays and weekends, after receiving a statement of deficiency. The plan of correction shall include a reasonable fixed time period within which deficiencies are to be corrected.

(3) After the plan of correction is submitted, the department shall determine whether the corrections proposed by the hospital would result in substantial compliance with the requirements of ch. 50, Stats., and department rules, and notify the hospital of the department's determination. If the department determines the corrections proposed by the hospital would not result in substantial compliance, the department's notice shall describe the deficiency of the plan of correction.

History: Cr. Register, January, 1988, No. 385, eff. 2−1−88; cr. (3) (i), Register, November, 1993, No. 455, eff. 12−1−93; correction in (3) (f) 2. made under s. 13.93 (2m) (b) 7., Stats., August, 2000, No. 536; correction in (3) (f) 2. made under s. 13.93 (2m) (b) 7., Stats., Register July 2001 No. 547; CR 03−033: am. (3) (h) Register December 2003 No. 576, eff. 1−1−04; corrections in (3) (a) 2. and (f) 2. made under s. 13.92 (4) (b) 7., Stats., Register January 2009 No. 637; CR 09−089: r. and recr. (3) (i), cr. (3) (j) Register March 2010 No. 651, eff. 4−1−10; CR 19−135: r. and recr. Register June 2020 No. 774, eff. 7−1−20.

DHS 124.06 Patient rights and responsibilities in critical access hospitals. (1) Every critical access hospital shall have written policies on patient rights and responsibilities, established by the governing body, which shall provide all of the following:

(a) The patient may not be denied appropriate care because of the patient's race, creed, color, national origin, ancestry, religion, sex, sexual orientation, marital status, age, newborn status, disability, or source of payment.

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(b) The patient shall be treated with consideration, respect and recognition of the patient's individuality and personal needs, including the need for privacy in treatment.

(c) The patient's medical record, including all computerized medical information, shall be kept confidential as required by law.

(d) The patient, or a person authorized to act on behalf of the patient in making health care related decisions, shall have access to the patient's medical record as permitted by law.

(e) The patient shall be entitled to know who has overall responsibility for the patient's care.

(f) The patient, or any person authorized to act on behalf of the patient in making health care related decisions, shall receive information about the patient's illness, course of treatment and prognosis for recovery.

(g) The patient shall have the opportunity to participate to the fullest extent possible in planning for the patient's care and treatment.

(h) The patient or his or her designated representative shall be given, at the time of admission, a copy of the critical access hospital's policies on patient rights and responsibilities.

(i) Except in emergencies, the consent of the patient or a person authorized to act on behalf of the patient in making health care related decisions shall be obtained before treatment is administered.

(j) The patient may refuse treatment to the extent permitted by law and shall be informed of the medical consequences of the refusal.

(k) The informed consent of the patient or a person authorized to act on behalf of the patient in making health care related decisions shall be obtained before the patient participates in any form of research.

(L) Except in emergencies, the patient may not be transferred to another facility without being given a full explanation for the transfer, without provision being made for continuing care and without acceptance by the receiving institution.

(m) The patient shall be permitted to examine, and to receive an explanation of, any bill that the patient receives from the critical access hospital, and the patient shall receive, upon request, information relating to financial assistance available through the critical access hospital.

(n) The patient shall be informed of the patient's responsibility to comply with the rules of the critical access hospital, cooperate in the patient's own treatment, provide a complete and accurate medical history, be respectful of other patients, staff and property, and provide required information concerning payment of charges.

(o) The patient shall be informed in writing about the critical access hospital's policies and procedures for initiation, review and resolution of patient complaints, including the address where complaints may be filed with the department.

(p) The patient may designate persons who are permitted to visit the patient during the patient's stay at the critical access hospital.

(2) A patient who receives treatment at a critical access hospital for mental illness, a developmental disability, alcohol abuse or drug abuse shall have, in addition, the rights listed under s. 51.61, Stats., and ch. DHS 94.

(3) Critical access hospital staff assigned to direct patient care shall be informed of and demonstrate their understanding of the policies on patient rights and responsibilities through orientation and appropriate in−service training activities.

History: Cr. Register, January, 1988, No. 385, eff. 2−1−88; CR 19−135: r. and recr. Register June 2020 No. 774, eff. 7−1−20; **CR 20−068: am. (1) (a) Register December 2021 No. 792, eff. 1−1−22.**

DHS 124.07 Maternity and neonatal care. (1) DEFINITIONS. In this section:

(a) "Neonatal" means pertaining to the first 28 days following birth.

(c) "Nurse−midwife" means an individual licensed under s. 441.15, Stats., and ch. N 4.

(d) "Perinatal" means pertaining to the mother, fetus or infant, in anticipation of and during pregnancy and through the first 28 days following birth.

(2) PERSONNEL. (a) A registered nurse shall be responsible for the admission assessment of the maternity patient in labor and continuing assessment and support of the mother and fetus during labor, delivery and the early postpartum period.

(b) A registered nurse shall be responsible for the admission assessment of the newborn infant and continuing assessment until the newborn infant is stabilized as defined by current, accepted standards of practice.

(c) Hospitals with maternity units shall have a qualified anesthesia provider available at all times to provide emergency care to maternity patients.

(3) ADMISSION AND PATIENT PLACEMENT. Hospitals with maternity units shall do all of the following:

(a) The hospital shall establish and implement written policies for maternity and non−maternity patients who may be admitted to the maternity unit, including a policy that delineates medical staff responsibility for the admission of maternity patients in non−emergency situations.

(b) The hospital's infection prevention policies shall address patient placement and visitation in the maternity unit.

(c) The hospital shall establish and implement written policies for admission of newborn infants, including newborn infants born outside the hospital, and criteria for identifying conditions for directly admitting or readmitting newborn infants to the newborn nursery or neonatal intensive care unit for further treatment and follow−up care. For an infant delivered outside the hospital, admission may be made directly to the newborn nursery or neonatal intensive care unit if the admission complies with infection control policies adopted by the hospital to protect patients from communicable disease or infection.

(4) TRANSFER. A maternity unit shall do all of the following:

(a) Provide adequate facilities, personnel, and equipment and support services for the care of high−risk infants, including premature infants, or a plan for transfer of these infants to a neonatal or pediatric intensive care unit.

(b) Establish and implement written policies and procedures for inter−hospital transfer of perinatal and neonatal patients.

(c) Establish and implement written policies for the transfer of infants from one hospital to another hospital.

(d) Have available personnel and equipment to transfer infants to another hospital. The execution of transfer is a joint responsibility of the sending and receiving hospitals.

(5) DELIVERY. Hospitals with maternity units shall do all of the following:

(a) If cesarean deliveries are not performed in the maternity unit, equipment for neonatal stabilization and resuscitation shall be available during delivery.

(b) Delivery rooms shall be used only for delivery and operating procedures related to deliveries unless permitted by a written safety risk assessment that facilitates safe delivery of care.

(6) TESTS FOR CONGENITAL DISORDERS. The hospital shall establish and implement written policies that address the screening and testing of newborns for congenital and metabolic disorders consistent with s. 253.13, Stats., and ch. DHS 115.

(7) SECURITY. (a) The hospital shall establish and implement written policies that address infant identification and security.

(b) An infant may be discharged only to a parent who has lawful custody of the infant or to an individual who is legally authorized to receive the infant. If the infant is discharged to a

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legally authorized individual, that individual shall provide identification and, if applicable, the identification of the agency the individual represents. The hospital shall record the identity of the legally authorized individual to whom the infant is discharged.

(8) LABOR−INDUCING MEDICATIONS. (a) Only a physician or a nurse−midwife may order the administration of a labor−inducing medication.

(b) Only a physician or a nurse−midwife or a registered nurse who has adequate training and experience may administer a labor−inducing medication.

(c) A registered nurse shall be present when administration of a labor−inducing medication is initiated and shall remain immediately available to monitor maternal and fetal well−being. Hospitals shall develop and implement policies allowing the registered nurse to discontinue the labor−inducing medication if circumstances warrant discontinuation and no standing orders by a physician or a nurse−midwife are in place authorizing their discontinuation.

(d) A registered nurse shall closely monitor and document the administration of a labor−inducing medication. Monitoring shall include monitoring of the fetus and monitoring of uterine contraction during administration of a labor−inducing medication.

(e) The physician or nurse−midwife, who prescribed the labor−inducing medication, or another physician or nurse−midwife, shall be readily available during its administration so that, if needed, he or she will arrive at the patient's bedside within 30 minutes after being notified.

(9) RELIGIOUS CIRCUMCISIONS. A separate room apart from the newborn nursery shall be provided when circumcisions are performed according to religious rites. A physician, physician's assistant or registered nurse shall be present during the performance of the religious rite. Aseptic techniques shall be used when an infant is circumcised.

History: Cr. Register, January, 1988, No. 385, eff. 2−1−88; CR 19−135: r. and recr. Register June 2020 No. 774, eff. 7−1−20; renum. (1) (b) to (d) under s. 13.92 (4) (b) 1., Stats., Register June 2020.

DHS 124.08 Forfeiture assessment. (1) In this section, "victim" means a female who alleges or for whom it is alleged that she suffered sexual assault and who, as a result of the sexual assault, presents as a patient at a hospital that provides emergency services.

(2) The department may directly assess a forfeiture for each violation of a requirement under s. 50.375 (2) or (3), Stats., for care of a victim by a hospital that provides emergency services. The department may assess the forfeitures as follows:

(a) $2,500 for a first violation of a requirement under s. 50.375 (2) or (3), Stats.

(b) $5,000 for a subsequent violation of a requirement under s. 50.375 (2) or (3), Stats.

Note: Section 50.375 (2), Stats., requires a hospital that provides emergency services to a victim to 1) provide to the victim medically and factually accurate and unbiased written and oral information about emergency contraception and its use and efficacy; 2) orally inform the victim of her option to receive emergency contraception at the hospital, her option to report the sexual assault to a law enforcement agency, and any available options for her to receive an examination to gather evidence regarding the sexual assault; and 3) except as specified in s. 50.375 (4), Stats., immediately provide to the victim upon her request emergency contraception, in accordance with instructions approved by the federal food and drug administration. If the medication is taken in more than one dosage, the hospital shall provide all subsequent dosages to the victim for later self administration.

Note: Section 50.375 (3), Stats., requires a hospital that provides emergency care to ensure that each hospital employee who provides care to a victim has available medically and factually accurate and unbiased information about emergency contraception.

(3) If the department determines that a forfeiture should be assessed for a particular violation, the department shall send a notice of assessment to the hospital. The notice shall specify the amount of the forfeiture assessed, the violation and the statute or rule alleged to have been violated, and shall inform the hospital of the right to a hearing under sub. (4) pursuant to s. 50.377 (3), Stats.

(4) Pursuant to s. 50.377 (4), Stats., all forfeitures shall be paid to the department within 10 days after receipt of a notice of assessment or, if the forfeiture is contested under sub. (5), within 10 days after receipt of the final decision after exhaustion of administrative review, unless the final decision is appealed and the order is stayed by court order.

(5) Pursuant to s. 50.377 (3), Stats., a hospital may contest an assessment of a forfeiture by the department under sub. (2) by sending, within 10 days after receipt of notice under sub. (3), a written request for a hearing under s. 227.44, Stats., to the division of hearings and appeals. The administrator of the division may designate a hearing examiner to preside over the case and recommend a decision to the administrator under s. 227.46, Stats. The decision of the administrator of the division shall be the final administrative decision. The division shall commence the hearing within 30 days after receipt of the request for a hearing and shall issue a final decision within 15 days after the close of the hearing.

History: CR 19−135: renum. from DHS 124.24 (3) Register June 2020 No. 774, eff. 7−1−20; correction in (1), (3) to (5) made under s. 13.92 (4) (b) 7., Stats., Register June 2020 No. 774.

DHS 124.09 Freestanding emergency departments. (1) DEFINITION. In this subchapter, "freestanding emergency department" means a dedicated location that is physically separate from a hospital campus that offers inpatient overnight care, with services and staff organized primarily for the purpose of delivering emergency medical services without requiring a previously scheduled appointment.

(2) FREESTANDING EMERGENCY DEPARTMENTS. (a) A freestanding emergency department must comply with subs. (3), (4), and (5) and have provider−based status under 42 CFR 413.65 as a department of a hospital that offers inpatient overnight care.

(b) A freestanding emergency department shall be under the direction of the emergency services department of a Wisconsin licensed hospital.

(c) A freestanding emergency department shall provide emergency services 24 hours a day, 7 days a week, 365 days a year, on an outpatient basis.

(3) PHYSICAL ENVIRONMENT. (a) A freestanding emergency department shall be identifiable to a patient.

(b) The exterior entrance of a freestanding emergency department shall be at grade level, well−marked, and illuminated, with a covered ambulance bay.

(c) The freestanding emergency department equipment shall be readily available, serviced, maintained and adequate to provide comprehensive emergency care.

(4) PERSONNEL. (a) There shall be sufficient qualified medical, nursing, and ancillary personnel available to the freestanding emergency departments at all times to manage the number and severity of emergency department cases anticipated by the location. At all times, freestanding emergency departments shall have on−site the following minimum staffing, equipment and services necessary to evaluate and treat patients:

1. One physician, who through education, training, and experience specializes in emergency medicine.

2. One registered nurse, who through education, training, and experience specializes in emergency nursing.

3. A laboratory technician to provide laboratory services.

(b) A person authorized to perform radiological services pursuant to ch. 462, Stats., shall be available at the freestanding emergency department, as follows:

1. At all times for plain films.

2. On−call to perform CT scanning within 30 minutes.

3. On−call to perform ultrasound within 1 hour.

(5) ANCILLARY SERVICES. (a) *Radiology.* 1. Plain film, CT scanner and ultrasound equipment shall be available.

2. Radiologist interpretation of CT scans and ultrasounds shall be available within one hour.

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3. The freestanding emergency department shall develop and implement a written policy for timely interpretation of plain film studies.

(b) *Laboratory.* 1. Blood or blood replacement shall be available within thirty minutes.

2. Services available within the freestanding emergency department shall be appropriate for the care of emergency medical cases anticipated by the location.

(c) *Pharmacy, respiratory and social services.* 1. The freestanding emergency department shall provide pharmacy and respiratory services appropriate for the care of emergency medical cases anticipated by the location.

2. Services and supplies available within the freestanding emergency department shall be appropriate for the care of emergency medical cases anticipated by the freestanding emergency department.

3. Written policies regarding the availability and utilization of social services shall be established.

(6) AMBULANCE DELIVERY. A freestanding emergency department shall:

(a) Establish written policies and procedures governing ambulance delivery of patients that are consistent with the local emergency medical service system.

(b) Communicate these policies to the local emergency medical services system to ensure appropriate routing of emergency cases by emergency medical technicians.

(c) Establish written policies regarding patient transfers to other medical facilities. The policies shall address transfers by ambulance and, if the freestanding emergency department determines it is appropriate for that location, by helicopter.

History: Cr. Register, January, 1988, No. 385, eff. 2−1−88; CR 19−135: r. and recr. Register June 2020 No. 774, eff. 7−1−20; correction in (1), (2) (c), (3) (a), (4) (b) (intro.), 2., 3. made under s. 35.17, Stats., Register June 2020 No. 774.

Subchapter V — Physical Environment

DHS 124.275 Definitions. In this subchapter:

(1) "Alteration" has the meaning provided in the International Building Code Sec. 202 as adopted in s. SPS 361.05.

(2) "Existing construction" means a building which is in place or is being constructed with plans approved by the department prior to the effective date of this chapter.

(3) "Life Safety Code" means the National Fire Protection Association's (NFPA) Standard 101.

(4) "New construction" means construction for the first time of any building or addition to an existing building, the plans for which are approved on or after July 1, 2020.

(5) "Owner" has the meaning provided in s. 101.01 (10), Stats.

Note: The International Building Code is located at www.iccsafe.org.

Note: Copies of the Life Safety Code and related codes can be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts, USA 02169−7471.

History: CR 19−135: renum. (intro.), (1), (2), (5) from DHS 124.29 (1) (intro.), (a) to (c), renum. (3), (4) from DHS 124.30 (1) (a), (b) under s. 13.92 (4) (b) 1., Stats, Register June 2020 No. 774; correction in (4) made under s. 13.92 (4) (b) 14., Stats., and correction in (5) made under s. 13.92 (4) (b) 7., Stats., Register June 2020 No. 774.

DHS 124.29 Plans for new construction and alterations. (2) SIGNING AND SEALING. Construction documents submitted to the department for review shall be prepared, signed and sealed in accordance with ch. 443, Stats., and s. A−E 2.02.

(3) CONTENTS AND INFORMATION. (a) Construction documents submitted to the department for review shall be dimensioned and drawn to scale. The scale used for the construction documents shall be indicated on the documents. An application form shall be included with the construction documents and information submitted to the department for examination and approval.

(b) Submittal to the department is as follows:

1. Except as provided in subd. 2., at least 4 sets of construction documents shall be submitted to the department for review.

2. a. At least one set of construction specifications shall be submitted to the department for review.

b. One complete set of plans may be submitted, provided it is accompanied with 3 copies of the cover sheet for the complete set, and provided all 4 cover sheets comply with sub. (2).

(c) Fees, as provided in s. DHS 124.31, shall be remitted to the department at the time the plans are submitted. No plan examinations, approvals, or onsite reviews shall be made until fees are received.

(4) PLAN APPROVAL. (a) The department shall review and make a determination under s. DHS 124.30 (3) on an application for plan review under this chapter within 30 business days upon submission of the application.

(b) An application for plan approval will not be granted if, upon examination, the department determines that the construction documents or application for approval require additional information.

(c) If, upon examination, the department determines that the construction documents substantially comply with s. DHS 124.30 (3), a conditional approval, in writing, shall be granted. The owner, before and during construction, shall comply with all conditions as stated in the construction approval.

(d) If, upon examination, the department determines that the construction documents do not substantially comply with this chapter, the application for conditional approval shall be denied, in writing.

(5) EXPIRATION OF APPROVAL. (a) *Building shell.* Plan approval by the department for new buildings and building additions shall expire 2 years after the approval date indicated on the approved building plans if the building shell is not closed−in within those 2 years.

(b) *Occupancy.* Plan approval by the department for new buildings and building additions shall expire 3 years after the approval date indicated on the approved building plans if the building is not ready for occupancy within those 3 years.

(c) *Alterations.* Plan approval by the department for interior building alterations shall expire one year after the approval date indicated on the approved building plans if the alteration work is not completed within that year.

(d) *HVAC construction only.* Plan approval by the department for heating, ventilating, or air conditioning construction that does not include any associated building construction shall expire 1 year after the approval date indicated on the approved plans if the building or building area affected by the plans is not ready for occupancy within that year.

(e) *Fire protection systems only.* Plan approval by the department for a fire protection system that does not include any associated building construction shall expire 2 years after the approval date indicated on the approved plans if the building or building area affected by the plans is not ready for occupancy within those 2 years.

(6) EXTENSION OF PLAN APPROVAL. Upon request and payment of the fee specified in s. DHS 124.31 (4) (e), the expiration dates in sub. (5) (a) to (e) may be extended, provided the request is submitted prior to expiration of the original approval.

(7) CHANGES TO APPROVED FINAL PLANS. Any changes in the approved final plans affecting the application of the requirements of this subchapter shall be shown on the approved final plans and shall be submitted to the department for approval before construction is undertaken. The department shall notify the hospital in writing of any conflict with this subchapter found in its review of modified plans and specifications.

(8) PERMISSION TO START CONSTRUCTION. (a) A building owner may request and the department may grant permission to

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start construction for the footings and foundations upon submission of construction documents under this section.

(b) The department shall review and make a determination on an application for permission to start construction of the footings and foundations within 3 business days of receipt of the application and all forms, fees, construction documents and information required to complete the review.

(c) A building owner who has been granted permission to start construction of the footings and foundations may proceed at the owner's own risk without assurance that a conditional approval for the building will be granted.

(9) ONSITE REVIEWS. At the request of the owner, the department shall conduct onsite reviews during the construction phase of the project including but not limited to framing reviews, above ceiling reviews, and finish reviews.

History: Emerg. renum. from DHS 124.27 (5), eff. 7−1−96; renum. from DHS 124.27 (5), Register, December, 1996, No. 492, eff. 1−1−97; CR 19−135: r. and recr. Register June 2020 No. 774, eff. 7−1−20; correction in (3) (b) 1., (5) (d), (6) made under s. 35.17, Stats., Register June 2020 No. 774; renum. (1) to DHS 124.275 (intro.), (1), (2), (5) under s. 13.92 (4) (b) 1., Stats., and correction in (6) made under s. 13.92 (4) (b) 7., Stats., Register June 2020 No. 774.

DHS 124.30 Standards. (2) PLAN REVIEW. Before the start of any new construction or alteration project for a hospital, the plans for the construction or alteration shall be submitted to the department, pursuant to s. DHS 124.29, for review and approval by the department.

(3) DEPARTMENT REVIEW. The department shall review new construction and alteration plans for compliance with all of the following:

(a) This chapter.

(b) Chapters SPS 361 to 366, except s. SPS 361.31 (3). Where chs. SPS 361 to 366 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.

(c) The provisions of the Life Safety Code adopted by the Conditions of Participation per s. 50.36, Stats.

History: Emerg. cr. eff. 7−1−96; cr. Register, December, 1996, No. 492, eff. 1−1−97; corrections in (1) made under s. 13.93 (2m) (b) 7., Stats., Register, January, 1999, No. 517; corrections in (1) made under s. 13.93 (2m) (b) 6. and 7. Stats., Register September 2003 No. 573; 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.; CR 19−135: r. and recr. Register June 2020 No. 774, eff. 7−1−20; renum. (1) (a), (b) to DHS 124.275 (3), (4) under s. 13.92 (4) (b) 7., Stats., and r. (1) (intro.) under s. 35.17, Stats., Register June 2020 No. 774.

DHS 124.31 Fees for plan reviews. (1) GENERAL. The fees established in this section shall be paid to the department for providing plan review services under this subchapter. The department may withhold providing services to parties who have past due accounts with the department for plan review services. Except as provided under sub. (4) (b), the fee for review of plans shall be based on the total gross floor area of s. SPS Table 302.31−1 and on the dollar value of the project to the table under sub. (3).

(2) DEFINITION. In this section, "miscellaneous plans" means plans that have no building or heating, ventilation and air conditioning plan submissions, including all of the following:

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

(b) Structural plans submitted as independent projects, such as docks or antennae.

(c) Plans for any other building component.

(3) FEE TABLE. Fee part based on project dollar value.

Project Dollar Value	Fee
Less Than $4,999	$125
$5,000 – $12,249	$175
$12,500 – $24,999	$375
$25,000 – $49,999	$475
$50,000 – $99,999	$625
$100,000 – $249,999	$775
$250,000 – $499,999	$925
$500,000 – $749,999	$1,175
$750,000 – $999,999	$1,550
$1,000,000 – $2,499,999	$2,350
$2,500,000 – $4,999,999	$4,675
$5,000,000 – $9,999,999	$6,250
$10,000,000 – $19,999,999	$12,500
$20,000,000 And Over	$20,000

(4) OTHER FEES. (a) *Fee for plan entry.* Each submission of plans for the project shall be accompanied by a $100 plan entry fee. When plans for multiple projects are submitted together, each project shall constitute a separate submission and requires a $100 plan entry fee.

(b) *Fee for miscellaneous plans.* The fee for a miscellaneous plan shall be $250. This fee is for plan review and onsite review.

(c) *Fee for permission to start construction.* The fee for permission to start construction shall be $75. This fee shall apply only to applicants proposing to start construction prior to approval of their plans by the department.

(d) *Fee for plan revision.* The fee for revision of previously approved plans shall be $75. 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.

(e) *Fee for extension of plan approval.* The examination fee for a plan approved for extension beyond the time limit specified in this chapter shall be $120 per plan.

(f) *Fee for petitions for variance.* The fee for reviewing commercial building code petitions for variance shall be in accordance with ch. SPS 302. The fee for reviewing a petition on a priority basis shall be in accordance with ch. SPS 302.

History: Emerg. cr. eff. 7−1−96; cr. Register, December, 1996, No. 492, eff. 1−1−97; CR 19−135: r. and recr. Register June 2020 No. 774, eff. 7−1−20; correction in numbering of (2) made under s. 13.92 (4) (b) 1., Stats., and correction in (4) (a) made under s. 35.17, Stats., Register June 2020 No. 774.

DHS 124.32 Patient rooms − general. (2) PRIVACY. Visual privacy shall be provided for each patient in multi−bed patient rooms. In new or remodeled construction, cubicle curtains shall be provided.

(3) TOILET ROOM. (a) In new construction, each patient room shall have access to one toilet without entering the general corridor area. One toilet room shall serve no more than 4 beds and no more than 2 patient rooms. A handwashing sink shall be provided either in each patient's room or in the adjoining toilet room.

(b) In new and remodeled construction, the door to the patient toilet room shall swing into the patient room, or two−way hardware shall be provided.

(4) MINIMUM FLOOR AREA. The minimum floor area per bed shall be 80 square feet in multiple patient rooms and 100 square feet in single patient rooms. The distance between patient beds in multi−patient rooms shall be at least 3 feet.

History: Emerg. renum. from DHS 124.27 (6), eff. 7−1−96; renum. from DHS 124.27 (6), Register, December, 1996, No. 492, eff. 1−1−97; CR 19−135: r. (1), (3) (c), (5) Register June 2020 No. 774, eff. 7−1−20.

DHS 124.34 Patient care areas. (3) UTILITY AREAS. (a) A utility room for clean linen and other clean articles shall be readily accessible to each nursing unit. The room shall contain at least:

1. Storage facilities for supplies;
2. A handwashing sink; and
3. Work counters.

(b) A utility room for soiled linen and other soiled articles shall be readily accessible to each nursing unit. The room shall include at least:

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1. A clinical sink or equivalent flush rim fixture;
2. A handwashing sink;
3. A work counter;
4. A waste receptacle; and
5. A linen receptacle.

(c) Individual patient toilet room bed pan washers are permitted in lieu of the clinical fixture requirement stated in par. (b) 1.

(8) PATIENT CALL SYSTEM. A reliable call mechanism shall be provided in locations where patients may be left unattended, including patient rooms, toilet and bathing areas and designated high risk treatment areas from which individuals may need to summon assistance.

History: Emerg. renum. from DHS 124.27 (8), eff. 7−1−96; renum. from DHS 124.27 (8), Register, December, 1996, No. 492, eff. 1−1−97; CR 19−135: r. (1), (2), cr. (3) (c), r. (4) to (7) Register June 2020 No. 774, eff. 7−1−20.

DHS 124.35 Additional requirements for particular patient care areas; psychiatric units. The requirements for patient rooms under s. DHS 124.34 apply to patient rooms in psychiatric nursing units and psychiatric hospitals except as follows:

(1) In new construction and remodeling a staff emergency call system shall be included. Call cords from wall−mounted stations of individual patient rooms may be removed when justified by psychiatric program requirements.

(2) Doors to patient rooms and patient toilet room doors may not be lockable from the inside.

(3) Patients' clothing and personal items may be stored in a separate designated area which is locked.

(4) Moveable hospital beds are not required for ambulatory patients.

History: Emerg. renum. from DHS 124.27 (9), eff. 7−1−96; renum. from DHS 124.27 (9), Register, December, 1996, No. 492, eff. 1−1−97; CR 19−135: r. (1), (3) to (7) Register June 2020 No. 774, eff. 7−1−20; renum. (2) to DHS 124.35 under s. 13.92 (4) (b) 1., Stats., Register June 2020 No. 774.

DHS 124.36 Other physical environment; fire report. All incidents of fire in a hospital shall be reported to the department within 72 hours.

Note: Information about online fire reporting is available at: http://www.dhs.wisconsin.gov/publications/p01729.pdf.

History: Emerg. renum. from DHS 124.27 (10), eff. 7−1−96; renum. from DHS 124.27 (10), Register, December, 1996, No. 492, eff. 1−1−97l; CR 19−135: r. (1) to (10) Register June 2020 No. 774, eff. 7−1−20; renum. (11) to DHS 124.36 under s. 13.92 (4) (b) 7., Stats., Register June 2020 No. 774.

Subchapter VI — Critical Access Hospitals

DHS 124.37 Applicability. This subchapter applies to the department and to all hospitals designated by the department as critical access hospitals.

History: Emerg. cr., eff. 9−12−98; cr. Register, January, 1999, No. 517, eff. 2−1−99.

DHS 124.38 Definitions. In this subchapter:

(1) "Clinical nurse specialist" means a registered nurse who is currently certified as a clinical nurse specialist by a national certifying body that is recognized by the state board of nursing.

(2) "Network hospital" means a full−time hospital that has an agreement with a critical access hospital to provide ongoing acute care services for patients transferred or referred from the critical access hospital.

(3) "Nurse practitioner" means a registered nurse who is currently certified as a nurse practitioner by a national certifying body that is recognized by the state board of nursing.

(4) "Rural health plan" means a plan approved by the federal centers for medicare and medicaid services that describes how the department will implement and administer parts of the federal medicare rural hospital flexibility program — critical access hospitals — under 42 USC 1395i−4.

(5) "Rural hospital" means a hospital that was initially approved as a hospital prior to January 1, 2003 and is located in a county that has at least a portion of a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as provided in 42 CFR 412.103(a)(1).

Note: The most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration is available via the ORHP website at http://www.raconline.org/topics/what−is−rural/faqs/#goldsmith or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9A−55, Rockville, MD 20857. 42 CFR 412.103 of the federal regulations addresses hospitals located in urban areas that want to apply for reclassification as rural hospitals.

History: Emerg. cr. eff. 9−12−98; cr. Register, January, 1999, No. 517, eff. 2−1−99; emerg. cr. (5), eff. 3−21−03; CR 03−042: am. (4), cr. (5) Register September 2003 No. 573, eff. 10−1−03; CR 19−135: r. and recr. (2) Register June 2020 No. 774, eff. 7−1−20.

DHS 124.39 Designation as a critical access hospital. (1) ELIGIBILITY. Except as provided under sub. (2) (a), to be eligible for designation as a critical access hospital, a hospital shall be all of the following:

(a) A hospital approved by the department under this chapter to operate as a hospital.

(b) Located in an area outside of a metropolitan statistical area as defined in 42 USC 1395ww(d), or located in a rural area of an urban county.

(c) Located more than a 35−mile drive from another hospital or certified by the department under sub. (2) as a necessary provider of health care services to residents in the area.

(d) A hospital that has a provider agreement to participate in medicare in accordance with 42 CFR 485.612.

(e) A hospital that has not been designated by the federal centers for medicare and medicaid services as an urban hospital for purposes of medicare reimbursement.

(2) APPLICATION FOR CERTIFICATION AS A NECESSARY PROVIDER FOR AN AREA. (a) 1. A hospital meeting the criteria under sub. (1) (a), (b), (d) and (e) may apply to the department for certification as a necessary provider of health care services to residents in its area if it cannot meet the criterion under sub. (1) (c) that it be located more than a 35−mile drive from another hospital.

2. A rural hospital meeting the criteria under sub. (1) (a), (d) and (e) may apply to the department for certification as a necessary provider of health care services to residents in its area if the rural hospital cannot meet the criteria under sub. (1) (b) and (c).

3. Application under subd. 1. or 2. shall be made in accordance with a format provided by the department.

Note: To obtain the format for the application, write or phone: Division of Quality Assurance, P.O. Box 2969, Madison, WI 53701−2969; (608) 266−7297.

(b) Upon receipt of a completed application from a hospital for certification as a necessary provider of health care services to residents in the area, the department shall review the application and shall approve or disapprove it within 60 days of receipt.

(3) APPLICATION FOR CRITICAL ACCESS HOSPITAL STATUS. (a) A hospital eligible under sub. (1) or (2) (a) for designation as a critical access hospital may apply to the department for designation. Application shall be made in accordance with a format provided by the department.

Note: To obtain the format for the application, write or phone: Division of Quality Assurance, P.O. Box 2969, Madison, WI 53701−2969; (608) 266−7297.

(b) Upon receipt of a completed application from a hospital for designation as a critical access hospital, the department shall review the application and shall determine if the applicant meets the federal conditions of participation in medicare for critical access hospitals under 42 CFR 485.601 to 485.645, and, if applicable, 42 CFR 412.103(a)(1). If the applicant hospital meets those federal regulations and all requirements under ss. DHS 124.40 and 124.41, the department shall, within 90 days after receipt of a completed application, recommend certification of the hospital as a critical access hospital to the federal centers for medicare and medicaid services.

Note: Section DHS 124.40 was repealed by CR 19−135, effective 7−1−20. This provision will be treated in future rulemaking.

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Note: The federal Centers for Medicare and Medicaid Services will notify the Department and the applicant hospital of the certification decision.

(c) Following notification by the federal centers for medicare and medicaid services that it has accepted the department's certification recommendation, the department shall issue a certificate of approval that establishes the applicant's critical access hospital status in the state.

History: Emerg. cr. eff. 9−12−98; cr. Register, January, 1999, No. 517, eff. 2−1−99; emerg. am. (1) (intro.) and (e), (2) (a) and (3), eff. 3−21−03; CR 03−042: am. (1) (intro.), (a), (b), (e), (2) (a) and (3) Register September 2003 No. 573, eff. 10−1−03.

DHS 124.41 Rural health plan. Before implementation of the state medicare rural hospital flexibility program pursuant to 42 USC 1395i−4 for the establishment of critical access hospitals, the department shall develop a rural health plan. The department shall submit the rural health plan to the federal centers for medicare and medicaid services for approval.

History: Emerg. cr. eff. 9−12−98; cr. Register, January, 1999, No. 517, eff. 2−1−99; CR 03−042: am. Register September 2003 No. 573, eff. 10−1−03.