Published under s. 35.93, Wis. Stats., by the Legislative Reference Bureau.

Chapter DHS 131

HOSPICES

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Note: Chapter HSS 131 was renumbered Chapter HFS 131 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, July, 1999, No. 523. Chapter HFS 131 was renumbered chapter DHS 131 under s. 13.92 (4) (b) 1., Stats., and corrections made under s. 13.92 (4) (b 7., Stats., Register January 2009 No. 637. Chapter DHS 131 as it existed on September 30, 2010 was repealed and a new chapter DHS 131 was created, effective October 1, 2010.

Subchapter I — General Provisions

DHS 131.11 Authority and purpose. This chapter is promulgated under the authority of s. 50.95, Stats., to establish minimum standards for the operation of hospice programs in Wisconsin. The purpose of the chapter is to ensure that hospice patients receive safe and adequate care and support and that the health and safety of hospice patients, employees and volunteers are protected.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.12 Applicability. This chapter applies to all organizations, programs and places operating as hospices in Wisconsin.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.13 Definitions. In this chapter:

(1) "Advance directive" means a written instruction, such as a living will under ch. 154, Stats., or a power of attorney for health care under ch. 155, Stats., or as otherwise recognized by the courts of the state, relating to the provision or nonprovision of health care when the individual is incapacitated.

(2) "Advanced practice nurse" means a person who is certified as an advanced practice nurse as provided in ch. N 8.

(3) "Attending physician" means a person who is either a doctor of medicine or osteopathy legally authorized to practice medicine and surgery under ch. 448, Stats., physician assistant or a nurse practitioner who meets the training, education, and experience requirements specified in s. DHS 105.20 (1) and the who identified by the patient, at the time he or she elects to receive hospice care, as having the greatest overall role in the determination and delivery of the individual's medical care.

(4) "Bereavement services" means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment.

(5) "Core team" means a defined group within the hospice's interdisciplinary group that has represented on it physician, nurse, social worker and bereavement or other counseling services and that is responsible for all aspects of care and services to a patient and the patient's family.

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

(7) "Employee" means a person who:

(a) Works for the hospice and for whom the hospice is required to issue a W–2 form on his or her behalf.

(b) If the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice.

(c) Is a volunteer under the jurisdiction of the hospice.

(8) "Family member" means an individual with significant personal ties to the hospice patient who is designated a family member by mutual agreement between the individual and the patient.

(9) "Hospice" means any of the following:

(a) An organization that primarily provides palliative care and supportive care to an individual with terminal illness where he or she lives or stays and, if necessary to meet the needs of an individual with terminal illness, arranges for or provides short-term inpatient care and treatment or provides respite care.

(b) A program within an organization that primarily provides palliative care and supportive care to an individual with terminal illness where he or she lives or stays, that uses designated staff time and facility services, that is distinct from other programs of care provided by the organization and, if necessary to meet the needs of an individual with terminal illness, that arranges for or provides short-term inpatient care and treatment or respite care.

(c) A place, including a freestanding structure or a separate part of a structure in which other services are provided, that primarily provides palliative and supportive care and a place of residence to individuals with terminal illness and provides or arranges for short-term inpatient care as needed.

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(10) "Hospice patient" or "patient" means an individual in the terminal stage of illness who has an anticipated life expectancy of 12 months or less and who has been admitted to the hospice.

(11) "Interdisciplinary group" or "IDG" means the group of hospice employees which has represented on it the core team services and may, in addition, have physical therapy, occupational therapy, speech pathology and nurse aide services.

(11m) "Nonambulatory" means unable to walk.

(12) "Nurse aide" means an individual employed by or under contract to a hospice to provide nurse aide services as specified in s. DHS 131.26 (2) (b) under the supervision of a registered nurse.

(12m) "Semiambulatory" means able to walk with difficulty or able to walk only with the assistance of an aid, such as crutches, a cane, or a walker.

(13) "Palliative care" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy and access to information.

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

(15) "Plan of care" means the written information that describes a patient's needs and related needs of the patient's family, goals and interventions by specified hospice employees or volunteers as well as a means for evaluating the effectiveness of the interventions.

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

(17) "Representative" means an individual who has the authority under s. 50.94, Stats., to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill patient who is mentally or physically incapacitated. This may include a legal guardian.

(18) "Respite care" means care provided to a terminally ill individual in order to provide temporary relief to the primary caregiver.

(19) "Restraint" means any of the following:

(a) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm that does not include a physical escort.

(b) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

(20) "Seclusion" means the involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving.

(20m) "Semiambulatory" means able to walk with difficulty or able to walk only with the assistance of an aid, such as crutches, a cane, or a walker.

(21) "Short-term inpatient care" means care provided to a terminally ill individual in an inpatient setting for brief periods of time for the purpose of pain control or acute or chronic symptom management.

(22) "Social worker" means an individual who holds a social worker certificate or a clinical social worker license under s. 457.08, Stats.

(23) "Supportive care" means services provided during the final stages of an individual's terminal illness and dying and after the individual's death to meet the psychosocial, social and spiritual needs of family members of the terminally ill individual and other individuals caring for the terminally ill individual.

(24) "Terminal illness" means a medical prognosis by a doctor of medicine or osteopathy that an individual's life expectancy is less than 12 months.

(25) "Volunteer" means an uncompensated staff person.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10; CR 19-092: r. and recr. (3), cr. (11m), (20m) Register July 2020 No. 775, eff. 8-1-20; correction in (3) made under s. 35.17, Stats., Register July 2020 No. 775.

DHS 131.14 License. (1) LICENSE REQUIREMENT. (a) No person may conduct, maintain, operate or otherwise participate in conducting, maintaining or operating a hospice unless the hospice is licensed by the department.

(b) A hospice program may have more than one office or facility. Multiple units do not need to be separately licensed if the hospice is able to demonstrate supervision and administration from the central office.

(2) APPLICATION. (a) Application for a license to operate a hospice shall be made in writing on a form provided by the department.

(b) The completed application shall contain all of the following information:

1. The name and address of the applicant.

2. The location of the hospice.

3. Identification of the person or persons administratively responsible for the program, and the affiliation, if any, of the person or persons with a licensed home health agency, hospital, nursing home or other health care facility.

4. The proposed geographic area the hospice will serve.

5. A listing of those hospice services provided directly by the hospice, and those hospice services provided through a contractual agreement.

6. A list of those providers under contract with the hospice to provide hospice services.

7. Evidence to establish that the applicant has sufficient resources to permit operation of the hospice for a period of at least 90 days.

8. Any additional information specified by the department as necessary to determine that the entity detailed in the application is a hospice and that the applicant is and is fit and qualified to operate it.

(c) The applicant shall submit the application form to the department accompanied by the applicable fee established under s. 50.93 (1) (c), Stats.

Note: To obtain an application form for a license, write the Bureau of Technology, Licensing and Education, Division of Quality Assurance, Department of Health Services, P.O. Box 2969, Madison, WI 53701-2969 or telephone (608) 266-2702. The completed application form should be sent to the same office.

(3) REVIEW OF THE APPLICATION. (a) *Investigation.* After receiving a complete application, the department shall investigate and inspect 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. An applicant that is currently certified as meeting conditions for medicare participation under 42 USC 1395 to 1395ccc, need not be investigated or inspected as a condition for issuance of a license.

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(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 health care provider with which the applicant is affiliated or was affiliated during the past 5 years. The department shall consider at least all of the following:

1. Any adverse action against the applicant by the licensing agency of this state or any other state relating to the applicant's operation of a hospice, home health agency, residential facility or health care facility. In this subdivision, "adverse action" means an action initiated by a state licensing agency which resulted in the denial, suspension or revocation of the license of a hospice, home health agency, residential facility or health care facility operated by the applicant.

2. Any adverse action against the applicant based upon noncompliance with federal statutes or regulations in the applicant's operation of a hospice, home health agency, residential facility or health care facility in this state or any other state. In this subdivision, "adverse action" means an action by a state or federal agency which resulted in civil money penalties, termination of a provider agreement, and suspension of payments or the appointment of temporary management of a hospice, home health agency, residential facility or health care facility operated by the applicant.

3. The frequency of noncompliance with state licensure and federal certification laws in the applicant's operation of a hospice, home health agency, residential facility or health care facility in this state or any other state.

4. Any denial, suspension, enjoining or revocation of a license that 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.

5. Any conviction of the applicant for a crime involving neglect or abuse of patients, or involving assaultive behavior, wanton disregard for the health or safety of others or any act of elder abuse under s. 46.90, Stats.

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

7. Any conviction of the applicant for a crime involving controlled substances under ch. 961, Stats.

8. Any knowing or intentional failure or refusal by the applicant to disclose required ownership information.

9. Any prior financial failure of the applicant that resulted in bankruptcy or in the closing of a hospice, home health agency or an inpatient health care facility or the relocation of its patients.

(4) PROVISIONAL LICENSE. After receiving a complete application for a new license, the department shall investigate the applicant to determine the applicant's ability to comply with this chapter. Prior to completing its investigation or if the hospice is not in operation at the time that application is made, the department may issue a provisional license. Unless sooner revoked or suspended, a provisional license shall be valid for no more than 24 months from the date of issuance.

(5) REGULAR LICENSE. (a) The department shall inspect a hospice prior to issuing a regular license unless sub. (3) (a) applies and the hospice need not be inspected.

(b) During the provisional period specified in sub. (4), the hospice shall actively serve at least 5 patients in Wisconsin. At the time of this inspection the hospice shall be actively providing services to at least 3 patients and be able to demonstrate the operational capability of all the facets of the program in order to be issued a regular license.

(c) A regular license is valid indefinitely unless revoked or suspended.

(7) ONGOING LICENSURE. (a) A regular license shall be valid indefinitely if the following condition is satisfied:

(b) Every 12 months, on a schedule determined by the department, the hospice submits an annual report to the department in the form and containing the information that the department requires, including payment of the applicable fee specified in s. 50.93 (1) (c), Stats. If a complete annual report is not timely filed, the department shall issue a warning to the licensee. If a hospice 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 license.

Note: To obtain an application form for renewal of a license, write the Bureau of Technology, Licensing and Education, Division of Quality Assurance, P.O. Box 2969, Madison, Wisconsin 53701-2969 or telephone (608) 266-2702.

(8) 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. (3) (b) 1. to 3., of substantial noncompliance with federal or this state's or any state's requirements, who fails under sub. (3) (b) 4. to 9. to qualify for a license, or who is found not in substantial compliance with this chapter. 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 under sub. (11) for appealing the denial.

(9) SCOPE OF LICENSE. A license is issued only for the premises identified in the license application, if the hospice is a residential facility, and only for the persons named in the license application, and may not be transferred or assigned by the licensee.

(10) REPORT OF CHANGES. (a) *Changes requiring notice.* The licensee shall, within 10 days, notify the department in writing of any changes in the services provided and any appointment or change of the administrator.

(b) *Changes requiring new application.* A new application under sub. (2) shall be submitted to the department within 10 working days when any of the following changes has occurred:

1. The corporate licensee has transferred 50% or more of the issued stock to another party or other parties.

2. The licensee has transferred ownership of 50% or more of the assets to another party or other parties.

3. There has been change in partners or partnership interests of 50% or greater in terms of capital or share of profits.

4. The licensee has relinquished management of the agency.

(11) SUSPENSION OR REVOCATION. The department by written notice to the applicant or recipient may suspend or revoke a license if the department finds that there has been a substantial failure to comply with the requirements of ss. 50.90 to 50.98, Stats., or this chapter. The notice shall identify the violation and the statute or rule violated, and shall describe the process under sub. (11) for appealing the decision.

(12) APPEAL OF DECISION TO DENY, SUSPEND OR REVOKE A LICENSE. (a) Any person aggrieved by the department's decision to deny a license or to suspend or revoke a license may request a hearing on that decision under s. 227.42, Stats., which shall be limited to the issues stated as the bases for denial, suspension or revocation in the written notice under sub. (10).

(b) The request for hearing shall be in writing, shall be filed with the department of administration's division of hearings and

appeals, and shall be sent to that office so that it is received there within 10 days after the date of the notice under sub. (10). A request for a hearing is considered filed upon its receipt by the division of hearings and appeals. Review is not available if the request is received more than 10 days after the date of the notice under sub. (10).

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

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.15 Inspections of licensed programs. The department shall conduct unannounced inspections of a hospice which may include home visits with prior patient consent or a review of the clinical records of any individual with terminal illness served by the hospice. The department may inspect or investigate a hospice as it deems necessary.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.16 Waivers and variances. (1) DEFINITIONS. In this section:

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

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

(2) REQUIREMENTS FOR WAIVERS AND 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 patient and that:

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

(b) An alternative to a requirement, including a new concept, method, procedure or technique, other equipment, other personnel qualifications, or the conducting of a pilot project, is in the interests of better care or management.

(3) PROCEDURES. (a) *Application.* 1. An application for a waiver of or variance from a requirement of this chapter shall be made in writing to the department, specifying all of 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.

e. Justification that a requirement under sub. (2) would be satisfied.

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

3. The department may require additional information from the hospice 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. A notice of denial 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 the hospice.

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

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

(c) *Hearings.* 1. Denial of a requested waiver or variance 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 for any of the following reasons:

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

2. The hospice has failed to comply with the waiver or variance as granted.

3. The licensee notifies the department in writing of the desire to relinquish the waiver or variance and be subject to the requirement for which the waiver or variance was previously granted.

4. Revocation is required by a change in law.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

Subchapter II — Patient Rights

DHS 131.17 Admission. (1) PROGRAM DESCRIPTION. A hospice shall have a written description of its program that clearly describes the general patient and family needs that can be met by the hospice, and that includes written admission policies that includes all of the following:

(a) Clearly define the philosophy of the program.

(b) Limit admission to individuals with terminal illness as defined under s. DHS 131.13 (24).

(c) Clearly define the hospice's limits in providing services and the settings for service provision.

(d) Ensure protection of patient rights.

(e) Provide clear information about services available for the prospective patient and his or her representative, if any.

(f) Allow an individual to receive hospice services whether or not the individual has executed an advance directive.

(2) PROGRAM EXPLANATION. (a) A hospice employee shall inform the person and his or her representative, if any, of admission policies under sub. (1).

(3) INITIAL DETERMINATION. (a) The hospice employee shall, based on the needs described by the person seeking admission or that person's representative, if any, or both, make an initial determination as to whether or not the hospice is generally able to meet those needs.

(b) If the hospice employee determines that the hospice does not have the general capability to provide the needed services, the hospice may not admit the person but rather shall suggest to the referring source alternative programs that may meet the described needs.

(4) PATIENT ACKNOWLEDGEMENT AND HOSPICE ACCEPTANCE. The person seeking admission to the hospice shall be recognized as being admitted after:

(a) Completion of the assessment under sub. (3).

(b) Completion of a service agreement in which:

1. The person or the person's representative, if any, acknowledges, in writing, that he or she has been informed about admission policies and services.

2. The hospice agrees to provide care for the person.

3. The person or the person's representative, if any, authorizes services in writing.

(5) PROHIBITION. Any person determined not to have a terminal illness as defined under s. DHS 131.13 (24) may not be admitted to the hospice.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.18 Discharge. (1) OBLIGATION. Once a hospice has admitted a patient to the program, and the patient or the

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patient's representative, if any, has signed the acknowledgement and authorization for services under s. DHS 131.17 (4) (b), the hospice is obligated to provide care to that patient.

(2) WRITTEN POLICY. The hospice shall have a written policy that details the manner in which the hospice is able to end its obligation to a patient. This policy shall be provided to the patient or patient's representative, if any, as part of the acknowledgement and authorization process at the time of the patient's admission. The policy shall include all of the following as a basis for discharging a patient:

(a) The hospice may discharge a patient:

1. Upon the request or with the informed consent of the patient or the patient's representative.

2. If the patient elects care other than hospice care at any time.

3. If the patient elects active treatment, inconsistent with the role of palliative hospice care.

4. If the patient moves out of the geographical area served by the hospice or into a facility that does not have a contract with the hospice.

5. If the patient requests services in a setting that exceeds the limitations of the hospice's authority.

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

7. For the patient's safety and welfare or the safety and welfare of others, if the hospice determines that the behavior of the patient or other persons in the patient's home is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.

8. If the hospice determines that the patient is no longer terminally ill.

(b) The hospice shall do all of the following before it seeks to discharge a patient whose behavior or the behavior of other persons in the patient's home, is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired:

1. Advise the patient that a discharge for cause is being considered.

2. Make a serious effort to resolve the problem or problems presented by the patient's behavior or situation.

3. Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services.

4. Document the matter and enter this documentation into the patient's clinical record.

(3) NOTICE. (a) When a patient is being discharged for a reason given in sub. (2) (a) 1.,2., 3., 4., 5., 7., or 8., the hospice shall give written notice of the discharge to the patient or patient's representative, if any, a family representative and the attending physician.

(b) When a patient is being discharged for the reason given in sub. (2) (a) 6., the hospice shall give written notice of the discharge at least 14 days prior to the date of discharge, and indicate a proposed date for pre-discharge planning. The written notice shall be given to the patient or patient's representative, if any, a family representative and the attending physician.

(4) PLANNING. The hospice shall conduct the pre-discharge planning with the patient or the patient's representative and review the need for discharge, assess the effect of discharge on the patient, discuss alternative placements and develop a comprehensive discharge plan.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10; CR 19-092: am. (2) (a) 4., 7., r. and recr. (3), am. (4) Register July 2020 No. 775, eff. 8-1-20.

DHS 131.19 Patient rights. (1) GENERAL INFORMATION. A hospice shall provide each patient and patient's representative, if any, with a written statement of the rights of patients before services are provided, and shall fully inform each patient and patient's representative, if any, of all of the following:

(a) Those patient rights and all hospice rules and regulations governing patient responsibilities, which shall be evidenced by written acknowledgement provided by the patient, if possible, or the patient's representative, if any, prior to receipt of services.

(b) The right to prepare an advance directive.

(c) The right to be informed of any significant change in the patient's needs or status.

(d) The hospice's criteria for discharging the individual from the program.

(2) RIGHTS OF PATIENTS. In addition to rights to the information under sub. (1), each patient shall have all of the following rights:

(a) To receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.

(b) To participate in planning care and in planning changes in care.

(c) To select or refuse care or treatment.

(d) To choose his or her attending physician.

(e) To confidential treatment of personal and clinical record information and to approve or refuse release of information to any individual outside the hospice, except in the case of transfer to another health care facility, or as required by law or third party payment contract.

(f) To request and receive an exact copy of one's clinical record.

(g) To be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property.

(h) To be free from restraints and seclusion except as authorized in writing by the attending physician to provide palliative care for a specified and limited period of time and documented in the plan of care.

(i) To be treated with courtesy, respect and full recognition of the patient's dignity and individuality and to choose physical and emotional privacy in treatment, living arrangements and the care of personal needs.

(j) To privately communicate with others without restrictions.

(k) To receive visitors at any hour, including small children, and to refuse visitors.

(L) To be informed prior to admission of the types of services available from the hospice, including contracted services and specialized services for unique patient groups such as children.

(m) To be informed of those items and services that the hospice offers and for which the resident may be charged, and the amount of charges for those services.

(3) PATIENT COMPLAINT PROCEDURE. Each patient shall have the right, on his or her own behalf or through others, to do all of the following:

(a) Express a complaint to hospice employees, without fear of reprisal, about the care and services provided and to have the hospice investigate the complaint in accordance with an established complaint procedure. The hospice shall document both the existence of the complaint and the resolution of the complaint.

(b) Express complaints to the department, and to receive a statement provided by the department setting forth the right to

Published under s. 35.93, Stats. Updated on the first day of each month. Entire code is always current. The Register date on each page is the date the chapter was last published.

Published under s. 35.93, Wis. Stats., by the Legislative Reference Bureau.

and procedure for filing verbal or written complaints with the department.

(c) Be advised of the availability of a toll-free hotline, including its telephone number, to receive complaints or questions about local hospices, and be advised of the availability of the long term care ombudsman to provide patient advocacy and other services under s. 16.009, Stats.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

Subchapter III — Patient Care

DHS 131.20 Assessment. (1) INITIAL ASSESSMENT. (a) If the hospice determines that it has the general capability to meet the prospective patient's described needs, a registered nurse shall perform an initial assessment of the person's immediate needs and shall describe in writing the person's current status, including physical condition, present pain status, emotional status, pertinent psychosocial and spiritual concerns and coping ability of the prospective patient and family support system, and shall determine the appropriateness or inappropriateness of admission to the hospice based on the assessment.

(b) The designated hospice employee shall confer with at least one other core team member and receive that person's views in order to start the initial plan of care.

(2) TIME FRAME FOR COMPLETION OF THE COMPREHENSIVE ASSESSMENT. The hospice interdisciplinary group, in consultation with the individual's attending physician, if any, shall complete the comprehensive assessment no later than 5 calendar days after the election of hospice care.

(3) CONTENT OF THE COMPREHENSIVE ASSESSMENT. The comprehensive assessment shall identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that shall be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment shall take into consideration all of the following factors:

(a) The nature and condition causing admission including the presence or lack of objective data and subjective complaints.

(b) Complications and risk factors that affect care planning.

(c) Functional status, including the patient's ability to understand and participate in his or her own care.

(d) Imminence of death.

(e) Severity of symptoms.

(f) Drug profile. A review of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:

1. Effectiveness of drug therapy.
2. Drug side effects.
3. Actual or potential drug interactions.
4. Duplicate drug therapy.
5. Drug therapy currently associated with laboratory monitoring.

(g) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment shall be incorporated into the plan of care and considered in the bereavement plan of care.

(h) The need for referrals and further evaluation by appropriate health professionals.

(4) UPDATE OF THE COMPREHENSIVE ASSESSMENT. The update of the comprehensive assessment shall be accomplished by the hospice interdisciplinary group in collaboration with the individual's attending physician, if any, and shall consider changes that have taken place since the initial assessment. The comprehensive assessment shall include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update shall be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. The hospice interdisciplinary group shall primarily meet in person to conduct the update of the comprehensive assessment.

(5) PATIENT OUTCOME MEASURES. (a) The comprehensive assessment shall include data elements that allow for measurement of outcomes. The hospice shall measure and document data in the same way for all patients.

(b) The data elements shall do all of the following:

1. Take into consideration aspects of care related to hospice and palliation.
2. Be an integral part of the comprehensive assessment.
3. Be documented in a systematic and retrievable way for each patient.

(c) The data elements for each patient shall be used in individual patient care planning and in the coordination of services, and shall be used in the aggregate for the hospice's quality assessment and performance improvement program.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10; CR 19-092: am. (1) (a) Register July 2020 No. 775, eff. 8-1-20.

DHS 131.21 Plan of care. (1) GENERAL REQUIREMENTS. A written plan of care shall be established and maintained for each patient admitted to the hospice program and the patient's family. The hospice plan of care is a document that describes both the palliative and supportive care to be provided by the hospice to the patient and the patient's family, as well as the manner by which the hospice will provide that care. The care provided to the patient and the patient's family shall be in accordance with the plan of care.

(2) INITIAL PLAN OF CARE. (a) The hospice shall develop an initial plan of care that does all of the following:

1. Defines the services to be provided to the patient and the patient's family.
2. Incorporates physician orders and medical procedures.

(b) The initial plan of care shall be developed upon conclusion of the assessment under s. DHS 131.20 (1) (a).

(c) The initial plan of care shall be developed jointly by the employee who performed the initial assessment and at least one other member of the core team.

(d) The registered nurse shall immediately record and sign a physician's oral orders and shall obtain the physician's countersignature within 20 business days.

(3) PLAN OF CARE. (a) *Integrated plan of care.* The hospice core team shall develop an integrated plan of care for the new patient within 5 days after the admission. The core team shall use the initial plan of care as a basis for team decision-making and shall update intervention strategies as a result of core team assessment and planning collaboration.

(b) *Content of the plan of care.* The hospice shall develop an individualized written plan of care for each patient. The plan of care shall reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care shall include all services necessary for the palliation and management of the terminal illness and related conditions, including all of the following:

1. Interventions to manage pain and symptoms.

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Published under s. 35.93, Wis. Stats., by the Legislative Reference Bureau.

2. A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.

3. Measurable outcomes anticipated from implementing and coordinating the plan of care.

4. Drugs and treatment necessary to meet the needs of the patient.

5. Medical supplies and appliances necessary to meet the needs of the patient.

6. The interdisciplinary group's documentation of the patient's or representative's, if any, level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.

(c) *Review of the plan of care.* The hospice interdisciplinary group in collaboration with the individual's attending physician, if any, shall review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. A revised plan of care shall include information from the patient's updated comprehensive assessment and shall note the patient's progress toward outcomes and goals specified in the plan of care. The hospice interdisciplinary group shall primarily meet in person to review and revise the individualized plan of care.

(d) *Bereavement plan of care.* The hospice core team shall review and update the bereavement plan of care, at minimum:

1. Fifteen calendar days following a patient's death.

2. Within 60 calendar days following the patient's death.

3. As often as necessary based on identified family needs.

4. At the termination of bereavement services.

(e) *Contents of the bereavement plan of care.* The bereavement plan of care shall include all of the following:

1. The family and caregiver's specific needs or concerns.

2. Intervention strategies to meet the identified needs.

3. Employees responsible for delivering the care.

4. Established timeframes for evaluating and updating the interventions.

5. The effect of the intervention in meeting established goals.

(f) *Record of notes.* The core team shall develop a system for recording and maintaining a record of notes within the plan of care.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10; CR 19-092: am. (2) (d) Register July 2020 No. 775, eff. 8-1-20.

DHS 131.22 Quality assessment and performance improvement. (1) PROGRAM STANDARDS. (a) The hospice shall develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program.

(b) The hospice's governing body shall ensure that the program reflects the complexity of its organization and services, involves all hospice services including those services furnished under contract or arrangement, focuses on indicators related to improved palliative outcomes, and takes actions to demonstrate improvement in hospice performance.

(c) The hospice shall maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to the department.

(2) PROGRAM SCOPE. (a) The program shall at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.

(b) The hospice shall measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.

(3) PROGRAM DATA. (a) The program shall use quality indicator data, including patient care, and other relevant data, in the design of its program.

(b) The hospice shall use the data collected to do all of the following:

1. Monitor the effectiveness and safety of services and quality of care.

2. Identify opportunities and priorities for improvement.

(c) The frequency and detail of the data collection shall be approved by the hospice's governing body.

(4) PROGRAM ACTIVITIES. (a) The hospice's performance improvement activities shall include all of the following:

1. Focus on high risk, high volume, or problem-prone areas.

2. Consider incidence, prevalence, and severity of problems in those areas.

3. Affect palliative outcomes, patient safety, and quality of care.

(b) Performance improvement activities track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.

(c) The hospice shall take actions aimed at performance improvement and, after implementing those actions. The hospice shall measure its success and track performance to ensure that improvements are sustained.

(5) PERFORMANCE IMPROVEMENT PROJECTS. The hospice shall develop, implement, and evaluate performance improvement projects.

(a) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, and shall reflect the scope, complexity, and past performance of the hospice's services and operations.

(b) The hospice shall document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.

(6) EXECUTIVE RESPONSIBILITIES. The hospice's governing body is responsible for ensuring all of the following:

(a) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.

(b) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.

(c) That one or more individuals who are responsible for operating the quality assessment and performance improvement program are designated.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.23 Infection control. (1) INFECTION CONTROL PROGRAM. The hospice shall maintain and document an effective infection control program that protects patients, families, visitors, and hospice employees by preventing and controlling infections and communicable diseases.

(2) PREVENTION. The hospice shall follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.

(3) CONTROL. The hospice shall maintain a coordinated agency-wide program for the surveillance, identification, preven-

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tion, control, and investigation of infectious and communicable diseases that:

(a) Is an integral part of the hospice's quality assessment and performance improvement program; and

(b) Includes all of the following:

1. A method of identifying infectious and communicable disease problems.

2. A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.

(4) EDUCATION. (a) The hospice shall provide infection control education to employees, contracted providers, patients, and family members and other caregivers.

(b) The hospice shall develop and implement initial orientation and ongoing education and training for all hospice workers having direct patient contact, including students, trainees and volunteers, in the epidemiology, modes of transmission, prevention of infection and the need for routine use of current infection control measures as recommended by the U.S. centers for disease control and prevention.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

Subchapter IV — Management

DHS 131.24 Employee health. (1) DISEASE SURVEILLANCE. Agencies shall develop and implement written policies for control of communicable diseases which take into consideration control procedures incorporated by reference in ch. DHS 145 and which ensure that employees with symptoms or signs of communicable disease or infected skin lesions are not permitted to work unless authorized to do so by a physician, physician assistant or advanced practice nurse.

(2) PHYSICAL HEALTH OF NEW EMPLOYEES. Each new employee, prior to having direct patient contact, shall be certified in writing by a physician, physician assistant or registered nurse as having been screened for tuberculosis, and clinically apparent communicable disease that may be transmitted to a patient during the normal employee's duties. The screening shall occur within 90 days prior to the employee having direct patient contact.

(3) CONTINUING EMPLOYEES. Each employee having direct patient contact shall be screened for clinically apparent communicable disease by a physician, physician assistant, or registered nurse based on the likelihood of their exposure to a communicable disease, including tuberculosis. The exposure to a communicable disease may have occurred in the community or in another location.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.25 Core services. (1) GENERAL REQUIREMENTS. A hospice is responsible for providing care and services to a patient and, as necessary, the patient's family, based on the plan of care developed by the core team. Volunteers shall participate in the delivery of program services.

(2) CORE TEAM. (a) Each member of the core team shall be an employee, including a volunteer of the hospice or be under a contract with the hospice as specified in par. (c).

(b) With respect to services provided to a patient, each core team member shall do all of the following:

1. Assess patient and family needs.

2. Promptly notify the registered nurse of any change in patient status that suggests a need to update the plan of care.

3. Provide services consistent with the patient plan of care.

4. Provide education and counseling to the patient and, as necessary, to the patient's family, consistent with the plan of care.

5. Participate in developing and revising written patient care policies and procedures.

(c) The hospice may contract for physician services as specified in par. (a). A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. A hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care and temporary travel of a patient outside of the hospice's service area.

(3) PHYSICIAN SERVICES. The hospice medical director, physician employees, and contracted physicians of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.

(a) All physician employees and those under contract must function under the supervision of the hospice medical director.

(b) All physician employees and those under contract shall meet this requirement by either providing the services directly or through coordinating patient care with the attending physician. If the attending physician is unavailable, the medical director, contracted physician, and or hospice physician employee is responsible for meeting the medical needs of the patient.

(4) NURSING SERVICES. (a) Nursing services shall be provided by or under the supervision of a registered nurse and shall consist of all of the following:

1. Regularly assessing the patient's nursing needs, implementing the plan of care provisions to meet those needs and reevaluating the patient's nursing needs.

2. Supervising and teaching other nursing personnel, including licensed practical nurses, nurse aides.

3. Evaluating the effectiveness of delegated acts performed under the registered nurse's supervision.

(b) Highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive, may be provided under contract.

(c) *Licensed practical nursing services.* If licensed practical nursing services are provided, the licensed practical nurse shall function under the supervision of a registered nurse with duties specified in writing and updated by a registered nurse.

(5) SOCIAL SERVICES. (a) Social services shall be provided by a qualified social worker and shall consist of all of the following:

1. Regularly assessing the patient's social service needs, implementing the plan of care to meet those needs and reevaluating the patient's needs and providing ongoing psychosocial assessment of the family's coping capacity relative to the patient's terminal condition.

2. Linking patient and family with needed community resources to meet ongoing social, emotional and economic needs.

(6) COUNSELING SERVICES. Counseling services shall be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process.

(a) *Bereavement services.* Bereavement services shall be provided to families of hospice patients. Each hospice shall have its own bereavement program. Bereavement services shall be:

Published under s. 35.93, Wis. Stats., by the Legislative Reference Bureau.

1. Coordinated by an individual who possesses the capacity by training and experience to provide for the bereavement needs of families, including the ability to organize a program of directed care services provided to family members. DHS 131.25 (6).

2. Compatible with the core team's direction within the plan of care for the patient.

3. Available for one year following the patient's death as part of an organized program and provide all of the following:

a. Orientation and training to individuals providing bereavement services to ensure that there is continuity of care.

b. Service intervention either directly or through trained bereavement counselors.

c. Assignment, supervision and evaluation of individuals performing bereavement services.

d. Referrals of family members to non-hospice community programs where appropriate.

(b) *Dietary counseling.* Dietary counseling services shall be provided only as authorized by the hospice and in conjunction with the plan of care. The services shall be provided by a registered dietitian or an individual who has documented equivalency in education or training. Dietary services shall be supervised and evaluated by a registered dietitian or other individual qualified under this paragraph who may delegate acts to other employees. Dietary counseling services shall consist of all of the following:

1. Assessment of nutritional needs and food patterns;

2. Planning diets appropriate for meeting patient needs and preferences; and

3. Providing nutrition education and counseling to meet patient needs, as well as necessary consultation to hospice employees.

(c) *Spiritual counseling.* The hospice shall do all of the following:

1. Provide an assessment of the patient's and family's spiritual needs.

2. Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires.

3. Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability.

4. Advise the patient and family of this service.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10; CR 19-092: am. (6) (a) 1., (b) Register July 2020 No. 775, eff. 8-1-20.

DHS 131.26 Non-core services. (1) GENERAL REQUIREMENTS. A hospice is responsible for providing care and services to a patient and, as necessary, the patient's family, based on the plan of care developed by the core team. Volunteers shall participate in the delivery of program services. The hospice may provide other services as follows:

(a) *Therapy services.* Therapy services are provided in accordance with the plan of care for the patient and by individuals who meet qualification requirements for therapy service delivery such as evidence of current licensure or registration and academic training. Therapy services shall consist of all of the following:

1. Physical, occupational, speech and language pathology or respiratory therapy.

2. The provision of a patient assessment as directed by the plan of care.

3. The development of a therapy plan of care.

(b) *Homemaker services.* If homemaker services are provided, they shall be provided in accordance with the patient's plan of care and shall consist of:

1. Housekeeping activities.

2. Performing errands and shopping.

3. Providing transportation.

4. Preparing meals.

5. Other assigned tasks intended to maintain the capacity of the household.

(2) NURSE AIDE SERVICES. The hospice may provide nurse aide services as follows:

(a) *Assignment.* Nurse aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a nurse aide shall be prepared by a registered nurse who is responsible for the supervision of a nurse aide as specified under par. (c).

(b) *Plan of care.* The nurse aide shall provide care in accordance with the patient's plan of care. Nurse aide services consist of, but are not be limited to all of the following:

1. Assisting patients with personal hygiene.

2. Assisting patients into and out of bed and with ambulation.

3. Assisting with prescribed exercises which patients and hospice aides have been taught by appropriate health care personnel.

4. Assisting patients to the bathroom or in using a bedpan.

5. Assisting patients with self-administration of medications.

6. Administering medications to patients if the aide has completed a state-approved medications administration course and has been delegated this responsibility in writing for the specific patient by a registered nurse.

7. Reporting changes in the patient's condition and needs.

8. Completing appropriate records.

(c) *Supervision of nurse aides.* 1. A registered nurse shall make an on-site visit to the patient's home no less frequently than every 14 days to assess the quality of care and services provided by the nurse aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The nurse aide does not have to be present during this visit.

2. If an area of concern is noted by the supervising nurse, then the hospice shall make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while the aide is performing care.

3. If an area of concern is verified by the hospice during the on-site visit, then the hospice shall conduct, and the nurse aide shall complete a competency evaluation.

4. A registered nurse shall make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while the aide is performing care.

(d) *Assessment of aide.* The supervising nurse shall assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include all of the following, but is not limited to:

1. Following the patient's plan of care for completion of tasks assigned to the nurse aide by the registered nurse.

2. Creating successful interpersonal relationships with the patient and family.

3. Demonstrating competency with assigned tasks.

4. Complying with infection control policies and procedures.

5. Reporting changes in the patient's condition.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.27 Volunteers. Prior to beginning patient care,

Published under s. 35.93, Wis. Stats., by the Legislative Reference Bureau.

a volunteer shall be oriented to the hospice program and shall have the training for the duties to which he or she is assigned.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.28 Governing body. (1) Each hospice shall have a governing body that assumes full legal responsibility for determining, implementing and monitoring the overall conduct and operation of the program, including the quality of the care and services.

(2) The governing body shall do all of the following:

(a) Be responsible for the establishment and maintenance of policies and for the management, operation and evaluation of the hospice.

(b) Adopt a statement that designates the services the hospice will provide and the setting or settings in which the hospice will provide care.

(c) Ensure that all services are provided consistent with accepted standards of professional practice.

(d) Appoint an administrator and delegate to the administrator the authority to operate the hospice in accordance with policies established by the governing body.

(e) Ensure that nursing and physician services and drugs and biologicals are routinely available on a 24 hour basis 7 days a week.

(f) Ensure that other covered services are available on a 24 hour basis when reasonable and necessary to meet the needs of the patient and family.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.29 Administration. (1) ADMINISTRATOR. The administrator shall be responsible for day-to-day operation of the hospice.

(2) DUTIES OF THE ADMINISTRATOR. The administrator shall do all of the following:

(a) Implement and regularly evaluate policies for the management and operation of the hospice and evaluation of the overall program performance of the hospice, and implement and regularly evaluate procedures consistent with those policies.

(b) Establish an organizational structure appropriate for directing the work of the hospice's employees in accordance with the program's policies and procedures.

(c) Maintain a continuous liaison between the governing body and the hospice employees.

(d) Ensure that employees are oriented to the program and their responsibilities, that they are continuously trained and that their performance is evaluated.

(e) Designate in writing, with the knowledge of the governing body, a qualified person to act in his or her absence.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.30 Professional management responsibility. (1) RESPONSIBILITY. The hospice is responsible for providing services to the patient or family, or both, based on assessed need and as established by the plan of care.

(2) CONTRACT SERVICES. The hospice may contract with other providers for the provision of services to a patient or the patient's family, or both, in which case the hospice shall retain responsibility for the quality, availability, safety, effectiveness, documentation and overall coordination of the care provided to the patient or the patient's family, or both, as directed by the hospice plan of care. The hospice shall:

(a) Ensure that there is continuity of care for the patient or the patient's family, or both, in the relevant care setting.

(b) Be responsible for all services delivered to the patient or the patient's family, or both, through the contract. The written contract shall include all of the following:

1. Identification of the services to be provided.

2. Stipulation that services are to be provided only with the authorization of the hospice and as directed by the hospice plan of care for the patient.

3. The manner in which the contracted services are coordinated and supervised by the hospice.

4. The delineation of the roles of the hospice and service provider in the admission process, assessment, interdisciplinary group meetings and ongoing provision of palliative and supportive care.

5. A method of evaluation of the effectiveness of those contracted services through the quality assurance program under s. DHS 131.22.

6. The qualifications of the personnel providing the services.

(c) Evaluate the services provided under a contractual arrangement on an annual basis.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.31 Employees. (1) CAREGIVER BACKGROUND CHECKS. Each hospice shall comply with the caregiver background check and misconduct reporting requirements in s. 50.065, Stats., and ch. DHS 12, and the caregiver misconduct reporting and investigation requirements in ch. DHS 13.

(2) GENERAL REQUIREMENTS. Prior to beginning patient care, every employee or contracted staff shall be oriented to the hospice program and the job to which he or she is assigned.

(3) ORIENTATION PROGRAM. A hospice's orientation program shall include all of the following:

(a) An overview of the hospice's goal in providing palliative care.

(b) Policies and services of the program.

(c) Information concerning specific job duties.

(d) The role of the plan of care in determining the services to be provided.

(e) Ethics, confidentiality of patient information, patient rights and grievance procedures.

(4) DUTIES. Hospice employees or contracted staff may be assigned only those duties for which they are capable, as evidenced by documented training or possession of a license or certificate.

(5) CONTINUOUS TRAINING. A program of continuing training directed at maintenance of appropriate skill levels shall be provided for all hospice employees providing services to patients and their families.

(6) EVALUATION. A hospice shall evaluate every employee annually for quality of performance and adherence to the hospice's policies. Evaluations shall be followed up with appropriate action.

(7) PERSONNEL PRACTICES. (a) Hospice personnel practices shall be supported by appropriate written personnel policies.

(b) Personnel records shall include evidence of qualifications, licensure, performance evaluations and continuing training, and shall be kept up-to-date.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.32 Medical director. (1) The hospice shall have a medical director who shall be a medical doctor or a doctor of osteopathy.

(2) The medical director shall do all of the following:

(a) Direct the medical components of the program.

Published under s. 35.93, Wis. Stats., by the Legislative Reference Bureau.

(b) Ensure that the terminal status of each individual admitted to the program has been established.

(c) Ensure that medications are used within accepted standards of practice.

(d) Ensure that a system is established and maintained to document the disposal of controlled drugs.

(e) Ensure that the medical needs of the patients are being met.

(f) Provide liaison as necessary between the core team and the attending physician.

(g) Ensure that a system is established for the disposal of controlled drugs.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.33 Clinical record. (1) GENERAL. A hospice shall establish a single and complete clinical record for every patient. Clinical record information shall remain confidential except as required by law or a third-party payment contract.

(2) DOCUMENTATION AND ACCESSIBILITY. The clinical record shall be completely accurate and up-to-date, readily accessible to all individuals providing services to the patient or the patient's family, or both, and shall be systematically organized to facilitate prompt retrieval of information.

(3) CONTENT. A patient's clinical record shall contain all of the following:

(a) The initial, integrated and updated plans of care prepared under s. DHS 131.21.

(b) The initial, comprehensive and updated comprehensive assessments.

(c) Complete documentation of all services provided to the patient or the patient's family or both, including:

1. Assessments.
2. Interventions.
3. Instructions given to the patient or family, or both.
4. Coordination of activities.

(d) Signed copies of the notice of patient rights under s. DHS 131.19 (1) (a) and service authorization statement under s. DHS 131.17 (4) (b).

(e) A current medications list.

(f) Responses to medications, symptom management, treatments, and services.

(g) Outcome measure data elements, as described in s. DHS 131.20 (5).

(h) Physician certification and recertification of terminal illness.

(i) A statement of whether or not the patient, if an adult, has prepared an advance directive; and a copy of the advance directive, if prepared.

(j) Physician orders.

(k) Patient and family identification information.

(L) Referral information, medical history and pertinent hospital discharge summaries.

(m) Transfer and discharge summaries.

(4) AUTHENTICATION. (a) *Entries.* All entries shall be legible, permanently recorded, dated and authenticated by the person making the entry, and shall include that person's name and title.

(b) *Written record.* A written record shall be made for every service provided on the date the service is provided. This written record shall be incorporated into the clinical record no later than 7 calendar days after the date of service.

(c) *Medical symbols.* Medical symbols and abbreviations may be used in the clinical records if approved by a written program policy which defines the symbols and abbreviations and controls their use.

(d) *Protection of information.* Written record policies shall ensure that all record information is safeguarded against loss, destruction and unauthorized usage.

(e) *Retention and destruction.* 1. An original clinical record and legible copy or copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of the patient shall be retained for a period of at least 5 years following a patient'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 hospice shall arrange for the storage and safekeeping of records for the periods and under the conditions required by this paragraph in the event the hospice closes.

3. If the ownership of a hospice changes, the clinical records and indexes shall remain with the hospice.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.34 Personnel qualifications. (1) PERSONNEL QUALIFICATIONS. All professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, shall be legally authorized, licensed, certified or registered in accordance with applicable federal, state and local laws, and shall act only within the scope of his or her state license, or state certification, or registration. Personnel qualifications shall be kept current at all times.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

Subchapter V — Physical Environment

DHS 131.35 Definitions. In this subchapter:

(1) "Existing construction" or "existing facility" means a building which is in place or is being constructed with plans approved by the department prior to August 1, 2020.

(2) "Freestanding hospice facility" means a residential facility serving 3 or more patients which is not located in a licensed hospital or nursing home.

(3) "Life Safety Code" means the National Fire Protection Association's 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 August 1, 2020.

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

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10; CR 19-092: am. (1), (3), (4), r. and recr. (5) Register July 2020 No. 775, eff. 8-1-20; correction in (1), (5) made under s. 13.92 (4) (b) 14., Stats., Register July 2020 No. 775.

DHS 131.36 Scope. This subchapter applies to freestanding hospice facilities.

Note: Inpatient hospices located in nursing homes or hospitals must meet applicable administrative codes.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10.

DHS 131.37 Physical plant. (1) GENERAL REQUIREMENTS. The building of a freestanding hospice shall be constructed and maintained so that it is functional for the delivery of hospice services, appropriate to the needs of the community and protects the health and safety of the patients. The provisions of this section apply to all new, remodeled and existing construction unless otherwise noted. Wherever a requirement in this section is in conflict with the applicable Life Safety Code under s. DHS 131.38, the Life Safety Code shall take precedence.

(5) PATIENT BEDROOMS. (a) *Design and location.* Patient bedrooms shall be designed and equipped for the comfort and

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privacy of the patient and shall be equipped with or located near toilet and bathing facilities.

(b) *Capacity.* 1. A patient bedroom may accommodate no more than 2 patients. Patients of the opposite sex may not be required to occupy the same sleeping room.

2. 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 multipatient rooms shall be at least 3 feet.

(c) *Bed arrangements.* 2. There shall be at least 3 feet between beds where the space is necessary for patient or staff access.

3. Visual privacy shall be provided for each patient in multibed patient rooms. In new or remodeled construction, cubicle curtains shall be provided.

(d) *Semiambulatory and nonambulatory patients.* For rooms with semiambulatory or nonambulatory patients, mobility space at the end and one side of each bed may not be not less than 4 feet. Adequate accessible space for storage of a patient's wheelchair or other adaptive or prosthetic equipment shall be provided and shall be readily accessible to the patient.

(e) *Equipment and supplies.* Each patient shall be provided with all of the following:

1. A separate bed of proper size and height for the convenience of the patient. Beds shall be at least 36 inches wide and shall be maintained in good condition.

2. Drawer space available in the bedroom for personal clothing and possessions.

3. Closet or wardrobe space with clothes racks and shelves in the bedroom.

(7) WINDOWS. (a) *Minimum size.* Every living and sleeping room shall have one or more outside-facing windows.

(b) *Openable bedroom window.* At least one outside window in a bedroom shall be openable from the inside without the use of tools.

(c) *Window screens.* All openable windows in habitable rooms shall have insect-proof screens.

(8) ELECTRICAL. (a) Every hospice facility shall be supplied with electrical service and shall have wiring, outlets and fixtures properly installed and maintained in good and safe working condition.

(b) Extension cords shall not be used in lieu of permanent wiring.

(c) Exposed wiring is prohibited.

(f) There shall be a switch or equivalent device for turning on at least one light in each room or passageway. The switch or equivalent device shall be located so as to conveniently control the lighting in the area.

(g) All electrical cords and appliances shall be maintained in a safe condition. Frayed wires and cracked or damaged switches, plugs and electric fixtures shall be repaired or replaced.

(9) PATIENT CALL SYSTEM. A reliable call mechanism shall be provided in every location 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.

(10) BEDDING AND LAUNDRY. There shall be separate clean linen and dirty linen storage areas.

(b) Each patient shall have available all of the following:

1. Sufficient blankets to keep warm.

2. A pillow.

3. Mattress and pillow covers as necessary to keep mattresses and pillows clean and dry.

Note: When plastic mattress covers are used, there shall be a mattress pad the same size as the mattress over the plastic mattress cover.

(c) Clean sheets, pillowcases, towels and washcloths shall be available at least weekly and shall be changed as necessary to ensure that at all times they are clean and free from odors.

(11) DAYROOM OR LOUNGE. At least one dayroom or lounge, centrally located, shall be provided for use of the patients.

(12) SIZE OF DINING ROOM. Dining rooms shall be of sufficient size to seat all patients at no more than 2 shifts. Dining tables and chairs shall be provided. Television trays or portable card tables may not be used as the primary dining tables.

(13) KITCHEN. The kitchen shall be located on the premises, or a satisfactory sanitary method of transportation of food shall be provided. If there is a kitchen on the premises, it shall meet food service needs and be arranged and equipped for proper refrigeration, heating, storage, preparation and serving of food. Adequate space shall be provided for proper refuse handling and washing of waste receptacles, and for storage of cleaning compounds.

(14) MULTIPURPOSE ROOM. If a multipurpose room is used for dining, diversional and social activities of patients, there shall be sufficient space to accommodate all activities and minimize their interference with each other.

(15) TOTAL AREA. (a) In existing facilities, the combined floor space of dining, recreation, and activity areas shall not be less than 15 square feet per bed. Solaria and lobby sitting space may be included, but shall not include required exit paths. A required exit path in these areas shall be at least 4 feet wide.

(b) In new construction, the combined floor space of dining, recreation, and activity areas shall not be less than 25 square feet per bed. Solaria and lobby areas, exclusive of traffic areas, shall be categorized as living room space.

(c) All required dining and living areas within the building shall be internally accessible to every patient of the hospice.

(d) Each habitable room shall contain furnishings appropriate to the intended use of the room. Furnishings shall be safe for use by patients, and shall be comfortable, clean and maintained in good repair.

(e) Adequate space and equipment shall be designated to meet the needs of the patients and family members for privacy and social activities.

(16) HEATING. (a) The facility shall have a heating system capable of maintaining a temperature of 72° F. (20° C.) during periods of occupancy. Temperatures during sleeping hours may be reduced to 68° F. (18° C.). Higher or lower temperatures shall be available upon request.

(b) The heating system shall be maintained in a safe and properly functioning condition.

(c) The use of portable space heaters is prohibited.

(17) BATH AND TOILET FACILITIES. (a) Each hospice shall have at least one separate bath and one separate toilet room or one combination bath and toilet room for the use of patients which is accessible from public, non-sleeping areas, except where private bath and toilet rooms are adjacent to each sleeping room.

(b) Each floor in which patient sleeping, dining and living rooms are located shall have bath and toilet facilities or one combination bath and toilet room for use of patients which is accessible from public, non-sleeping areas, except where private bath and toilet rooms are adjacent to each bedroom.

(c) All bath and toilet areas shall be well lighted.

(d) Toilets, bathtubs and showers used by residents shall pro-

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vide for individual privacy. If door locks are used for privacy they shall be operable from both sides in an emergency.

(e) All toilet and bathing areas, facilities and fixtures shall be kept clean, in good repair and in good working order.

(18) WATER SUPPLY. (a) Each sink, bathtub and shower shall be connected to hot and cold water, and adequate hot water shall be supplied to meet the needs of the patients.

(b) Hot water from taps accessible to patients shall not exceed 115° F.

(c) Where a public water supply is not available, the well or wells shall be approved by the Wisconsin department of natural resources. Water samples from an approved well shall be tested at least annually at the state laboratory of hygiene or another laboratory approved under 42 CFR 493 (CLIA).

(d) The hospice shall make provision for obtaining emergency fuel and water supplies.

(20) FACILITY MAINTENANCE. (a) The building shall be maintained in good repair and free of hazards such as cracks in floors, walls or ceilings, warped or loose boards, warped, broken, loose or cracked floor covering such as tile or linoleum, loose handrails or railings, and loose or broken window panes.

(b) All electrical, mechanical, water supply, fire protection and sewage disposal systems shall be maintained in a safe and functioning condition.

(c) All plumbing fixtures shall be in good repair, properly functioning and satisfactorily provided with protection to prevent contamination from entering the water supply piping.

(d) Rooms shall be kept clean, well ventilated and tidy.

(e) All furniture and furnishings shall be kept clean and maintained in good repair.

(f) Storage areas shall be maintained in a safe, dry and orderly condition. Attics and basements shall be free of accumulation of garbage, refuse, soiled laundry, discarded furniture, old newspapers, boxes, discarded equipment and similar items.

(g) Abrasive strips or nonskid surfaces to reduce or prevent slipping shall be used where slippery surfaces present a hazard.

(h) The grounds, yards, and sidewalks shall be maintained in a neat, orderly and safe condition.

(21) FLOORS AND STAIRS. Floors and stairs shall be maintained in a nonhazardous condition.

(22) EXITS. Sidewalks, doorways, stairways, fire escapes and driveways used for exiting shall be kept free of ice, snow and obstructions.

(23) DOOR LOCKS. The employee in charge of the facility on each work shift shall have a key or other means of opening all locks or closing devices on all doors in the facility.

(24) EMERGENCY PLAN. (a) Each hospice shall have a written plan posted in a conspicuous place which specifies procedures for the orderly evacuation of patients in case of an emergency. The plan shall include an evacuation diagram. The evacuation diagram shall in addition be posted in a conspicuous place in the facility.

(b) The licensee, administrator and all staff who work in the hospice facility shall be trained in all aspects of the emergency plan.

(c) The procedures for exiting or taking shelter in the event of a fire, tornado, flooding or other disaster to be followed for patient safety shall be clearly communicated by the staff to the patients within 72 hours after admission and practiced at least quarterly by staff.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10; correction in (1) made under s. 13.92 (4) (b) 7., Stats., Register September 2010 No. 657; corrections in (4) (a) and (b), (19) (a) to (c) made under s. 13.92 (4) (b) 7., Stats., Register January 2012 No. 673; CR 19-092: r. (2) to (4), am. (5) (a), r. and recr. (5) (a), am. (5) (b) 1., r. (5) (c) 1., am. (5) (d), (e) 3., r. (6), am. (7) (a), (c), r. and recr. (8) (b), (c), r. (8) (d), (e), am. (16) (c), (17) (a) 3., r. (17) (b), am. (18) (b), r. (19), (25) Register July 2020 No. 775, eff. 8-1-20; change in numbering in (17) made under s. 13.92 (4) (b) 1., Stats., Register July 2020.

DHS 131.38 Fire protection. (1) BASIC RESPONSIBILITY. The hospice shall provide fire protection adequate to ensure the safety of patients, staff and others on the hospice's premises. Necessary safeguards such as extinguishers, sprinkling and detection devices, fire and smoke barriers and ventilation control barriers shall be installed to ensure rapid and effective fire and smoke control.

(2) LIFE SAFETY CODE. Facilities shall meet the applicable provisions of the 2012 edition of the Life Safety Code (LSC).

Note: Copies of the 2012 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, 1 Batterymarch Park, Quincy, MA 02169.

(3) FIRE SAFETY EVALUATION SYSTEM. An existing facility that does not meet all requirements of the applicable Life Safety Code may be considered in compliance with it if the facility achieves a passing score on the Fire Safety Evaluation System (FSES) developed by the U.S. department of commerce, national bureau of standards, to establish safety equivalencies under the Life Safety Code.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10; CR 16-087: am. (2) Register September 2017 No. 741, eff. 10-1-17; CR 19-092: renum. (1) to (intro.) Register July 2020 No. 775, eff. 8-1-20; renum. (intro.) to (1) under s. 13.92 (4) (b) 1., Stats., and create (3) (title) under s. 13.92 (4) (b) 2., Stats., Register July 2020 No. 775.

DHS 131.39 Fire safety. (1) FIRE INSPECTION. The licensee of the hospice shall do all of the following:

(a) The hospice shall obtain an annual inspection of the facility by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years.

(b) The hospice shall provide to the emergency preparedness authority a copy of the facility written plan of orderly evacuation of patients in the event of fire.

(2) SMOKING. (a) A written policy on smoking, consistent with the provisions in the Wisconsin Clean Indoor Air Act, s. 101.123, Stats., shall be developed by the licensee of the facility which shall designate areas outside the building where smoking is permitted, if any, and shall be clearly communicated by the staff to a patient within 24 hours after the patient's admission.

(3) FIRE EXTINGUISHER. (a) At least one fire extinguisher with a minimum 2A, 10-B-C rating shall be provided on each floor of the facility. A fire extinguisher shall be located at the head of each stairway. In addition, an extinguisher shall be located so that the maximum area per extinguisher does not exceed 3000 square feet and travel distance to an extinguisher does not exceed 75 feet. The extinguisher on the kitchen floor level shall be mounted in or near the kitchen.

(b) All fire extinguishers shall be maintained in readily useable condition and inspected annually. One year after the initial purchase of a fire extinguisher and annually after that the extinguisher shall be provided with a tag which indicates the date of the most recent inspection.

(c) An extinguisher shall be mounted on a wall or a post where it is clearly visible, unobstructed and mounted so that the top is not over 5 feet high. An extinguisher may not be tied down, locked in a cabinet or placed in a closet or on the floor except that it may be placed in a clearly marked, unlocked wall cabinet used exclusively for that purpose.

(5) FIRE PROTECTION SYSTEMS. (a) *Location.* No facility may install a smoke detection system that is not approved by the department.

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(b) *Smoke detection systems.* Each facility shall have, at a minimum, a low-voltage interconnected smoke detection system to protect the entire facility so that if any detector is activated it triggers an alarm audible throughout the building.

(c) *Installation, testing and maintenance.* Smoke detectors shall be installed, tested and maintained in accordance with NFPA 72-2013 edition. Smoke alarm detectors powered by the hospice electrical system shall be tested according to the manufacturer's recommendation but not less than once a month. The hospice shall maintain a written record of tests for the previous 2 years.

Note: Copies of the NFPA 72 National Fire Alarm and Signaling Code, 2013 edition are on file in the Department's Division of Quality Assurance and the Legislative Reference Bureau and can be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169.

(d) *Location of detectors.* 1. At least one smoke detector shall be located at each of the following locations:

a. At the head of every open stairway.

b. On the stair side of every enclosed stairway on each floor level.

c. In every corridor, spaced not more than 30 feet apart and not further than 15 feet from any wall.

d. In each common use room, including living rooms, dining rooms, family rooms, lounges and recreation rooms but not including kitchens, bathrooms or laundry rooms.

e. In each sleeping room in which smoking is allowed.

f. In each room of the staff living quarters, including the staff office but not including kitchens and bathrooms.

g. In the basement or in each room in the basement except a furnace room or laundry room.

h. In rooms which are differentiated by one or more ceiling drops which exceed 12 inches in height.

2. Detectors in rooms shall be mounted no more than 30 feet apart and no more than 15 feet from the closest wall unless the manufacturer specifies a greater or lesser distance for effective placement. Large rooms may require more than one smoke detector in order for the detection system to provide adequate protection.

(6) HEAT DETECTION. (a) Hospice facilities shall install at least one heat detector integrated with the smoke detection system at each of the following locations:

1. The kitchen.

2. Any attached garage.

(b) Smoke and heat detectors installed under this section shall be listed by a nationally recognized testing laboratory.

(7) ATTACHED GARAGES. (a) Common walls between a hospice facility and an attached garage shall be protected with not less than one layer of 5/8-inch Type X gypsum board with taped joints, or equivalent, on the garage side and with not less than one layer of 1/2-inch gypsum board with taped joints, or equivalent, on the hospice side. The walls shall provide a complete separation.

(b) Floor-ceiling assemblies between garages and the hospice facility shall be protected with not less than one layer of 5/8-inch type X gypsum board on the garage side of the ceiling or room framing.

(c) Openings between an attached garage and a hospice facility shall be protected by a self-closing 1-3/4 inch solid wood core door or an equivalent self-closing fire-resistive rated door.

(d) The garage floor shall be pitched away from the hospice facility and at its highest point shall be at least 1-1/2 inches below the floor of the facility.

(e) If a required exit leads into the garage, the garage shall have at least a 32 inch wide service door.

(8) FIRE REPORT. All incidents of fire in a hospice shall be reported to the department within 72 hours.

Note: Online fire reporting is available at: Health Care Facility Report F-62500 at: https://www.dhs.wisconsin.gov/publications/p01729.pdf.

History: CR 10-034: cr. Register September 2010 No. 657, eff. 10-1-10; CR 19-092: r. and recr. (1), r. (4), am. (5) (c) 1., r. (5) (c) 2., am. (6) (a) (intro.), (b), cr. (8) Register July 2020 No. 775, eff. 8-1-20; renum. (5) (c) 1. to (5) (c) under s. 13.92 (4) (b) 1., Stats., and correction in (5) (c) made under s. 35.17, Stats., Register July 2020 No. 775.

DHS 131.40 Plans for new construction and alterations. (1) DEFINITION. In this section, "alteration" has the meaning provided in s. SPS 361.05 (1) International Building Code, Sec. 202.

(2) SIGNING AND SEALING. Construction documents submitted to the department for review shall be prepared, signed and sealed as required by ch. 443, Stats., and s. A-E 2.02.

(3) CONTENTS AND INFORMATION. (a) 1. Construction documents submitted to the department for review shall be dimensioned and drawn to scale.

2. The scale used for the construction documents shall be indicated on the documents.

(b) 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 shall be remitted at the time the plans are submitted. No plan examinations, approvals, or onsite reviews shall be made until fees are received.

(4) APPLICATION APPROVAL. (a) A plan review application form shall be included with the construction documents and information submitted to the department for examination and approval. The department shall review and make a determination on an application for plan review under this chapter within 30 business days.

(b) An application for conditional 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 and the application for approval comply substantially with this chapter, a conditional approval, in writing, shall be granted and the plans shall be stamped conditionally approved. All conditions stated in the conditional approval shall be complied with by the applicant before or during construction.

(d) If, upon examination, the department determines that the construction documents or application for approval 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

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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 one 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 131.42 (3) (d), 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 hospice 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 start construction for the footings and foundations upon submission of construction documents under s. DHS 131.40 (3).

(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 under s. DHS 131.42 (3) (b), 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. The department may conduct onsite reviews during the construction phase of the project including framing reviews, above ceiling reviews, and finish reviews.

History: CR 19-092: cr. Register July 2020 No. 775, eff. 8-1-20.

DHS 131.41 Plan review. (1) Before the start of any construction or alteration project for a hospice, the plans for the construction or alteration shall be submitted to the department, pursuant to s. DHS 131.40, for review and approval by the department.

(2) The department shall review hospice construction and alteration plans for compliance with all of the following:

(a) This chapter.

(b) The Wisconsin Commercial Building Code, chs. SPS 361 to 366, with the exception of 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) 2012 edition of the Life Safety Code NFPA 101.

Note: Copies of the Life Safety Code NFPA documents and related codes are on file in the Department's Division of Quality Assurance and the Legislative Reference Bureau and are available at the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169-7471.

History: CR 19-092: cr. Register July 2020 No. 775, eff. 8-1-20.

DHS 131.42 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. 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 schedule under sub. (2).

(2) FEE 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

(3) OTHER FEE PROVISIONS RELATED TO REVIEW OF PLANS. (a) *Fee for miscellaneous plans.* The fee for a miscellaneous plan review and inspection shall be $250. 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. Miscellaneous plans include:

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

2. Structural plans submitted as independent projects, such as docks or, antennae; and

3. Plans for any building component.

(b) *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 under s. DHS 131.40 (8).

(c) *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.

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

(e) *Fee for plan entry.* In addition to the plan review and inspection fees for a project, each separate submission of plans for the project shall be accompanied by a $100.00 plan entry fee. When plans for multiple projects are submitted together, each project shall constitute a separate submission and requires a $100.00 plan entry fee.

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

History: CR 19-092: cr. Register July 2020 No. 775, eff. 8-1-20.

Published under s. 35.93, Stats. Updated on the first day of each month. Entire code is always current. The Register date on each page is the date the chapter was last published.