



March 23, 2010

The following Question and Answer session occurred at WALA's 15th Annual Spring Conference at the Kalahari on March 23 from 12:30 – 4:30 p.m. during the Pre-Event “DHS-83, It's Answer Time!” This session allowed an opportunity for providers to get answers to questions regarding the 83 code implemented in April of 2009. The state representatives who participated in this session were:

1. Kevin Coughlin, Director of BAL, Green Bay, WI
2. Doug Englebert, Pharmacy Practice Consultant BAL, Madison, WI
3. Sherri Olson, RN, Nursing Consultant BAL

Although these answers are from some of our experts within Division of Quality Assurance (DQA), they are not official answers of the department. Some of these Questions and Answers will be brought through the department review process including Office of Legal Counsel and added to the official Q & A document posted on the DHS website.

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DHS 83 – It’s Answer Time!

Kevin Coughlin
 Doug Englebert
 Sherri Olson

Disclaimer

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- Compliance with new DHS 83 codes has burdened providers with unfunded mandates. How do you rationalize this as the State moves into Family Care and MCOs continue to pressure providers for significant rate reductions?
- HFS 83 had been involved in a “rewrite mode” since approximately 1998. Early on in the rewrite the CBRF Forum later known as the Assisted Living Forum (CBRF Breakout) was appointed as the advisory committee. This group included the 5 major provider associations, advocacy groups, other key stakeholders as well as many facilities. After an exhaustive process the final document had significant consensus across the many diverse stakeholders. The rule then went through a small business impact review, legislative reviews as well as public hearing
<https://health.wisconsin.gov/admrules/public/Rmo?nRmold=4>

- When are interpretative guidelines going to be written for DHS 83, so surveys are not subject to surveyor individual interpretations? What if surveyor says they would like to see a particular thing in a facility, and it is not in the regs are we required to follow their wish versus what regs require?
- There will not be interpretive guidelines written regarding DHS 83. Clarifications regarding the regulations will come out via DQA memos and are also available through training material created by DQA. BAL has a comprehensive QA process to ensure we are following our mandates as a regulatory agency as well as consistent application of the regulations statewide. This program includes: Bi-monthly Assisted Living Forum; bi-weekly QA Committee; bi-weekly WAVE Committee; bi-monthly all staff meeting; bi-monthly BAL management meeting; bi-monthly BAL Directors meeting; bi-monthly support staff meeting; periodic surveyor training; monthly regional team meetings. The goal of all these meetings are to address issues quickly and communicate effectively throughout the state.

(answer continued)

Answer continued

- In addition, all violations written by a surveyor are reviewed by the supervisor. If there is a violation subject to enforcement there is an additional review by the enforcement specialist. Some potential violations discussed at the exit conference may not end up on the SOD. You can also contact the supervisor if there are concerns and some violations may be appealed through the Division of Hearings and Appeals. See next slide...

Post Survey Questionnaire



- 2009 - 64 respondents
- Satisfaction with survey tasks 98.50%
- On Site - 4.57
 - Knowledgeable - 4.63
 - Professional - 4.73
 - Respectful - 4.72
- SOD – 4.33

(1 = strongly disagree, 5 = strongly agree)

- By defining the scope of Administrator duties and qualifications the State has, in effect, culminated the duties that are typically handled by multiple layers in an agency into one single position. How does the State justify this? Shouldn't it be the agency's decision, based on the unique nature of their business, to determine how their organizational structure and qualifications of employees will meet desired or mandated outcomes?
- I do not agree with the statement. DHS 83.02(4) "Administrator" means an employee, including the licensee, or an employee designated by the licensee, who is responsible for the management and day-to-day operation of the CBRF. (virtually the same as HFS 83). There has not been a change in this area. There was and still is the requirement for the Administrator to be "responsible" for the operations. This requirement does not indicate that they have to do all the duties themselves. Facilities can still be run their operations based on the unique nature of their business, and determine how their organizational structure and qualifications of employees will meet desired or mandated outcomes.

- *There IS a question coming at the end of this section:* The definition of a resident who requires assist of staff to ambulate. DHS 83.02(6) - (6) "Ambulatory" means the ability to walk without difficulty or help. DHS 83.02(51) - (51) "Semi-ambulatory" means a person is able to walk with difficulty or only with the assistance of an aid such as crutches, cane or a walker. DHS 83.02(34) (34) "Non-ambulatory" means a person who is unable to walk, but who may be mobile with the help of a wheelchair or other mobility devices.
QUESTION: Is a resident who requires assist of staff to ambulate in the home, either stand by, hand held or physical assist, considered semi-ambulatory? In this case a wheelchair is used only for outings or long durations.
- DHS 83.02(51) – In general, the person described in this scenario would be considered semi-ambulatory.

• 83.03 Variance and Waiver

- Answer: The Bureau of Assisted Living has a statewide committee to review any facility requests for waivers, variances or exceptions to a requirement of DHS 83, as well as any requests that require department approval. The committee consists of the regional directors, bureau director and nurse consultant. Other consultants are invited as topics indicate. The committee meets by Live Meeting every other week. Approvals or denials are determined during the meeting. A request may be deferred if additional information is needed to make a decision.

- 83.03 Variance and Waiver. When do our current variances and waivers expire?

- Answer: Technically, all existing variances, waivers issued prior to the promulgation of DHS 83 expired on 4/1/09 because all the codes changed. To prevent the WAVE committee from being overwhelmed with renewal requests and thus delaying the responses to new requests, all existing variances and waivers can remain in place until addressed by the surveyor at the time of the next survey unless circumstances indicate a more timely renewal.

- 83.12 (4) (c) Investigation - Other Reporting: Do I have to report injuries if the resident is sent only to the emergency room, and not the hospital? What is considered a "serious injury."
- Yes. "Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident." Examples of "serious injury."
1: An aging resident with diabetes sustains a heart attack and is admitted to the hospital. This is not reportable because heart disease is a common complication of diabetes.
2: A resident falls and sustains a hip fracture, requiring hospitalization. This is reportable because the fall itself is not a natural progression of the disease process and is unintended.
#3: A resident falls and hurts their ankle and is taken to the emergency room. Scenario 1 – X-ray reveals no fracture, ankle wrapped and ice applied – not reportable. Scenario 2 – X-ray reveals a fracture, the ankle is casted and the resident returns home – reportable.

- How long must we keep the following papers in these files: Monthly med sheets? 24 hour care notes? Changes in Admission Agreements (if changed?) (If a resident is in a CBRF for 5-10 years, the files do overflow

- 83.13 General records, retention and posting and 83.42 Resident records addresses this issue. Monthly med sheets, 24 hour care notes and admission agreements – Since this is part of the resident record it needs to be retained for 7 years following discharge. Two years of information should be readily accessible in the facility and then other information could be safely stored but accessible in the event it would be needed as part of an investigation.

- When "house rules" are to be posted, is that rules for employees or rules for residents?

- DHS 83.13(3)(b) requires house rules to be posted. These are house rules for residents

- 83.15(1)(a) One of the administrator qualifications is an associate degree or higher in a health care related field. What fields does this include?

- Answer: Health care related fields consist of medical doctor, doctor of osteopathy, registered nurse, pharmacist, physical therapy, occupational therapy, speech therapy, health care administration, geriatrics, public health, social work and psychology.

- 83.15(1) As a registered nurse, would I be required to take the test for administrator to own an assisted living? EXPAND AGAIN ON WHO CAN BE AN ADMINISTRATOR

- Answer: DHS 83.15(1)(a) lists one of the qualifications for an administrator as having an associate degree or higher from an accredited college in a health care related field. The college-based educational preparation for a registered nurse consists of either an associated degree from a technical college or a bachelor's degree from a college or university. Therefore, a registered nurse is qualified to become an administrator without completing a department-approved administrator's training course.

- 83.15(2) If an administrator was **grandfathered** at the time of activation of the rewrite of DHS 83 (4/1/09), and the person goes to another facility within the same organization does their grandfathered qualification follow the person? What if the facility is with another organization? Are there any set criteria for a person being the administrator of more than 1 facility?

- Answer: If an administrator was grandfathered on 4/1/09, that person is considered to be a qualified administrator of any facility. If a person is the administrator of more than 1 facility, that individual needs to be able to meet the responsibilities for an administrator for each of the facilities as required in DHS 83.15(3).

- Expand please on Administrator responsibilities.

- DHS 83.15(3) contains the administrator responsibilities. The administrator is responsible for supervising the entire daily operation of the facility. This includes all resident care and services, personnel, finances and physical plant. The administrator is responsible for ensuring that all employees are properly trained and are competent in performing their duties. Whenever the administrator is not present in the facility, a qualified resident care staff needs to be designated as in charge.

- 83.16 Employees. Must all my resident care staff (RCS) be at least 18 years old?

- Answer: DHS 83.16(2) requires resident care staff to be 18 years old. Providers may submit waiver requests for resident care staff under the age of 18, which will be reviewed on an individual basis. Previous approvals have included conditions for minimal training requirements, supervision and allowable duties. DHS 83.02(47) defines "resident care staff" by responsibilities.

- 83.17 Hiring and Employment. In reference to 83.17 and the screening for communicable disease with caregivers. Is there a form that our community can use for this?
- Answer: 83.17(2) does not require the use of a specific form for the documentation of screening for communicable disease and there is no department form available. The method of documentation can be determined by the practitioner who conducts the screening. Practitioners are not required to state that an individual is "free" of communicable disease. The purpose of screening is to identify the presence of a contagious disease that could pose a risk to the health of residents. Practitioners can evaluate the general likelihood of communicable disease by methods such as interviews, general observations and assessment of vital signs. TB screening should be performed according to CDC standards. Documentation only needs to show that the employee has been screened for clinically apparent communicable disease including tuberculosis.

- 83.20 questions Hopefully with the release of the memo in early March most will be answered. BTW, one of the Roundtables will have direct access to the CCDET website
- 83.20 - DHS link to CBRF training
http://dhs.wisconsin.gov/ri_DSL/CBRF/CBRFintro.htm

- As a tax payer how can I be assured that there is no conflict of interest between BAL and UW Oshkosh as third party supervisor of training information? Seems as though the cost for UW Oshkosh logging training information is merely a money making venture \$25.00 per person trained seems exorbitant amount of money for data entry, in this age of technology tracking can be automated. The cost of training trainers is also extreme.....how are small providers supposed to survive and hire staff to meet state mandated requirements?
- DHS 83.20. Please be assured DQA followed the proper procedures allow by law to secure a contract with UW Oshkosh through an interagency agreement. There is no conflict of interest. Because UW Oshkosh is a "public entity" they cannot make a profit. The next question addresses what the \$25.00 is used for. We are confident that if this were to be bid out to the private sector the cost would have been much higher. When DHS 83 was re-written there were a number of training requirements that no longer require department approval. Many of these training programs can be brought in-house by facilities which can reduce training cost overall. It was anticipated in the re-write that any additional costs associated with the registry and approved trainers would be primarily offset by reduction with the number of approved training hours. In addition, the department approved training requirements are one-time only. Once an employee is on the registry they stay on the registry.

- A number of providers feel the \$25/student for the four 83.20 curriculums is too expensive. Please explain the process to arrive at this fee and what it is used for.
- 83.20 - The \$25/student is for the creation, processing, and maintenance of the student registry. This was a new registry that needed to be created without any new money. UW Oshkosh has spent the last 7 months creating the website with no start up money. Cost of the registry include software cost, software development, website development, technical assistance, information validation, data entry, storage, maintenance, report design and production, all the quality assurance processes and all the associated labor costs. Complaint investigations related to the student registry is also funded by this fee. Details on the next slide.....

- Tasks that were completed before the roll-out date included:
- Setting up the processes needed such as the email address, spreadsheet to track trainer application process, and preplanning all other services
 - Create a new database to put approved instructors and employees who have successfully completed trainings
 - Create reports for approved instructors (6 different reports) and employees (1 report)
 - Create fillable forms and information sheets for approved trainers
 - Create the CBRF Training and Registry Services website
 - Securing BAL approval and make changes and updates as needed
 - This doesn't include getting curriculum development, which was paid by BAL
- Once the website and process has gone live:
- Processing applications – many which need clarification – they've forgotten information, either too much or too little money send, etc.
 - Entry of instructor information to database
 - Updating the website and forms as needed
 - Running reports twice a week and uploading to website
 - Answering CBRF Training and Registry Services email
 - Providing informational presentations around the state

- CBRF Training and Registry Services – University of WI-Oshkosh documents for Instructor Guidelines and Requirements for CBRF Training and Registry Services indicate... "All instructors must follow the requirements listed below to maintain approval." "The curriculum should only be shared with students and approved instructors." Please explain the rationale for not sharing the curriculum openly with providers. Providers must have an understanding of the training a caregiver receives in order to properly supplement facility orientation and training and well as prepare appropriate annual training. The goal is to build a skill set among caregivers, not to build a secret set of materials and test questions. In addition, in organizations where trainers are company employees who will only train company staff, the company plays a role in quality assurance.
- 83.20 - This process has not changed from the CBRF approved training under HFS 83. At that time, the department did not copy and post curriculum submitted by approved programs. It is important that the curriculum stays only with "approved trainers" for the integrity of the program. UW Oshkosh has a comprehensive quality assurance program set up that enables them to quickly make changes and get information out to "approved trainers". If there are questions the facility has of an employee's training they could ask the employee to see their "participant guides" which are very comprehensive.

- CBRF Training and Registry Services – University of WI-Oshkosh documents for Instructor Guidelines and Requirements for CBRF Training and Registry Services indicate.... “Employee Registry Protocol – Submit the completed class roster to UW Oshkosh within 2 business days of course completion.” Please explain why instructors have 2 business days to submit class registry and UW has 15 business days to add people to the Registry. 2 business days is an unreasonable standard. Getting a check out of any typical accounting department in 2 business days is a manual check process reserved for emergencies, not normal course of business.
- DHS 83.20 – The department and UW Oshkosh has received some excellent feedback related to this issue. I am happy to report that we are changing this requirement to 10 business days. This will cause an increase in the amount of time from the date of the training to the date the name is posted to the registry.

- Has the State considered extending the April 1st deadline to allow time for Train the Trainer curriculum development and roll out to ensure providers have adequate means of meeting compliance with training employees in Standard Precautions and Medication Administration?
- We are not going to delay the requirements until the train the trainer programs are available. Part of this entire change was to focus on improving the trainers. This process has raised the bar for who would be training staff in assisted living. There was significant contributions by the TAG committees on who would qualify as an instructor. Overall we want trainers in the first level which are people with extensive program knowledge in the subject area. Already we have a significant number of applicants. We will continue to monitor access and UW Oshkosh is moving quickly with the development of the criteria for the train the trainer programs. During this time we will be “reasonable regulators” if we do find non-compliance. With Standard Precautions we will look to see if facilities tried to secure training, and what type of orientation training was provided. Of significant note: Previous “approved” medication management required an RN or other licensed person to do this training. There could be an ancillary non-licensed person involved with some aspects of the training.

- I’m not sure who to talk to about this, but we are having a big concern about the new requirement related to Standard Precautions training and the “trainer” requirement. Our company has 27 facilities and in order for the staff to be able to have this training prior to working the floor, the Directors do this training on the first day of hire. It will be impossible to have staff trained in Standard Precautions before working the floor if they have to attend a class taught by an RN. Any guidance you can give me will be much appreciated.

Answer to question about standard precautions

- Answer: DHS 83.20(2) requires all employees who may be occupationally exposed to blood or body fluids to complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. In order to prevent the transmission of potentially infectious agents, staff members need to be able to implement standard precautions in all situations involving resident care. A new employee should not perform resident care if he or she has not received the standard precautions training. Staffing accommodations would be necessary to prevent the employee who has not yet received training in standard precautions from being in a situation in which potential exposure could occur. OSHA also requires this and their penalties are much higher than DQA.

(answer continued)

Standard Precautions, continued

- Persons other than a registered nurse may teach Standard Precautions which may provide more options for locating a class. The qualifications for trainers of DHS approved Standard Precautions in the absence of a medical professional license are:
 1. Successful completion of a WI DHS approved Train-the-Trainer course in Standard Precautions; or
 2. Currently employed by a WI Technical College to teach at least one course in standard precautions or blood-borne pathogens; or
 3. Currently certified by the American Red Cross to teach a blood-borne pathogens course; or
 4. A minimum of 2 years full-time direct care experience in a health care setting and completion of a WI DHS approved or equivalent course in Standard Precautions and receive consultation from a licensed medical professional individual as identified.

(answer continued)

- Standard Precautions, continued

During this time we will be “reasonable regulators” if we do find non-compliance. With Standard Precautions we will look to see if facilities tried to secure training, what approved trainers were available in the area and what type of orientation training was provided.

- In 83.24 Exemption, in (3) Exemptions from Standard Precautions, in (b) "employees who can provide documentation that they have had training from a regulated health care entity in the practice of standard precautions within the previous year."
who are those regulated entities who might provide such training?
Please give examples of what that means.
- Answer: A "regulated health care entity" is one that is also regulated by DQA, such as a nursing home, home health agency, hospice organization or hospital. Example: A Resident Care Assistant was employed as a CNA in a nursing home prior to beginning employment in the CBRF on 2/2/10. She received training in standard precautions from the NH on 4/15/09. The NH sent a copy of the documentation from her personnel file to the CBRF. She is exempt from standard precautions training.

- 83.21 (3) All Employee Training- Challenging Behaviors/ Suicide Prevention For Challenging Behaviors in All Employee Training, do I have to train "suicide prevention" and what resources are available for me to train this new topic?
- DHS 83.21 (3) Training for recognizing, preventing, managing and responding to challenging behaviors training shall include AS APPLICABLE: if you have a facility that has residents who are suicidal or have conditions like severe depression which may have suicidal situations then training must be provided. For suicide the training may be limited to recognizing issues and reporting...but in some cases the facility may be providing interventions and therefore intervention training should be provided as well. Resources can be found at:
<http://www.hopes-wi.org> ;
http://www.mhawisconsin.org/Content/suicide_prevention.asp;
<http://dhs.wisconsin.gov/health/InjuryPrevention/pdffiles/WISuicidePrevStrategy.pdf>

- When they are talking about the 15 hours of continuing education and how it needs to be completed in the calendar year, do they mean starting on the employees anniversary date or on Jan 1st? 83.25 states: The administrator and resident care staff receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. That means that once an employee has been hired, that the 15 hour requirement starts with the "first calendar" year and they then need 15 hours. In other words, you hire an employee Dec 1, 2009. That trainee has to do all the current training etc. - some now, some within 90 days. And "beginning with the first full calendar year of employment", the employee then has to start the 15 hours. That would be January 1, 2010. So the employee would need 15 hours in 2010. We do feel you can use part of the other training you have to do as the 15 hours of continuing ed, just keep track of the time and topics and make sure it is in their file as 83.25 continuing ed per the documentation instructions in 83.26 - (2) *Employee orientation and hours of continuing education shall be documented in the employee's file.*
- **83.25 Continuing Ed.** Yes, the 15 hours is based on the first "full" (Jan 1-Dec. 31st) and every calendar year after the date of hire, and is not based on the employee's hire date. This example is correct.

- My facility has informed our MCO that we can afford to subsidize only five slots for Family Care members. A long-time resident runs out of funds, applies to the MCO and is eligible for Family Care funding. The MCO offers us their standard rate that is substantially below our private pay rate and will not meet our private pay rate. We do not wish to discharge the resident, but cannot afford to subsidize any more residents. Our question: will BAL allow this to be an involuntary discharge? From our point of view, 83.31 (4) (b) (1) allows for Involuntary Discharge for "Nonpayment of charges, following reasonable opportunity to pay." The resident cannot pay the private pay rate, they MCO will not pay it, we have no more slots for Family Care and we refuse to go broke. While we do not wish to involuntarily discharge this resident, **can** we involuntarily discharge them per the regulations? We of course will abide by all the requirements in the rest of 83.31 for 30-day written notice, providing assistance in relocation, notice requirements, etc.

- DHS 83.31 When the Bureau of Assisted Living gets involved with an appeal of an involuntary discharge we obtain information from both sides to see if a facility "can" do an involuntary discharge per the CBRF regulations. When a facility discharges for non-payment per 83.31 (4) (b) (1) factors we may look at include:
1. Is this person now eligible for Family Care or some other type of payment. Is this truly non-payment then?
 2. If they are eligible for Family Care, is there a difference between the Family Care amount and what they were paying private pay or what they were assessed at? How has this difference been charged? Can someone else pay the difference? Has there been a "reasonable amount of time and opportunity" to pay the difference.
 3. Is this truly an issue of non-payment or is it that the facility does not want to have another person in their facility receiving public funding?
 4. What was the person promised when they came to the facility? What does the program statement say, what does the admission agreement say? For example we have had cases that had something to the effect of: "We are a Family Care facility. If you run out of money you will be able to stay at our facility under family care. You can stay at our facility and never have to go to a nursing home". At times these may not become an involuntary discharge. It is my understanding that when the person is running out of money they would go to the ADRC and get option counseling. With the philosophy of Family Care there may be a number of options the person wishes to explore that they did not know were available to them when they came as a private pay resident. This type of hypothetical could lead to voluntary discharge initiated by the resident.

Overall the Bureau of Assisted Living looks at an involuntary discharge as this is the resident's home. The responsibility is on the facility to prove that the regulations allow them to "involuntarily" discharge this resident from there home.

- A resident has a legal guardian, this resident was EM-1'd out of our facility on 2-9-10 to...Psychiatric Unit because she struck out at a staff member and also at a visitor. She is returning today. Here are my questions please and thank you. This resident is coming back to the facility today with a court order to medicate which to my understanding is that this resident (via the court) is ordered to take their medication for their safety or for others safety. Another way of stating this is to say that this resident by court order has lost the right to refuse medication and that staff can medicate this resident even if it means to hold the resident still while administering an injection to calm them down.
QUESTION: Can I actually do this in an Assisted Living Setting or is this level of care out of my regulations. I am anticipating I will not have to use this court order to medicate however there is no guarantee and for this resident's safety and medication compliance to take her meds by mouth I could be in the situation of having to use this court order to medicate. **QUESTION:** Again is this process of court ordering to medicate something that is within my legal state regulation to be able to be to administer in an Assisted Living Setting or must I be a Skilled Nursing Home?

Answer to question about court ordered medications

- Answer: 83.32(3)(h) states the resident has the right to refuse medication unless the medication is court ordered. The facility should be in contact with the court and attempt to have some input into the decision by which the facility will be abiding. The facility needs to determine how it will implement a court order for medications and that order should specify which medications the resident cannot refuse, as well as how they are to be administered. A court order could state that living in the least restrictive setting is contingent upon compliance with medications. The facility needs to adhere to the requirements of 83.37(2)(e) regarding administration of injections by a RN and 83.32(3) regarding department approval of physical restraints that might be used.
- The department's Client Rights Office is a resource for questions regarding resident rights. Their web site is located at: <http://dhs.wisconsin.gov/clientrights/index.htm>

- Case scenario, maintaining a resident at risk in the home. DHS 83.27(2)(b) A person who is destructive of property or self, or who is physically or mentally abusive to others, unless the CBRF has sufficient resources to care for such an individual and is able to protect the resident and others. DHS 83.32(3)(i) *Prompt and adequate treatment.* Receive prompt and adequate treatment that is appropriate to the resident's needs. DHS 83.32(3)(L) *Least restrictive environment.* Have the least restrictive conditions necessary to achieve the purposes of the resident's admission. The CBRF may not impose a curfew, rule or other restriction on a resident's freedom of choice. A resident clearly is at risk of imminent injury due to persistent unsafe behaviors and or physical limitations. The resident is oriented and makes his or her own decisions. Every intervention imaginable has been put into place to limit the potential for injury. The resident, family, case manager and ombudsman do not want measures that restrict the resident's independence. They do not want restraints of any kind, alarms or 24 hour supervision. The case manager and ombudsman do not feel the resident would receive any benefit from discharging to another environment. **QUESTION:** Aware of the requirements per DHS 83 and the fact that CBRFs do not have risk agreements incorporated into the regulations. **Can a CBRF apply for a waiver to form a risk agreement with the resident and retain the resident in the home? Does the CBRF need a risk agreement in these cases?**

• Answer

- DHS 83.35 Assessment ISP and evaluations. Risk agreements are unique to Residential Care Apartment Complexes and are defined in those administrative codes and are not appropriate for CBRFs. The assessment, ISP and evaluation process is the vehicle to identify the issues, establish the services and frequency and define goals and desired outcomes. The development should include all the key parties including the person's identified above. It is important that everyone is on board with this comprehensive care plan. When a facility is challenged with some difficult situations they may want to secure a consultant to come in and help work through some possible alternatives. Ultimately the responsibility for the care is with the licensee and there are some risks you may not want to accept. A involuntary discharge may be the only alternative.

- There are many questions on BAL's intent on measurable goals. Please expand.

- DHS 83.35(3)(a)3 Comprehensive Individual Service Plan. This rule identifies required components for the ISP including: Needs, desired outcomes, methods, interventions and measurable goals. Measurable goals is a way to determine if methods and interventions are working to attain desired outcomes and meet resident needs. Some measurable goals are easier than others. For example, warfarin will have an INR of 2-3. Other measures that are easier are blood pressure and blood glucose. Other measures are more difficult. For example measuring behaviors, sleepless nights, eating habits. If you are identifying a resident need and a desired outcome you need to develop a way to measure progress.

- Lots of questions on when change in condition requires an update in the ISP and when "others as appropriate" per 83.35 (3) (d). Please expand on this issue and all its related sub-issue.
- The significant change in condition language no longer exists in this section. The requirement is for a change in resident needs, abilities, or physical or mental condition. So if a resident cannot hold a utensil to eat due to a broke arm the resident has a change in need and ability requiring an update to the ISP. Input to the ISP includes language "others as appropriate." The individuals who should be involved are dependent on the identified needs, objectives, interventions, and measurable outcomes. If this is a medication related intervention then the pharmacist may be a good choice to have input. If it is a dietary issue then a dietitians input may be appropriate.

- When posting Employees on time schedules, do first and last name HAVE to be included on the roster?

- DHS 83.36 Staffing requirements (2) Staffing Schedule ..."The schedule shall include each employee's full name, job assignment and time worked." Yes, first and last name.

- Can a pharmacist delegate nebulizers? One part of regulations says nurse only in meds delegation.
- DHS 83.37 (2)(b)&(e). No. The regulations allow a pharmacist to be involved in coordinating, directing and inspecting medication administration. However, actual delegation can only be done by an RN. The practice act for a pharmacist does not allow a pharmacist to delegate medication administration.

- LOTS of questions in nurse delegation? Please expand on that.
- 83.37(2)(b)&(e) Nurse delegation involves actual delegation and then supervision of delegated acts. Delegation is regulated by the Nursing Board. "Delegated nursing act" means acts delegated to an L.P.N. or less-skilled assistant by an R.N. N6.03(3) defines the supervision and direction of delegated nursing acts an R.N. shall:
 - (a) Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised;
 - (b) Provide direction and assistance to those supervised;
 - (c) Observe and monitor the activities of those supervised; and,
 - (d) Evaluate the effectiveness of acts performed under supervision.

LOTS of questions in nurse delegation? Please expand on that.

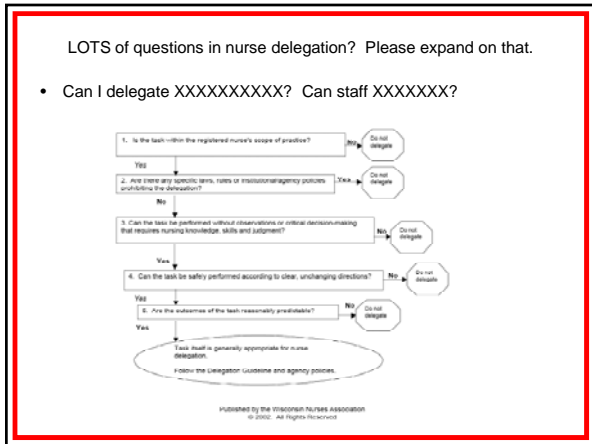
- Nurse Practice Act Definitions for Supervision
 - N6.02 (6) "Direct supervision" means immediate availability to continually coordinate, direct and inspect at first hand the practice of another.
 - N6.02 (7) "General supervision" means regularly to coordinate, direct and inspect the practice of another.

LOTS of questions in nurse delegation? Please expand on that.

- Plain Language
 - Delegate what you know.
 - Delegate what they know.
 - Delegate only if there are clear directions.
 - Delegate only when there is a predictable outcome....e.g. stable condition.
- Delegation Quality Assurance
 - Ongoing Training
 - Ongoing Demonstration Feedback
 - Ongoing Outcome Observation

LOTS of questions in nurse delegation? Please expand on that.

- Can LPN delegate
 - Not Allowed Per N6
 - Can supervise
 - Can reinforce training



- Diabetes pens cannot be used by the resident, even when they show they can. Any suggestions on how to better handle this.
- Please review the insulin section of the BAL medication management resource:
http://dhs.wisconsin.gov/ri_DSL/MedManagement/insulinAdmin.pdf
DHS 83.37(2)(e) All injections in a CBRF require administration by a registered nurse (RN), practical nurse or RN delegation unless resident self administers insulin. If resident self administers they can use insulin pens or any other system they wish. A RN or LPN can use pens or can draw insulin from a vial to a syringe. A RN with delegation can teach staff to use insulin pens or can teach and delegate to staff drawing up insulin. Some of the insulin pens are not being manufactured any longer and therefore are becoming unavailable. If you have been using pens you may have residents that require reassessment and staff that need retraining on drawing of insulin.

- A CBRF resident takes the city bus to attend work once a week. His employer requires the resident's medications to be delivered to the facility and that facility staff hand medications to work staff. The facility does not feel it is safe to transfer the resident's punch card with him as he travels on the city bus. Codes do not allow staff to take medications out of unit dose packaging for routine events. How can the facility meet all requirements while also maintaining the resident's independent bus travel and allowing medication transfer between staff?
- DHS 83.37(3)(a) A sample of multiple, potential options include:
 - a. The prescription may be changed so that the medication does not need to be taken at work.
 - b. The employer maintains a month's supply of medication so that handoffs can be made monthly rather than weekly.
 - c. After consideration, an employer may allow a resident to hand-off medications to work staff. If medication tampering is a concern, the use of some type of sealed, tamper-evident packaging may be possible.
 - The resident, work staff, facility staff, and the pharmacist need to discuss and understand all relevant regulations and/or requirements and find a viable solution that maintains the resident's desired level of independence.

- What should a CBRF require as far as documentation from a Home Health agencies or Hospice agency if they are providing services to one of our residents? Should they send us the clinical records of their patients.
- DHS 83.38(1)(g)3. The CBRF shall document communication with the resident's physician and other health care providers, and shall record any changes in the resident's health or mental health status in the resident's record
DHS 83.42 **Resident records.** (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment. (i) Documentation of all other services including rehabilitation services, treatments and therapeutic diets.
Regulations do not required copies of the HHA clinical record. The overall care of the resident is the key with an emphasis on good communication and effective coordination of care. Progress notes shared back and forth could be an effective tool. The process should be worked out ahead of time. BAL will be working with BHS for a future interface document between AL and home health.

- I really feel that part of the states success with the implementation and enforcement of the DHS codes is from the good communication that there is between the state's directors and surveyors and the companies such as ours that follow the codes when performing our fire protection services in the CBRFs. It makes it a lot easier and clearer.
I want to follow up on our conversation we had today regarding the interpretation of a code section DHS 83.48 (1) (b). What the paragraph is stating are two separate requirements that may be getting combined and enforced incorrectly by some of the state surveyors.
The first part of the requirements in (b) states that "smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturers recommendations". The requirements per NFPA 72 is that the initiating devices be tested and maintained by properly trained personnel on an annual basis. They are referring to fire alarm systems and interconnected smoke detection systems that have a fire control panel. The panels and all of its circuits, wiring and components are continuously supervised for their integrity. These panels use the building electrical power as its primary power source and have a backup battery source for its secondary power in case of a power outage. The detectors are actually powered directly from the fire control panel not the building electrical system. If any of the smoke detectors are removed or the wire going to them disconnected or disabled the fire control panel sounds a trouble condition.
The second part of the requirement in (b) states that "smoke detectors powered by the CBRFs electrical system shall be tested by CBRF personnel according to manufacturer's recommendations, but not less than once every other month". The smoke detectors that they are referring to here are the interconnected ones that are powered directly from the buildings power and are connected directly to a circuit breaker in the buildings breaker panel. These detectors are the 120 volts AC type that are not supervised in any way. If one were to be taken down no one would ever know until it was time to be tested. These detectors are still tested by a trained fire protection company on an annual basis to meet NFPA 72 requirements. The testing of the 120 volt AC detectors on a every other month basis will help ensure the detectors are working properly until the annual inspection by the service company.
- DHS 83.48(1)(b) – Excellent answer. Yes, this is also how DQA interprets this requirement. We have provided additional clarification to our staff related to this area.

- May a brother and sister share a room together?
- DHS 83.54 – Maybe? Is this something that has been assessed as optimal? Was this the arrangement when they were living at home? How will they be afforded privacy? Are all parties in agreement with this arrangement?

- There is still confusion regarding toilet doors that are required to swing out unless it has two way hardware.
- DHS 83.59(2)(e) - Statewide waiver to this provision was issued July 15, 2009.
http://dhs.wisconsin.gov/ri_DSL/Publications/09-031.htm

- The other question I have was regarding the requirements of the **exit lights being lighted at all times**. Section DHS 83.59 (7)(b) states that all exit signs shall be lighted at all times. In (7)(a) directly above it, it is real specific in stating that all emergency egress lighting shall be provided with a stand-by power source. I have been told by a state surveyor and a state supervisor that the intent was not to have battery back up but that if there was an exit sign installed that the bulbs had to be working and 120 volts had to be going to it so that it was operating. On the flip side, I have had a state surveyor "write up" a CBRF because their interpretation of the code was to be lite at all times means it had to have battery back up. I had lost the service on a large group of CBRF's because they felt I had not informed them of the changes and have since replaced all their exit signs with battery back up ones.

For what it's worth my thought process is that the buildings that are licensed as a CBRF had the exit signs installed at the time of construction and apparently it was not required at that time as the exit signs operated on A/C power only. If the intent is to have battery back up exit signs, 99% of the CBRF's will have to have the old ones removed and the new ones installed.
- 83.59(7)(a) & (b) – (a) and (b) are very distinct and separate requirements. The intent in (a) is that when a facility's power source is lost, lighting in exit passageways and stairways will automatically be restored by a battery or generator operated emergency lighting system or device. The intent of (b) is that all exit signs that are required by the department of Commerce be lighted at all times. This can be accomplished by the exit sign being powered by facilities electric with a backup battery or generator or the exit sign could be lighted by an adjacent emergency light with backup power.

- What was the State's purpose in increasing the scope of plan reviews for CBRFs to include existing buildings?
- DHS 83.63(2)(b) and (5)(c)– Over the years people have converted a number of different structures into CBRFs including very old homes, old nursing homes, convents, motels, business, funeral homes, apartment buildings, flop houses, etc. Many times Commerce did not review these as a "change in use". When our surveyors went in they found significant non-compliance with the regulations. Plan review protects both the applicant and the department to ensure the building requirements of DHS 83 are met prior to occupancy.

- How does the State plan to ensure prompt plan review? Plan reviews are currently scheduled to occur more than 2 months after receipt of the plan. It is apparent that the State is not prepared to handle the additional demands of plan reviews. Has the State considered how delaying the plan review process reduces provider's ability to make structural changes in a timely manner to ensure cost effective models?
- DHS 83.63 – A few months ago the perfect storm occurred with engineering and plan review. We had vacancies and new staff, new federal work that was a priority and mandated furloughs where engineers were laid off for a period of time. All this led to some significant delays. A number of strategies have been put into place and the delays have been significantly reduced (see next slide). In addition, the DQA is exploring a long term solution. Challenge right now is that there are engineers in all three of the division's 4 bureaus (not BAL) with 8 different supervisors and both federal and state workload.

Plan Review

By Type Fac	Avg. # Days	# PR	# PR, according to Age of Plans				
			0-14 Days	15-29 Days	30-44 Days	45-60 Days	> 60 Days
CBRF 02/23/10	48	25	6	6	6	1	5
CBRF 03/05/10	39	16	5	4	5	0	2
CBRF 03/19/10	19	11	6	5	0	2	0

- We are a non-smoking campus and a resident decides to start smoking. The resident walks off campus to smoke, the staff feel this is unsafe due to having to cross a street with uneven pavement. The family has stated and documented that they want their parent to do "whatever" they would like, even if it's a safety concern. Staff directed resident in safe procedures for ambulating across this street and offered a paid assistant to join him/her (which is refused). What else should or could the facility do? Does the facility hold liability if this resident is hit by a car or injured in some other way crossing the street?
- DHS 47(5) - What else should or could the facility do? Make sure it is in the ISP and everyone has signed. Make sure the safe procedures is well documented with signatures from all involved. Continue to reassess the situation. Does the facility hold liability if this resident is hit by a car or injured in some other way crossing the street? Maybe yes, maybe no. And it may depend on whose perspective (Regulator, Civil Attorney, Law enforcement, Insurance Company) Ultimately a facility needs to assess the risk they are willing to accept.

- ### Resources
- CBRF Q & A Document
<http://dhs.wisconsin.gov/bqaconsumer/AssistedLiving/dhs83Q&A09.pdf>
 - CBRF training webcast
http://dhs.wisconsin.gov/ri_DSL/Training/dqaWebcasts.htm
 - Medication Management Initiative
http://dhs.wisconsin.gov/ri_dsl/MedManagement/asstlvqMML.htm
 - DQA CBRF Pharmacy Q&A
http://dhs.wisconsin.gov/ri_DSL/MedManagement/cbrfPharmFAQs.pdf
 - Memos
http://dhs.wisconsin.gov/ri_DSL/CBRF/CBRFnodMemos.htm
 - Standards of Practice
http://dhs.wisconsin.gov/ri_DSL/Providers/standards.htm
 - Other Resources (strategies to support compliance)
http://dhs.wisconsin.gov/ri_DSL/Providers/resources.htm
 - Consultants
http://dhs.wisconsin.gov/ri_DSL/dqaConsltLst.htm

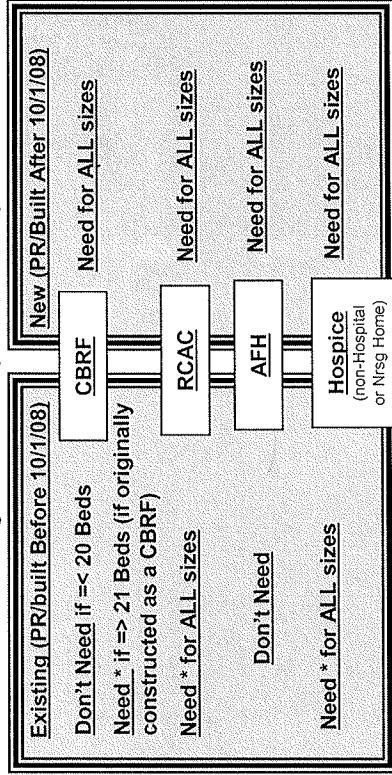
Disclaimer

- *Although these answers are from some of our experts within DQA, they are not official answers of the department. Some of these Questions and Answers will be brought through our department review process including Office of Legal Counsel and added to the official Q & A document posted on the DHS website.*

What You Need to Know About Carbon Monoxide Alarms in Health Care

A. WHO NEEDS CARBON MONOXIDE ALARMS?

Residential Bldgs Exclude Hospitals & Nursing Homes



- * Don't Need if there is
- NO attached garage
 - NO fuel burning appliances
 - or all fuel burning appliances are "sealed combustion" & are under warranty or inspected annually for CO emission.

B. WHAT KIND OF ALARM IS NEEDED?

Existing (PR/built Before 10/1/08) You can choose to install Carbon Monoxide Alarms that are	New (PR/Built After 10/1/08) You Must install Carbon Monoxide Alarms that are
<ul style="list-style-type: none"> • Battery Powered, or • Plug-In, or • Electrically Wired 	<ul style="list-style-type: none"> • Electrically Powered, • Have Battery Back-Up, • Are Interconnected so any alarm sounds in the entire dwelling unit

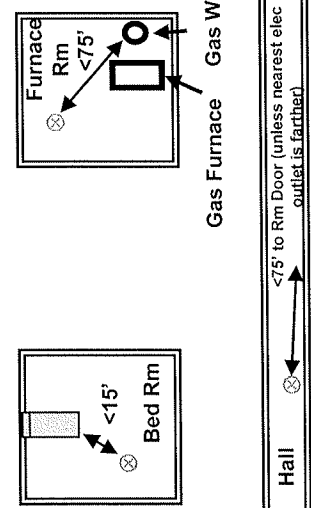
All alarms must be listed as UL2034 or UL 2075 compliant

C. WHEN MUST THEY HAVE TO BE INSTALLED?

Existing (PR/built Before 10/1/08) They <u>Must</u> be installed Prior to April 1, 2010	New (PR/Built After 10/1/08) They <u>Must</u> be installed before you open
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D. WHERE MUST THEY GET INSTALLED?

	Apartment	Boarding
1. In the Basement	X	X
2. In all Dwelling Units with a fuel burning appliance	X	
3. In Dwelling Units adjacent to a fuel burning appliance	X	
4. In Hall with a door that opens into room with a fuel burner	X	
5. In any non-sleeping room with a fuel-burning appliance	X	X



E. HOW MUST THEY BE INSTALLED?

In all cases the Carbon Monoxide Alarms must be installed according to the manufacturer's written instructions
(Keep a copy in your files)

F. HOW MUST THEY MAINTAINED?

In all cases the Carbon Monoxide Alarms must be maintained according to the manufacturer's written instructions
(Keep a copy in your files)

Must repair within 5 days of report by resident/staff of a malfunction or if missing

WHAT TO DO IF THERE IS AN ALARM!

1. Silence Alarm; 2. Leave Bldg or Get to Window 3. Call 911 (if anyone is ill)