DHS 132.70 Special requirements when persons are admitted for short-term care

(1)

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

(2)

PROCEDURES FOR ADMISSION. Respite care. For a person admitted to a facility for respite care, the following admission and resident care planning procedures may be carried out in place of the requirements under ss. DHS 132.52 and 132.60(8): (a) A registered nurse or physician shall complete a comprehensive resident assessment of the person prior to or on the day of admission. This comprehensive assessment shall include evaluation of the person's medical, nursing, dietary, rehabilitative, pharmaceutical, dental, social and activity needs. The consulting or staff pharmacist shall participate in the comprehensive assessment. As part of the comprehensive assessment, when the registered nurse

or physician has identified a need for a special service, staff from the discipline that provides the service shall, on referral from the registered nurse or physician, complete a history and assessment of the person's prior health and care in that discipline. The comprehensive resident assessment shall include:1. A summary of the major needs of the person and of the care to be provided; 2. The attending physician's plans for discharge. (b) The registered nurse, with verbal agreement of the attending physician, shall develop a written plan of care for the person being admitted prior to or at the time of admission. The plan of care shall be based on the comprehensive resident assessment under par. (a), the physician's orders, and any special assessments under par. (a). (c) The facility shall send a copy of the comprehensive resident assessment, the physician's orders and the plan of care under par. (b) to the person's attending physician. The attending physician shall sign the assessment and the plan of care within 48 hours after the person is admitted.

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2.

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(b)

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

(c)

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

(3)

ADMISSION INFORMATION. (a) This subsection takes the place of s. DHS 132.31(1) (d) 1 for persons admitted for respite care or recuperative care. (b) No person may be admitted to a facility for respite care or recuperative care without signing or the person's guardian or designated representative signing an acknowledgement of having received a statement before or on the day of admission that indicates the expected length of stay, with a note that the responsibility for care of the resident reverts to the resident or other responsible party following expiration of the designated length of stay.

(a)

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

(b)

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(4)

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

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(7)

RECORDS. (a) Contents. The medical record for each respite care resident and each recuperative care resident shall include, in place of the items required under s. DHS 132.45(5): 1. The resident care plan prepared under sub. (2) (b). 2. Admission nursing notes identifying pertinent problems to be addressed and areas of care to be maintained; 3. For recuperative care residents, nursing notes addressing pertinent problems identified in the resident care plan and, for respite care residents, nursing notes prepared by a registered nurse or licensed practical nurse to document the resident's condition and the care provided; 4. Physicians' orders; 5. A record of medications; 6. Any progress notes by physicians or health care specialists that document resident care and progress; 7. For respite care residents, a record of change in condition during the stay at the facility; and 8. For recuperative care residents, the physician's discharge summary with identification

of resident progress, and, for respite care residents, the registered nurse's discharge summary with notes of resident progress during the stay. (b) Location and accessibility. The medical record for each short-term care resident shall be kept with the medical records of other residents and shall be readily accessible to authorized representatives of the department.

(a)

Contents. The medical record for each respite care resident and each recuperative care resident shall include, in place of the items required under s. DHS 132.45(5): 1. The resident care plan prepared under sub. (2) (b). 2. Admission nursing notes identifying pertinent problems to be addressed and areas of care to be maintained; 3. For recuperative care residents, nursing notes addressing pertinent problems identified in the resident care plan and, for respite care residents, nursing notes prepared by a registered nurse or licensed practical nurse to document the resident's condition and the care provided; 4. Physicians' orders; 5. A record of medications; 6. Any progress notes by physicians or health care specialists that document resident care and progress; 7. For respite care residents, a record of change in condition during the stay at the facility; and 8. For recuperative care residents, the physician's discharge summary with identification of resident progress, and, for respite care residents, the registered nurse's discharge summary with notes of resident progress during the stay.

1.

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

2.

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3.

For recuperative care residents, nursing notes addressing pertinent problems identified in the

resident care plan and, for respite care residents, nursing notes prepared by a registered nurse or licensed practical nurse to document the resident's condition and the care provided;

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Physicians' orders;

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A record of medications;

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

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

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

(b)

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