PACAH Spring Conference 2018
LSC Updates

Presented by:

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Division of Safety Inspection

PA Department of Health

Overview

- CMS Emergency Preparedness Update
- CMS Rule Change – Resident Rooms
- Fire Door Maintenance
- NFPA 99 Risk Assessment
- Electronic Plan Review
- Online Occupancy Request Form

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CMS Emergency Preparedness Rule

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CMS Emergency Preparedness

- CMS Survey & Certification Letter 17-05-All Information on the Implementation Plans for the Emergency Preparedness Regulation
  - Provides resources and a link to answers of Frequently Asked Questions
- CMS Survey & Certification Letter 17-21-All Information to Assist Providers and Suppliers in Meeting the Testing and Training Requirements of the Emergency Preparedness Requirements
  - Clarification that facilities are to conduct community-based exercises and not wait for CMS to provide interpretive guidelines

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CMS Emergency Preparedness

- CMS S&C Letter 17-21-All
  - Released 3/24/2017
  - Information to assist in meeting the new training and testing requirements of the CMS emergency preparedness Final Rule
  - Clarifies that all affected facilities must meet all the requirements of the rule by 11/15/2017

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CMS Emergency Preparedness

- CMS S&C Letter 17-21-All
- Because the Final Rule has an implementation date of 11/15/2017, one year following the effective date, facilities are expected to meet the requirements of the training and testing program by the implementation date – 11/15/2017

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CMS Emergency Preparedness

- CMS S&C Letter 17-21-All
- CMS realizes that some facilities are waiting for the interpretive guidance to begin planning the required testing exercises, CMS considers this tact not necessary nor advised
- Facilities found to have not completed these exercises or other requirements of the Final Rule by 11/15/2017 will be cited for non-compliance

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CMS Emergency Preparedness

- CMS S&C Letter 17-21-All
- In order to meet the requirements, CMS strongly encourages facilities to seek out and to participate in a full-scale, community-based exercise and to have completed a tabletop exercise by the implementation date

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CMS Emergency Preparedness

- CMS S&C Letter 17-21-All
- CMS understands that a full-scale, community-based exercise may not always be possible for some facilities due to local and state emergency resources
- In those cases, a facility must complete an individual facility-based exercise and document the circumstances
  - What emergency agencies or health coalitions were contacted?
  - Specific reason(s) that a community exercise could not be completed

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CMS Emergency Preparedness

- CMS S&C Letter 17-21-All
- CMS has created a resource website to assist facilities in complying with the Final Rule
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html

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CMS Emergency Preparedness

- Website Resource
  - Names of State Health Care Coalitions
  - CMS Provider and Supplier Types Impacted
  - Table Breakdown of the Requirements by Provider Type
  - Definitions
  - Frequently Asked Questions

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CMS Emergency Preparedness

- Survey results from November 15, 2017 to March 13, 2018
- How many EP deficiencies?
  - Note that DSI only surveys hospitals, nursing homes, surgery centers and ICF/IID's for EP requirements
- 661
- How many facilities were cited for not having any plan at all?
- 19

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CMS Emergency Preparedness

- Top 5 EP deficiency tags from November 15, 2017 – March 13, 2018
  - E0039 – EP Testing Requirements
  - E0024 – Policies/Procedures – Volunteers and Staffing
  - E0026 – Roles Under a Waiver Declared by Secretary
  - E0015 – Subsistence Needs for Staff and Patients
  - E0037 – EP Training Program

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CMS Emergency Preparedness

- <u>E0039 – EP Testing Requirements</u>
- (2) Testing. The [facility, except for LTC facilities] must conduct exercises to test the emergency plan at least annually. The [facility] must do all of the following:
- *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]
- (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

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- <u>E0039 – EP Testing Requirements Continued</u>
- (ii) Conduct an additional exercise that may include, but is not limited to the following:
- (A) A second full-scale exercise that is community-based or individual, facility-based.
- (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
- (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

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CMS Emergency Preparedness

- E0024 – Policies/Procedures – Volunteers and Staffing
- [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]
- (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

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CMS Emergency Preparedness

- <u>E0026 – Roles Under a Waiver Declared by Secretary</u>
- [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]
- (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

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CMS Emergency Preparedness

- E0015 – Subsistence Needs for Staff and Patients
- [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:
- (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:

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CMS Emergency Preparedness

- <u>E0015 – Subsistence Needs for Staff and Patients Continued</u>
- (i) Food, water, medical and pharmaceutical supplies
- (ii) Alternate sources of energy to maintain the following:
- (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
- (B) Emergency lighting.
- (C) Fire detection, extinguishing, and alarm systems.
- (D) Sewage and waste disposal.

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CMS Emergency Preparedness

- E0037 – EP Training Program
- (1) Training program. The [facility] must do all of the following:
- (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
- (ii) Provide emergency preparedness training at least annually.
- (iii) Maintain documentation of the training.
- (iv) Demonstrate staff knowledge of emergency procedures.

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CMS Emergency Preparedness

- 1135 Waiver process guidance being created by HAP
- The guidance mirrors the information provided by CMS at the following link: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers.html

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CMS Emergency Preparedness

- When the President declares a disaster or emergency, and the HHS Secretary declares a public health emergency, there are options to waive or modify certain requirements.
- Examples:
  - Conditions of participation
  - EMTALA
  - Stark self-referral sanctions
  - Additional examples can be found on the CMS website

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Long Term Care Update

- CMS Survey and Certification Letter 17-07-NH, November 9, 2016
- First comprehensive review and update of the CMS long term care regulations since 1991, despite substantial changes in service delivery

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Long Term Care Update

- This update contained massive changes to the health survey requirements, to include new deficiency tags and a new survey process
- Many have missed the changes in Physical Environment to resident rooms

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Long Term Care Update

- F462
- §483.90(e) Bathroom Facilities Each resident room must be equipped with or located near toilet and bathing facilities. For facilities that receive approval of construction from State and local authorities or are newly certified after November 28, 2016, each residential room must have its own bathroom equipped with at least a commode and sink.

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Long Term Care Update

- F457
- §483.90 (d)(1) Bedrooms must-
- §483.90(d)(1)(i) Accommodate no more than four residents;. For facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, bedrooms must accommodate no more than two residents.

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Long Term Care Update

- 2012 Life Safety Code definition of Reconstruction
  - Section 43.2.2.1.4: The reconfiguration of a space that affects an exit or a corridor shared by more than one occupant space; or the reconfiguration of a space such that the rehabilitation work area is not permitted to be occupied because existing means of egress and fire protection systems, or their equivalent, are not in place or continuously maintained.

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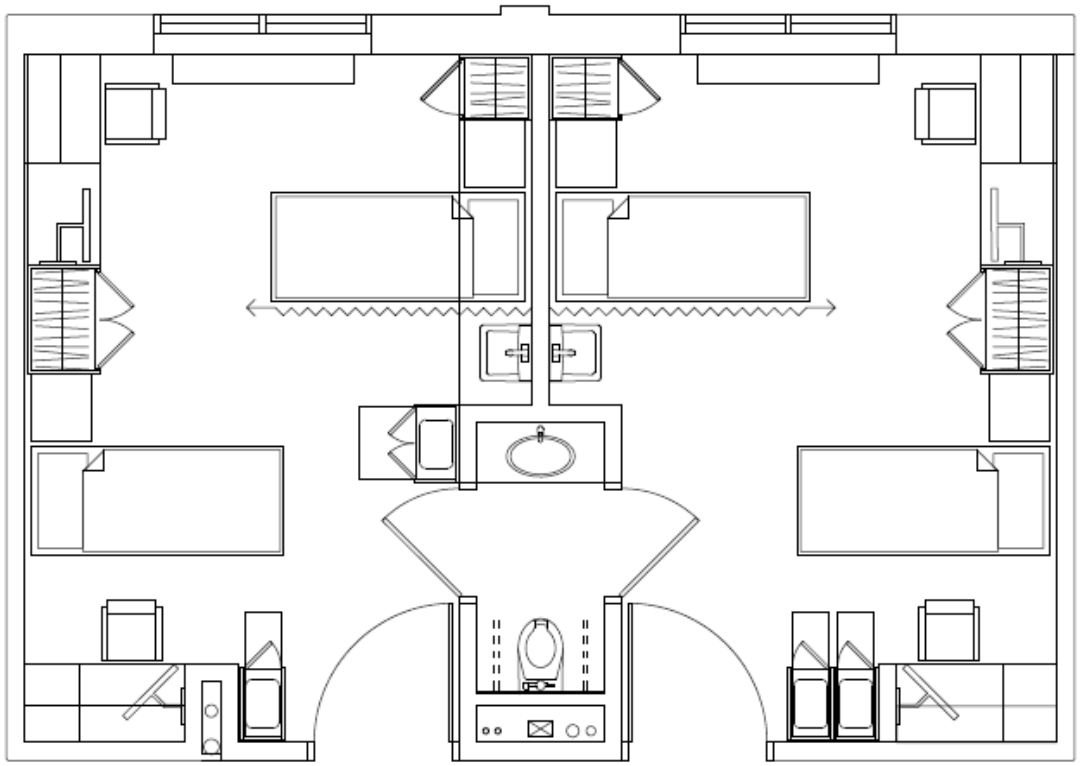
Long Term Care Update



EXISTING UNIT

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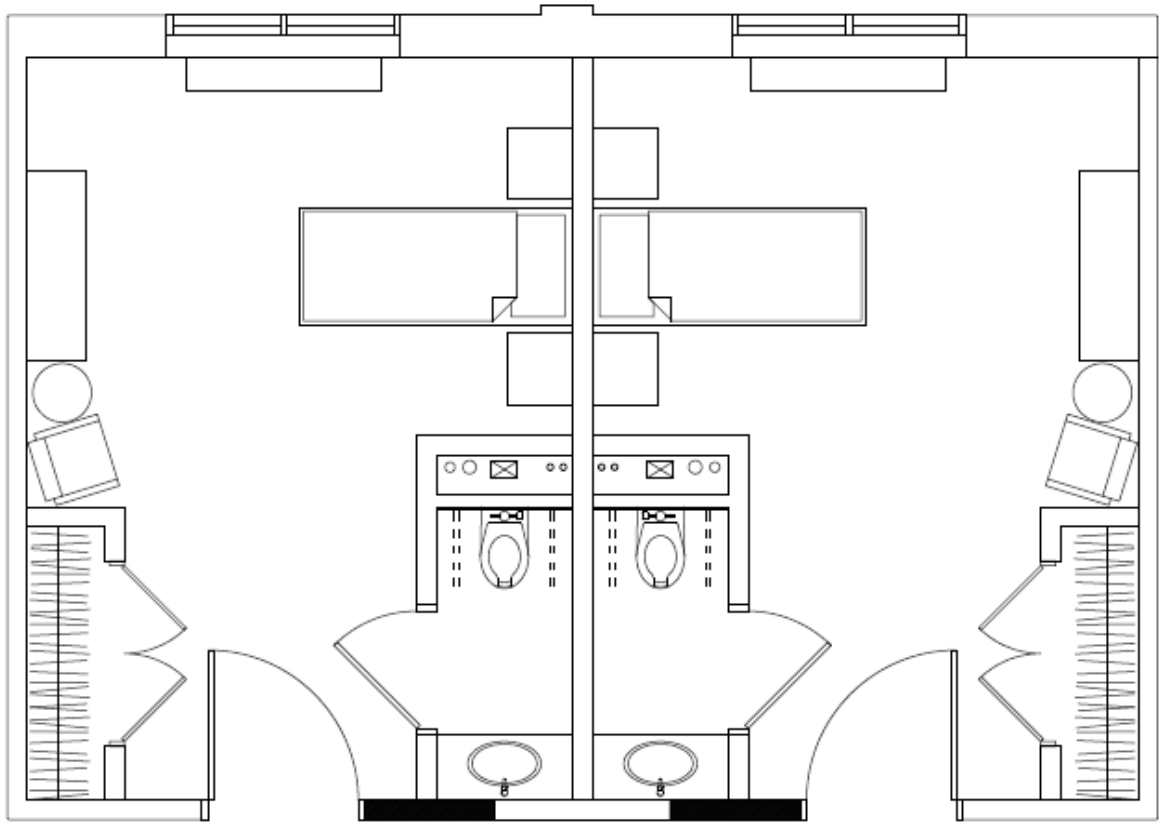
Long Term Care Update



PROPOSED SINGLE OCCUPANCY UNITS

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CMS 2012 LSC Adoption

- CMS adopted the 2012 LSC and HCFC with an effective date of July 5, 2016
- The 2012 LSC replaced the 2000 edition, which has been in use since September 2003
- PADOH state licensure requirements also adopted the regulations to follow CMS for survey consistency

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CMS 2012 LSC Adoption

- What is the importance of the July 5, 2016 effective date:
  - The date determines whether the building component is surveyed as new or existing
  - Those with a plan approval date on or before the effective date are considered existing
  - Those with a plan approval date after the effective date are considered new

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CMS 2012 LSC Adoption

- Separate from the effective date, the implementation date was November 1, 2016
- The implementation date is the date that the state agencies and CMS Regional Offices began completing surveys of health care facilities to the 2012 code requirements

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CMS 2012 LSC Adoption

- CMS made modifications to the adoption of the 2012 LSC and HCFC
  - CMS has excluded Chapters 7, 8, 12 and 13
- These can be found in the final rule:
  - https://www.federalregister.gov/articles/2016/05/04/2016-10043/medicare-and-medicaid-programs-fire-safety-requirements-for-certain-health-care-facilities

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CMS 2012 LSC Adoption

- A major change to the survey process is the organization of LSC deficiency tags
- All K-tags will be three digits and are organized by LSC section, LSC sub-section and then numerical order in that sub-section
- For example:
  - K18 … K363
  - K29 … K321

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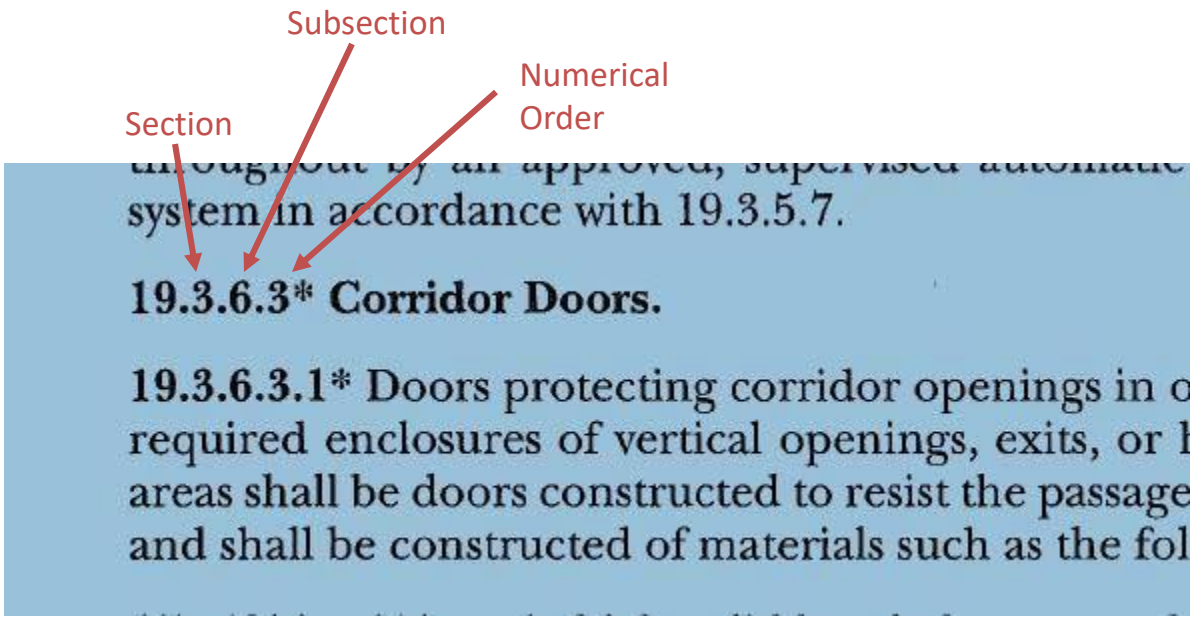
CMS 2012 LSC Adoption

– K363



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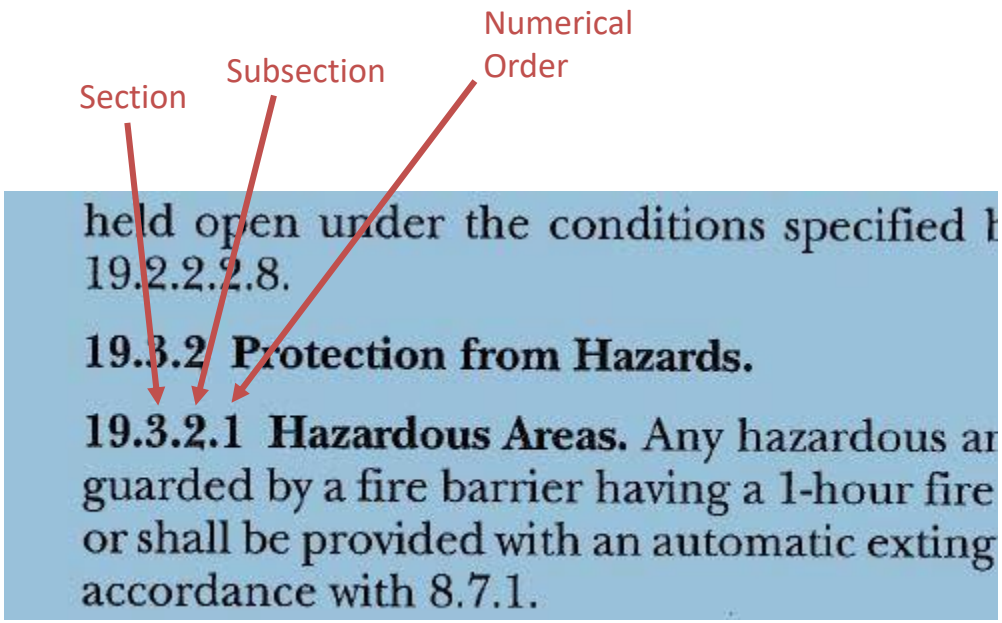
CMS 2012 LSC Adoption

– K321



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Fire Door Maintenance

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Fire Door Maintenance

- Fire-rated door assemblies
  - Applies to new and existing installations
  - Inspected and tested not less than annually
  - Written record shall be signed and kept for inspection by the AHJ – This is a comprehensive document
  - Functional testing by knowledgeable individuals
  - Repairs shall be made “without delay”

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Fire Door Maintenance

- Fire-rated door assemblies – Swinging doors
  - Prior to testing, a visual inspection of both sides must be performed, to include the following:
    - No holes or breaks in surfaces of door or frame
    - Glazing, vision light frames and glazing beads
    - No visible signs of damage to the door, frame, hinges, and hardware
    - No parts are missing or broken
    - Door clearances are appropriate
    - Self-closing device operating properly

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Fire Door Maintenance

- Fire-rated door assemblies – Swinging doors
  - Visual inspection continued:
    - If installed, the coordinator is working
    - Latching hardware operates
    - No auxiliary hardware installed that would interfere with proper door operation
    - No field modifications that would void the label
    - Gasketing and edge seals, if required, are inspected

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Fire Door Maintenance

- Similar requirements for horizontal sliding, vertically sliding and rolling doors
- Recommend that facilities begin preparing for the door testing and inspection requirements – do not wait to get cited first

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Fire Door Maintenance

- NFPA's Health Care Interpretations Task Force (HITF)
- *MISSION: To provide consistent interpretations on national codes and standards referenced by CMS, JCAHO and state and territorial authorities having jurisdiction. This will be accomplished through the evaluation of field conditions, surveyor/inspector/fire marshal interpretations, and questions by consumers of these services generated through a member of the task force.*
- July 15, 2016 HITF meeting discussed fire doors that no longer were required to be fire-rated

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Fire Door Maintenance

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Fire Door Maintenance

- **QUESTION.** Is it permissible to remove the label on a fire protection rated door that is installed in a location where a fire protection rated door is not required?
- **RESPONSE.** YES. Removing the label can be considered the same as rendering the door as other than a fire protection rated door. Covering the label is not an option. It should also be noted that the provisions of NFPA 80 do not apply.

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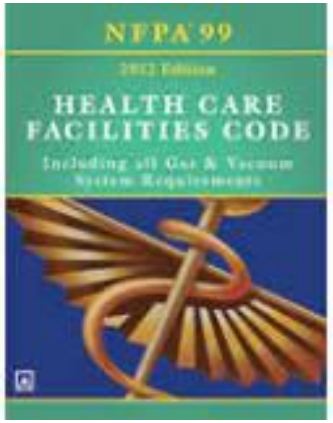
NFPA 99 Risk Assessment



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NFPA 99 Risk Assessment

NFPA 99-2012 Risk Assessment Tool

Instructions for Using the ASHE NFPA 99 Risk Assessment Tool

Prior to implementing this risk assessment tool, the following steps should be taken:

1. Establish a multidisciplinary team with knowledge of the facility's space use, patient care services, clinical practices, and other areas as appropriate.
2. Familiarize the team with the risk category definitions found in chapters 4 (Fundamentals) and 12 (Emergency Management) of NFPA 99-2012: *Health Care Facilities Code* . These definitions are included in the category legends on each worksheet; mouse over the "Category Legends" box to see them.
3. Familiarize the team with the ways in which system and equipment operability can affect patient safety.

This risk assessment tool contains three worksheets (Systems, Equipment, and Emergency Management) as indicated on the worksheet tabs below.

Notes: This risk assessment tool has been developed to help health care facility staff comply with the risk-based, patient-focused approach required by NFPA 99: Health Care Facilities Code beginning with the 2012 edition. Rather than using the former occupancy-based approach, NFPA 99 now has the same requirements for a procedure no matter where it takes place, focusing on risks to patients and caregivers and on patient outcomes.

This completed risk assessment should be used to determine the steps needed to respond to the identified risks as outlined in NFPA 99. It should be kept as a record of the decisions made and updated annually.

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NFPA 99 Risk Assessment

- CMS Deficiency Tag - K 901
- Fundamentals - Building System Categories
- Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)

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NFPA 99 Risk Assessment

- CMS Central Office has stated that SA surveyors are to review the facility's risk assessment, which was completed by qualified personnel, ***for new systems only***
- Per NFPA 99, the risk assessment should follow procedures outlined in ISO/IEC 31010, NFPA 551, SEMI S10-0307E, or other formal processes

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NFPA 99 Risk Assessment

- Category 1 – Failure of facility systems is likely to cause major injury or death to patients or caregivers
- Category 2 – Failure of facility systems is likely to cause minor injury to patients or caregivers
- Category 3 – Failure of facility systems is not likely to cause injury, but can cause patient discomfort
- Category 4 – Failure of facility systems would not have any impact on patient care

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NFPA 99 Risk Assessment

- Note that this is for *facility systems*
- This includes more than the medical gas and electrical systems commonly thought of in the previous editions of NFPA 99
- The category definitions of Chapter 4 are then applied to the requirements in Chapters 5 – 11 (Note that CMS did not adopt Chapters 7 and 8)

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Electronic Plan Review

- Starting October 1, 2016, the process for plan review changed from paper submittal to electronic submittal
- Plan submitters must set up a library with DSI to submit and retrieve reviewed plans
  - One library per architectural office, engineer office, health care facility or other submitter
  - The library account can be a resource account
  - Any questions can be directed to Pamela Brown at 717 787-1911

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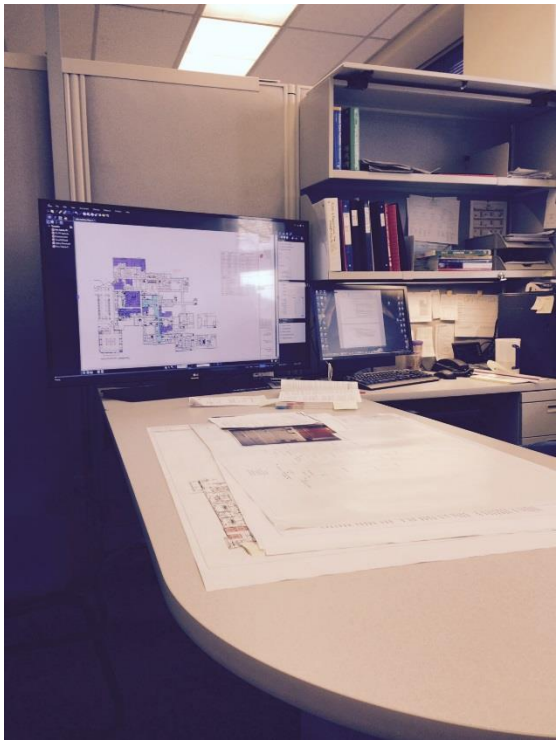
Electronic Plan Review

– This…

To this…



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Electronic Plan Review

- **<u>One printed set of approved plans must continue to be onsite at all times</u>**
  - No final occupancy approval will be granted if approved plans are not onsite
  - If this issue is found during the construction project, construction will be stopped until such time that DOH approved plans are onsite
  - This includes any approved revisions
- If a facility wishes to propose an alternate source of supplying onsite approved plans that are readily accessible to LSC surveyors, they are to contact their field office for prior approval

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Electronic Plan Review

- Required documentation for plan review remains the same
- Functional program narrative per FGI Guidelines
- Any DAAC exceptions for a final plan review are received before final plan submittal
  - Submit as a preliminary review
- Safety Risk Assessment (SRA) – not just an Infection Control Risk Assessment
- New Plan Review Checklist requires that the submitter check the box stating that an SRA was completed and available onsite to the survey team

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Occupancy Surveys

- Requests for occupancy surveys are electronic
- All requests will be submitted electronically through the DOH website – **no exceptions**
  - Provides consistency
  - Eliminates confusion on requests
  - Better tracking of occupancies
  - Goal is to streamline the process
- http://www.health.pa.gov/facilities/Licensees/Building%20Safety/Pages/default.aspx#.WAUxsqPD-_5

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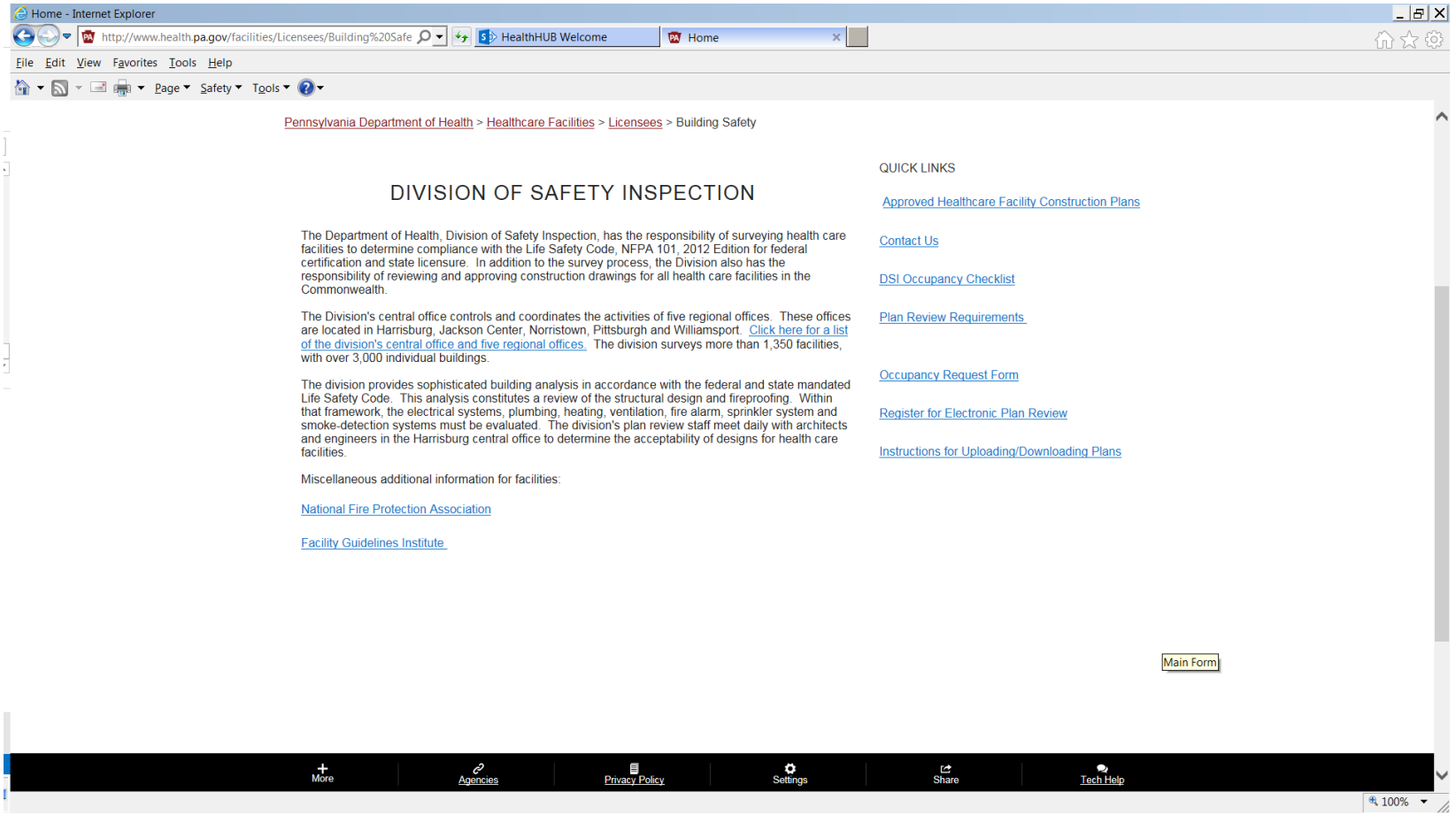
Occupancy Surveys



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Questions?

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