Department of Health Update

Presented by:

Susan Williamson, Director

Division of Nursing Care Facilities

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Facility and Survey Data 1st Half 2018

Facilities

- 699 Facilities
- 88,042 Beds

Surveys Completed

- 2,374 Total surveys
- 368 Re-licensure/recertification surveys (Full Health Surveys)
- 697 Revisits (to all types of surveys)
- 1,979 On-site visits (includes complaint visits)

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Facility and Survey Data 2017

Facilities

- 699 Facilities
- 88,003 Beds

Surveys Completed

- 5,262 Total surveys
- 761 Re-licensure/recertification surveys (Full Health Surveys)
- 1,679 Revisits (to all types of surveys)
- 4,245 On-site visits (includes complaint visits)

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Facility and Survey Data 2016

Facilities
- 704 Facilities
- 88,184 Beds

Surveys Completed
- 5,320 Total surveys
- 712 Re-licensure/recertification surveys (Full Health Surveys)
- 1,706 Revisits (to all types of surveys)
- 4,239 On-site visits (includes complaint visits)

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Facility and Survey Data 2015

Facilities
- 702 Facilities
- 88,233 Beds

Surveys Completed
- 4,277 Total surveys
- 711 Re-licensure/recertification surveys (Full Health Surveys)
- 1,316 Revisits (to all types of surveys)
- 3,327 On-site visits (includes complaint visits)

Statewide Deficiency Free Surveys

1st ½ 2018: 33 Full Health Surveys were deficiency free

2017: 43 Full Health Surveys were deficiency free

2016: 38 Full Health Surveys were deficiency free

2015: 53 Full Health Surveys were deficiency free

2014: 68 Full Health Surveys were deficiency free

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Surveys with Scope & Severity D & Above

	1st ½ 2018	2017	2016	2015
Standard Surveys	333	706	665	650
Complaint Surveys	446	984	996	703
Substandard Quality of Care	0	1	6	3
Immediate Jeopardy Tags	16	30	39	12

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Frequency of DNCF Visits 1st Half 2018

Number of Visits	% of PA facilities
20 +	0.14%
10 to 19	1.86%
6 to 9	8.44%
2 to 5	*56.94%*
1	21.03%
0	11.59%

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Frequency of DNCF Visits 2017

Number of Visits	% of PA facilities
20 +	1.72%
10 to 19	17.74%
6 to 9	25.04%
2 to 5	*46.78%*
1	8.30%
0	0.43%

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Frequency of DNCF Visits 2016

Number of Visits	% of PA facilities
20 +	0.85%
10 to 19	17.90%
6 to 9	25.43%
2 to 5	*45.31%*
1	9.80%
0	0.71%

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Frequency of DNCF Visits 2015

Number of Visits	% of PA facilities
20 +	1.00%
10 to 19	8.83%
6 to 9	21.51%
2 to 5	*53.85%*
1	14.10%
0	0.71%

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Provisional Licenses Issued

1st ½ 2018 – 1   2013 – 2

2017 – 35   2012 – 2

2016 – 39   2011 - 18

2015 – 19   2010 – 10

2014 – 9   2009 – 29

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State Actions

Total state actions for 1st ½ 2018	Total state actions for 2017	Total state actions for 2016	Total state actions for 2015
Pl/CP= 0	Pl/CP= 2	Pl/CP= 3	Pl/CP= 6
Pll/CP= 0	Pll/CP= 3	Pll/CP= 0	Pll/CP= 2
Plll/CP= 0	Plll/CP= 1	Plll/CP= 0	Plll/CP= 0
PIV/CP = 0	PIV/CP = 0	PIV/CP = 0	PIV/CP = 0
Pl only= 1	Pl only= 14	Pl only= 32	Pl only= 7
Pll only= 0	Pll only= 11	Pll only= 4	Pll only= 2
PIII only = 0	PIII only = 4	PIII only = 0	PIII only = 1
PIV only= 0	PIV only= 0	PIV only= 0	PIV only= 1
CP only= 29	CP only= 95	CP only= 53	CP only= 24
Total = 30	Total = 130	Total = 92	Total = 43

Pl=Provisional l license
Pll=Provisional ll license
Plll=Provisional lll license

PIV = Provisional IV license
CP=Civil Penalty

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1st ½ 2018 Complaint Data

Complaint Data

- Total received= 1,943

- Total substantiated= 585 (30.11%)

- Onsite investigations conducted= 1,870 (96.24%)

- Substantiated complaints with citations issued at "G" or above= 15 (.77%)

Most Frequently Filed

- Care or Services   64.66%
- Resident Rights   14.31%
- Environment   12.72%

Complaint Tags

- Total tags cited related to complaints = 544

- Highest S/S cited during complaint surveys = L

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2017 Complaint Data

Complaint Data

- Total received= 3,757

- Total substantiated= 1,425 (36.61%)

- Onsite investigations conducted= 3,702 (98.54%)

- Substantiated complaints with citations issued at "G" or above= 128 (3.29%)

Most Frequently Filed

- Care or Services   65.66%
- Resident Rights   15.61%
- Environment   11.08%

Complaint Tags

- Total tags cited related to complaints = 1,352

- Highest S/S cited during complaint surveys = L

2016 Complaint Data

Complaint Data

- Total received = 3,485

- Total substantiated = 1,208 (34.66%)

- Onsite investigations conducted = 3,174 (91.08%)

- Substantiated complaints with citations issued at "G" or above = 139 (3.99%)

Most Frequently Filed

- Care or Services   64.45%
- Resident Rights   17.18%
- Environment   11.31%

Complaint Tags

- Total tags cited related to complaints = 685

- Highest S/S cited during complaint surveys = L

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2015 Complaint Data

Complaint Data

- Total received = 2,591

- Total substantiated = 863 (33.31%)

- Onsite investigations conducted = 2,330 (89.93%)

- Substantiated complaints with citations issued at "G" or above = 73 (2.82%)

Most Frequently Filed

- Care or Services   66.77%
- Resident Rights   14.73%
- Environment   9.32%

Complaint Tags

- Total tags cited related to complaints = 642

- Highest S/S cited during complaint surveys = L

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Frequently Cited Tags

Listed below are the top 5 most frequently cited tags in order from most cited.

1st ½ 2018	2017	2016	2015	2014
F684	F309	F309	F309	F309
F880	F323	F323	F441	F441
F689	F441	F441	F514	F514
F656	F514	F514	F323	F323
F812	F371	F371	F371	F371

F684 / F309	=PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
F880 / F441	=INFECTION CONTROL, PREVENT SPREAD, LINENS
F656 / F514	=RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE
F689 / F323	=FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
F812 / F371	=FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

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1st ½ 2018 Incidents

- Total number of incident reports received: 14,877

- Most Frequently reported events
  - Transfer to Hospital – 5,743
  - Other – 2,409
  - Abuse – 2,406

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2017 Incidents

- Total number of incident reports received: 26,279

- Most Frequently reported events
  - Transfer to Hospital – 10,781
  - Abuse – 4,303
  - Other – 4,208

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2016 Incidents

- Total number of incident reports received: 23,398

- Most Frequently reported events
  - Transfer to Hospital – 10,489
  - Abuse – 3,647
  - Other – 3,154

2015 Incidents

- Total number of incident reports received: 21,788

- Most Frequently reported events
  - Transfer to Hospital – 10,432
  - Abuse – 2,941
  - Other – 2,547

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IDR

2015
131 Tags disputed
25% deleted (33)
11%   revised (15)

2016
232 Tags disputed
19% deleted (45)
11% revised (26)

2017
135 Tags disputed
24% deleted (33)
13% revised (17)

1st ½ 2018
67 Tags disputed
52% deleted (35)
18% revised (12)

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State IIDR

2015
30 Tags disputed
20% deleted (6)
10%   revised (3)

2016
78 Tags disputed
13% deleted (10)
10% revised (8)

2017
40 Tags disputed
10% deleted (4)
8% revised (3)

1st ½ 2018
9 Tags disputed
0% deleted (0)
0% revised (0)

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Federal IIDR

2015
2 Tags disputed
0% deleted (0)
0%   revised (0)

2016
8 Tags disputed
0% deleted (0)
38% revised (3)

2017
20 Tags disputed
0% deleted (0)
30% revised (6)

1st ½ 2018
0 Tags disputed
N/A% deleted (0)
N/A% revised (0)

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License Application Errors

- If the facility had a recent change of ownership, please refer to the license application that was submitted for that transaction when completing the facility license renewal application.

- When completing a license renewal application, always make sure that the responses to all the questions, including Attachments, contain accurate and current information.

License Application Errors

1. Is the facility and/or building owned or leased? If 'leased' is checked, identify the correct <u>name and address</u> of the Lessor.

2. List <u>names and addresses</u> of persons having ownership interest of 5 percent or more. As applicable, provide names and addresses of each person related to the facility's existing/current ownership.

License Application Errors

3. As applicable, identify <u>names and addresses</u> of board members and/or trustees. Please include a position/title of the main officers/board members.

4. Is the facility's ownership involved with a pyramid or parent corporate structure? Include the <u>name and address</u> of the parent corporation or pyramid corporate structure.

License Application Errors

5. Does the owner(s) or corporate members have financial interest in other health care facilities? Identify the <u>names and addresses</u> for other health facilities.

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Civil Rights Survey Errors

When completing the civil rights survey in the application, always make sure that the responses are complete in each Section with accurate and current information.

1. Section II A - Attach the facility's non-discrimination policy for review.

Civil Rights Survey Errors

2. Section II C2 – If 'Yes' is selected, the response requires an explanation of the content of information about filing a complaint of discrimination with the Agencies as addressed in the question.

3. Section II C3 – If 'Yes' is selected, the response requires an explanation of the content of information about filing a complaint of discrimination with PA Human Relations Commission as addressed in the question.

Civil Rights Survey Errors

4. Section IV C - If 'Yes' is selected, the response requires a description of the policy content and what types of accommodations are provided to handicapped employees.

5. Chart 1 Board - The attachment must be submitted according to the **chart format**, as shown, and include accurate and current information. If not applicable, indicate this response in the attachment.

Civil Rights Survey Errors

6. Charts 5 – The attachment must be submitted according to the **chart format**, as shown, and include accurate and current information. If not applicable, indicate this response in the attachment.

7. Charts 6 – The attachment must be submitted according to the **chart format**, as shown, and include updated and accurate information.

Resources

- DNCF 717-787-1816
- DSI 717-787-1911
- Message Board
  - https://www.health.pa.gov
- CMS Website
  - www.cms.hhs.gov
- State Operations Manual
  - http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf

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Overview

- CMS Emergency Preparedness Update

- Common Emergency Preparedness Deficiencies

- Life Safety Code Update

- CMS Rule Change – Resident Rooms and Bathrooms

- Common LSC Deficiencies

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CMS Emergency Preparedness Rule

- "Establishes national emergency preparedness requirements for Medicare and Medicaid-participating providers and suppliers to plan adequately for both natural and man-made disasters, and coordinate with federal, state, tribal, regional, and local emergency preparedness systems."

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CMS Emergency Preparedness Rule

- 42 CFR § 483.73 – Emergency Preparedness
- LTC facility must establish and maintain an emergency preparedness plan
- Must be reviewed and updated annually

- The plan must do the following:
  - Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents
  - Include strategies for addressing emergency events identified by the risk assessment
  - Address resident population, including, but not limited to, persons at-risk, the types of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans

- The plan must do the following:
  - Include a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when it applies, of its participation in collaborative planning efforts

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- The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan
- The policies and procedures must be reviewed and updated at least annually

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- The policies and procedures must address the following:
  - Provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, to include:
    - Food, water, medical and pharmaceutical supplies
    - Alternate sources of energy to maintain:
      - Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions
      - Emergency lighting
      - Fire detection, extinguishing and alarm systems
      - Sewage and waste disposal

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CMS Emergency Preparedness Rule

- The policies and procedures must address the following:
  - A system to track the location of on-duty staff and sheltered residents in the LTC facility's care during an emergency
  - If on-duty staff or sheltered patients are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location

- The policies and procedures must address the following:
  - Safe evacuation from the LTC facility, to include:
    - Consideration of care and treatment of needs of evacuees
    - Staff responsibilities
    - Transportation
    - Identification of evacuation location(s)
    - Primary and alternate means of communication with external sources of assistance

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- The policies and procedures must address the following:
  - A means to shelter in place for residents, staff, and volunteers who remain in the LTC facility
  - A system of medical documentation that does the following:
    - Preserves resident information
    - Protects confidentiality of resident information
    - Secures and maintains the availability of records

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CMS Emergency Preparedness Rule

- The policies and procedures must address the following:
  - The use of volunteers in an emergency and other staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency
  - Development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain continuity of services
  - The role of the LTC 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

CMS Emergency Preparedness Rule

- The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually

CMS Emergency Preparedness Rule

- The emergency preparedness communication plan must include:
  - Names and contact information for the following:
    - Staff
    - Entities providing services under arrangement
    - Residents' physicians
    - Other LTC facilities
    - Volunteers
  - Contact information for the following:
    - Federal, State, tribal, regional, and local emergency preparedness staff
    - Other sources of assistance

- The emergency preparedness communication plan must include:
  - Primary and alternate means for communicating with the following:
    - LTC facility's staff
    - Federal, State, tribal, regional or local emergency management agencies
  - A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care
  - A means, in the event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii)

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CMS Emergency Preparedness Rule

- The emergency preparedness communication plan must include:
  - A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4)
  - A means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee
  - A method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives

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- The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan and policies and procedures

- The training and testing program must be reviewed and updated at least annually

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CMS Emergency Preparedness Rule

- Training Program – The LTC facility must do all of the following:
  - 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 roles
  - Provide emergency preparedness training at least annually
  - Maintain documentation of all emergency preparedness training
  - Demonstrate staff knowledge of emergency procedures

CMS Emergency Preparedness Rule

- Testing – The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills of all of the following:

  – Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, individual, facility-based. If the LTC 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

- Testing continued:
  - Conduct an additional exercise that may include, but is not limited to the following:
    - A second full-scale exercise that is individual, facility-based
    - 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
    - Analyze the LTC 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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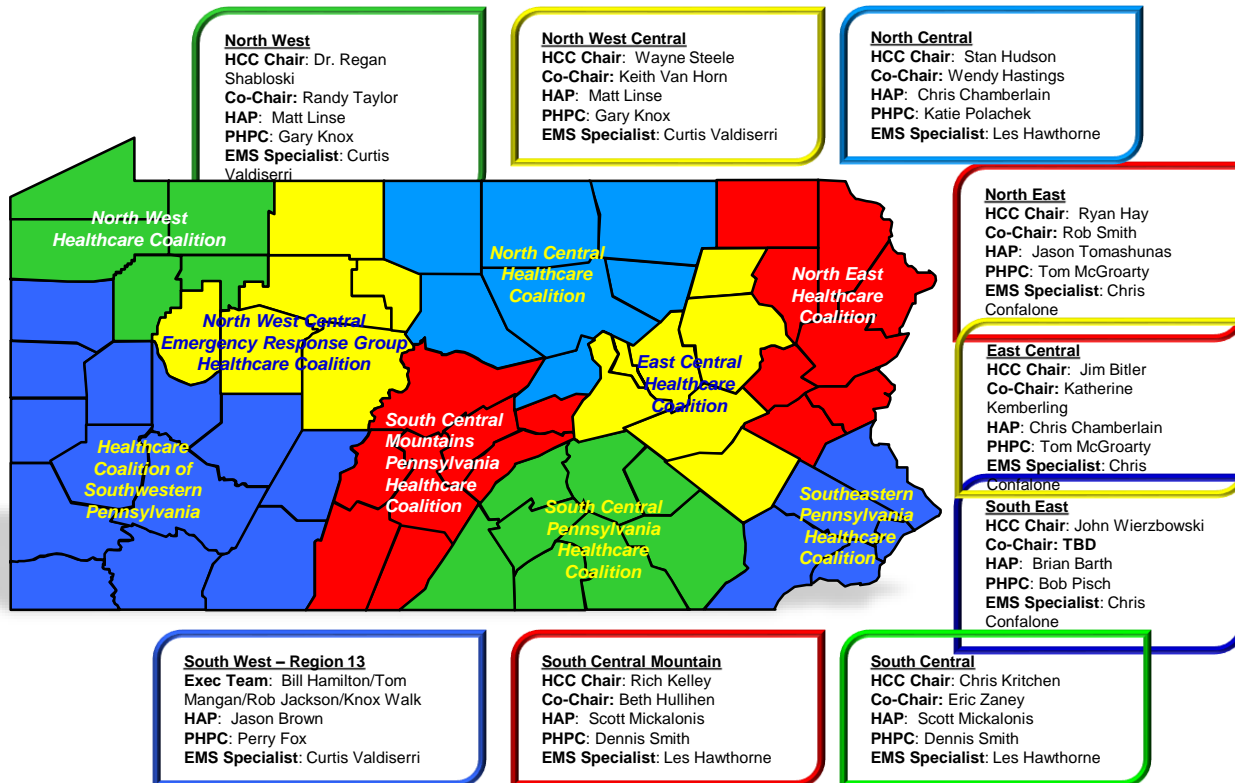# CMS Emergency Preparedness Rule

- CMS S&C Letter 17-05-All
  - Released 10/28/2016
  - Provides resources and a link to a Frequently Asked Questions (FAQ) document
  - Survey and Certification emergency preparedness web page: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html

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CMS Emergency Preparedness Rule

- 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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PA HEALTH CARE COALITION CONTACTS 2018

Updated 05.22.2018

North West
HCC Chair: Dr. Regan Shabloski
Co-Chair: Randy Taylor
HAP: Matt Linse
PHPC: Gary Knox
EMS Specialist: Curtis Valdiserri

North West Central
HCC Chair: Wayne Steele
Co-Chair: Keith Van Horn
HAP: Matt Linse
PHPC: Gary Knox
EMS Specialist: Curtis Valdiserri

North Central
HCC Chair: Stan Hudson
Co-Chair: Wendy Hastings
HAP: Chris Chamberlain
PHPC: Katie Polachek
EMS Specialist: Les Hawthorne

North East
HCC Chair: Ryan Hay
Co-Chair: Rob Smith
HAP: Jason Tomashunas
PHPC: Tom McGroarty
EMS Specialist: Chris Confalone

East Central
HCC Chair: Jim Bitler
Co-Chair: Katherine Kemberling
HAP: Chris Chamberlain
PHPC: Tom McGroarty
EMS Specialist: Chris Confalone

South East
HCC Chair: John Wierzbowski
Co-Chair: TBD
HAP: Brian Barth
PHPC: Bob Pisch
EMS Specialist: Chris Confalone

South West – Region 13
Exec Team: Bill Hamilton/Tom Mangan/Rob Jackson/Knox Walk
HAP: Jason Brown
PHPC: Perry Fox
EMS Specialist: Curtis Valdiserri

South Central Mountain
HCC Chair: Rich Kelley
Co-Chair: Beth Hullihen
HAP: Scott Mickalonis
PHPC: Dennis Smith
EMS Specialist: Les Hawthorne

South Central
HCC Chair: Chris Kritchen
Co-Chair: Eric Zaney
HAP: Scott Mickalonis
PHPC: Dennis Smith
EMS Specialist: Les Hawthorne

Map regions:
- North West Healthcare Coalition
- North West Central Emergency Response Group Healthcare Coalition
- North Central Healthcare Coalition
- North East Healthcare Coalition
- Healthcare Coalition of Southwestern Pennsylvania
- South Central Mountains Pennsylvania Healthcare Coalition
- East Central Healthcare Coalition
- South Central Pennsylvania Healthcare Coalition
- Southeastern Pennsylvania Healthcare Coalition

HCC – Healthcare Coalition
HAP – Hospital Association of PA
PHPC – Public Health Preparedness Coordinator
EMS Specialist – Emergency Medical Services Specialist.

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Operations

- **EAST CENTRAL (Berks, Columbia, Luzerne, Montour, Northumberland, Schuylkill, Wyoming Counties)**
  HOSPITAL ASSOCIATION REP – Christopher Chamberlain cchamberlain@haponline.org Cell: (484) 769-4855
  PUBLIC HEALTH PREPAREDNESS COORD – Tom McGroarty tmcgroarty@pa.gov Cell: 570-793-2052

- **NORTH CENTRAL (Bradford, Clinton, Lycoming, Potter, Sullivan, Tioga, Union Counties)**
  HOSPITAL ASSOCIATION REP – Christopher Chamberlain cchamberlain@haponline.org Cell: (484) 769-4855
  PUBLIC HEALTH PREPAREDNESS COORD – Catherine Polachek cpolachek@pa.gov Cell: 717-319-5894

- **NORTHEAST (Carbon, Lackawanna, Lehigh, Monroe, Northhampton, Pike, Susquehanna, Wayne Counties)**
  HOSPITAL ASSOCIATION REP – Jason Tomashunas jasont@haponline.org Cell: 570-466-1356
  PUBLIC HEALTH PREPAREDNESS COORD – Tom McGroarty tmcgroarty@pa.gov Cell: 570-793-2052

- **NORTHWEST (Crawford, Erie, Forest, Venango, Warren Counties)**
  HOSPITAL ASSOCIATION REP – Matt Linse mlinse@haponline.org Cell: 814-504-6715
  PUBLIC HEALTH PREPAREDNESS COORD – Gary Knox gknox@pa.gov Cell: 724-269-5927

- **NORTHWEST CENTRAL (Cameron, Clarion, Clearfield, Elk, Jefferson, McKean Counties)**
  HOSPITAL ASSOCIATION REP – Matt Linse mlinse@haponline.org Cell: 814-504-6715
  PUBLIC HEALTH PREPAREDNESS COORD – Gary Knox gknox@pa.gov Cell: 724-269-5927

- **SOUTHCENTRAL (Adams, Cumberland, Dauphin, Franklin, Lancaster, Lebanon, Perry, York Counties)**
  HOSPITAL ASSOCIATION REP – Scott Mickalonis, smickalonis@haponline.org Cell: 484-368-9050
  PUBLIC HEALTH PREPAREDNESS COORD – Dennis Smith dennsmith@pa.gov Cell: 717-350-9111

- **SOUTHCENTRAL MOUNTAIN (Bedford, Blair, Centre, Fulton, Huntingdon, Juniata, Mifflin, Snyder Counties)**
  HOSPITAL ASSOCIATION REP – Scott Mickalonis, smickalonis@haponline.org Cell: 484-368-9050
  PUBLIC HEALTH PREPAREDNESS COORD – Dennis Smith dennsmith@pa.gov Cell: 717-350-9111

- **SOUTHEAST (Bucks, Chester, Delaware, Montgomery, Philadelphia Counties)**
  HOSPITAL ASSOCIATION REP – Brian Barth bbarth@haponline.org Cell: 610-389-2372
  PUBLIC HEALTH PREPAREDNESS COORD – Bob Pisch rpisch@pa.gov Cell: 717-265-6012

- **SOUTHWEST (Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Mercer, Somerset, Washington, Westmoreland Counties)**
  HOSPITAL ASSOCIATION REP – Jason Brown jbrown@haponline.org Cell: 717.395.1599
  PUBLIC HEALTH PREPAREDNESS COORD – Perry Fox pfox@pa.gov Cell: 717-319-9342
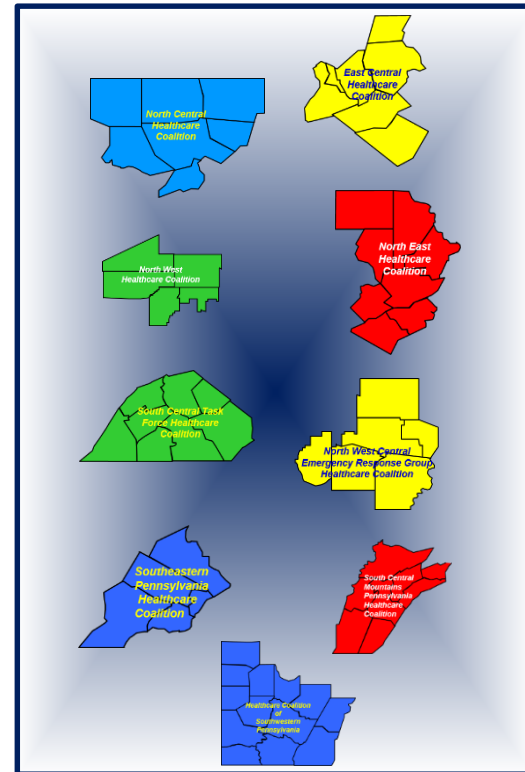
CMS Emergency Preparedness Rule

- 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 Rule

- CMS S&C Letter 17-21-All

- <u>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</u>

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CMS Emergency Preparedness Rule

- 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

CMS Emergency Preparedness Rule

- 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 Rule

- 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 Rule

- CMS S&C Letter 17-29-All
- Advanced Copy – Appendix Z, Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures
- 74 page document that is part of the State Operations Manual providing guidance to state agencies in reference to surveying for emergency preparedness compliance
- Tags are separate from Health or LSC tags and are "E" tags
- State survey agencies have the discretion regarding whether Health or LSC surveyors conduct the emergency preparedness surveys

- Definitions

- <u>Emergency/Disaster</u>: An event that can affect the facility internally as well as the overall target population or the community at large or community or a geographic area.

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CMS Emergency Preparedness Rule

- Definitions
- <u>Emergency</u>: A hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to respond rapidly and effectively. It requires a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) to meet the expected outcome, and commonly requires change from routine management methods to an incident command process to achieve the expected outcome (see "disaster" for important contrast between the two terms).
- *Reference:* Assistant Secretary for Preparedness and Response (ASPR) *2017-2022 Health Care Preparedness and Response Capabilities Document (ICDRM/GWU Emergency Management Glossary of Terms)* (November 2016).

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CMS Emergency Preparedness Rule

- Definitions
- <u>Disaster</u>: A hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to respond rapidly and effectively. Despite a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) and change from routine management methods to an incident command/management process, the outcome is lower than expected compared with a smaller scale or lower magnitude impact (see "emergency" for important contrast between the two terms).
- *Reference:* Assistant Secretary for Preparedness and Response (ASPR) *2017-2022 Health Care Preparedness and Response Capabilities Document (ICDRM/GWU Emergency Management Glossary of Terms)* (November 2016).

- Definitions

- <u>Emergency Preparedness Program</u>: The Emergency Preparedness Program describes a facility's comprehensive approach to meeting the health, safety and security needs of the facility, its staff, their patient population and community prior to, during and after an emergency or disaster. The program encompasses four core elements: an Emergency Plan that is based on a Risk Assessment and incorporates an all hazards approach; Policies and Procedures; Communication Plan; and the Training and Testing Program.

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- Definitions

- <u>Emergency Plan</u>: An emergency plan provides the framework for the emergency preparedness program. The emergency plan is developed based on facility- and community-based risk assessments that assist a facility in anticipating and addressing facility, patient, staff and community needs and support continuity of business operations.

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CMS Emergency Preparedness Rule

- Definitions
- <u>All-Hazards Approach</u>: An all-hazards approach is an integrated approach to emergency preparedness that focuses on identifying hazards and developing emergency preparedness capacities and capabilities that can address those as well as a wide spectrum of emergencies or disasters. This approach includes preparedness for natural, man-made, and or facility emergencies that may include but is not limited to: care-related emergencies; equipment and power failures; interruptions in communications, including cyber-attacks; loss of a portion or all of a facility; and, interruptions in the normal supply of essentials, such as water and food. All facilities must develop an all-hazards emergency preparedness program and plan.

- Definitions

- <u>Facility-Based</u>: We consider the term "facility-based" to mean the emergency preparedness program is specific to the facility. It includes but is not limited to hazards specific to a facility based on its geographic location; dependent patient/resident/client and community population; facility type and potential surrounding community assets- i.e. rural area versus a large metropolitan area.

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- Definitions
- <u>Full-Scale Exercise</u>: A full scale exercise is an operations-based exercise that typically involves multiple agencies, jurisdictions, and disciplines performing functional (for example, joint field office, emergency operation centers, etc.) and integration of operational elements involved in the response to a disaster event, i.e. ''boots on the ground'' response activities (for example, hospital staff treating mock patients).

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- Definitions
- <u>Hazard Vulnerability Assessments</u> (HVAs) are systematic approaches to identifying hazards or risks that are most likely to have an impact on a healthcare facility and the surrounding community. The HVA describes the process by which a provider or supplier will assess and identify potential gaps in its emergency plan(s). Potential loss scenarios should be identified first during the risk assessment. Once a risk assessment has been conducted and an facility has identified the potential hazards/risks they may face, the organization can use those hazards/risks to conduct a Business Impact Analysis.

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- Definitions

- <u>Risk Assessment</u>: The term risk assessment describes a process facilities use to assess and document potential hazards that are likely to impact their geographical region, community, facility and patient population and identify gaps and challenges that should be considered and addressed in developing the emergency preparedness program. The term risk assessment is meant to be comprehensive, and may include a variety of methods to assess and document potential hazards and their impacts. The healthcare industry has also referred to risk assessments as a Hazard Vulnerability Assessments or Analysis (HVA) as a type of risk assessment commonly used in the healthcare industry.

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- Definitions

- <u>Staff</u>: The term "staff" refers to all individuals that are employed directly by a facility. The phrase "individuals providing services under arrangement" means services furnished under arrangement that are subject to a written contract conforming with the requirements specified in section 1861(w) of the Act.

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- Definitions
- Table-top Exercise (TTX): A tabletop exercise involves key personnel discussing simulated scenarios in an informal setting. TTXs can be used to assess plans, policies, and procedures. A tabletop exercise is a discussion-based exercise that involves senior staff, elected or appointed officials, and other key decision making personnel in a group discussion centered on a hypothetical scenario. TTXs can be used to assess plans, policies, and procedures without deploying resources.

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CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)

- Q: Can continuity of operations, delegations of authority, succession planning be included in the Emergency Operations Plan, or do you expect to see separate plans?

- A: We are not requiring a specific format for how a facility should have their Emergency Plans documented and in which order. Upon survey, a facility must be able to provide documentation of these requirements in the plan and show where the plans are located.

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CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)

- Q: For formatting of the documentation, the standard state policies & procedures are required. Our documents are structured as an Emergency Operations Plan with addendums. Is this allowable?

- A: We are not requiring a specific format for the manner in which a facility should have their Emergency Plans documented. Upon survey, a facility must be able to provide documentation of the policies and procedures and show surveyors where the policies and procedures are located.

CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)

- Q: CMS does not require an approved emergency preparedness plan from the local emergency official but must show coordination with local emergency management officials. What level of coordination will be considered acceptable for the facility emergency plan approval. Will a facility only need an approval for their emergency plan from the CMS servicing agency?

- A: Facilities must document efforts made by the facility to cooperate and collaborate with emergency preparedness officials... the rule states that facilities must document efforts made by the facility to cooperate and collaborate with emergency preparedness officials... We are not requiring official "sign-off" from local emergency management officials.

CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)

- Q: What is the regulation's definition or intent behind the word "community"?

- A: We did not define community, to afford providers the flexibility to develop disaster drills and exercises that are realistic and reflect their risk assessments…. In the proposed rule, we indicated that we expected hospitals and other providers to participate in the healthcare coalitions in their area for additional assistance in effectively meeting this requirement.

- Frequently Asked Questions (From CMS resource website)

- Q: What are the consequences for not meeting these new requirements? Will any leniency be given for organization that have started this type of planning but didn't complete by 11/15/2017? Will any warnings be issued before any actions taken against a particular organization?

- A: Facilities have one year to implement the emergency preparedness requirements… There will be no exceptions for the requirements and non-compliance will follow the same process….

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CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)

- Q: Will this be an incentive-penalty such as those associated with Meaningful Use? Will it just be a penalty? How will surveys be conducted? When will we have access to the survey tool?

- A: The implementation of this new regulation is not linked to an incentive program... same enforcement process as with any other Condition that is found to be out of compliance... We anticipate releasing the Interpretive Guidelines and Survey Procedures in spring of 2017….

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- Frequently Asked Questions (From CMS resource website)

- Q: What process/documentation/resources will SA surveyors use to assure compliance with the various facility types?

- A: As always, surveyors will use the Interpretive Guidelines and Survey Procedures in the State Operations Manual. Surveyors will also be trained on the requirements before implementation.

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CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)
- Q: Please define "all-employees" in the term of being able to demonstrate knowledge of emergency plans and procedures.
- A: Employee's or the term ''staff'' refers to all individuals that are employed directly by a facility. The phrase ''individuals providing services under arrangement'' means services furnished under arrangement that are subject to a written contract conforming with the requirements specified in section 1861(w) of the Act. We refer providers back to the regulation text for further information (81 FR. 63891).

CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)
- Q: What kind of training will be developed specifically for providers and suppliers to prepare for implementation of the rule?
- A: CMS does not expect to develop training specifically for providers and suppliers. Healthcare associations and state, local and other Federal healthcare agencies may provide training for providers and suppliers. However, training provided by these organizations is only a tool to assist facilities in preparing for implementation of the rule and does not mean that a provider or supplier is in compliance by having received the training.

CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)
- Q: Which Hazard Vulnerability Assessment (HVA) or Risk Assessment is recommended for use by providers? How will surveyors review the Risk Assessments for compliance?
- A: Providers and suppliers must have a written Risk Assessment based on an "all-hazards" approach, or HVA. We are not requiring a specific format to be used, however, we recommend facilities who have not prepared a Risk Assessment to reach out to ASPR TRACIE who can provide additional resources. Additional guidance will be forthcoming in the Interpretive Guidelines that will include survey procedures for surveyors.

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CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)
- Q: General inquiry on generator: Does the generator have to be able to power up AC/Heat. Can you please clarify for me, is that a requirement with the final rule?
- A: The Emergency Preparedness regulation requires Hospitals, Critical Access Hospitals and Long-term Care Facilities to have generators. The regulation also requires health care facilities to have alternate sources of energy to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. If a facility needs a generator to meet the temperature requirement then it must provide the necessary level of generator with a capacity to run a HVAC system.

CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)

- Q: Are all Nursing Homes required to have a generator? What if the Nursing Home doesn't currently have a generator? Must they install one? Is compliance with NFPA 70 & NFPA 110 sufficient, or are there additional requirements regarding the generator and/or fuel capacity?

- A: The emergency preparedness rule requires long term care (LTC) facilities to have a generator. The regulation also requires LTC facilities to have alternate sources of energy to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. If a facility needs a generator to meet the temperature requirement then it must provide the necessary level of generator with a capacity to run a HVAC. There may be state and local regulations that have additional requirements regarding the generator and any required fuel capacity.

CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)

- Q: The rule implies that facilities need to ensure their vendors have a business continuity plan to continue to provide a supply source during times of emergency. Do you have any guidance as to what vendors need to have or what they should provide to these facilities that will make the facilities compliant?

- A: Facilities are required to provide subsistence needs for staff and patients, whether they evacuate or shelter in place. Those provisions include but are not limited to: food, water, medical supplies and pharmaceutical supplies.

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CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)

- Q: What are the requirements for facilities regarding HVAC systems and alternate source energy?

- A: The following providers have a mandatory requirement based on the new EP regulation to have an emergency and standby power system, i.e. a generator: Hospitals, LTC, and CAHs. The following providers have a mandatory requirement based on the new EP regulation to have an alternate source of energy to maintain temperatures to protect [patient, resident, participant, client] health and safety and for the safe and sanitary storage of provisions: RNHCI, Hospice (inpatient), PRTF, PACE, Hospitals, LTC, ICF/IIDs, and CAH. During an emergency situation, the providers listed above with a mandatory requirement for alternate sources of energy, must be able to maintain temperatures. Maintaining temperatures could involve heating or cooling the facility to maintain temperature levels within the facility to protect the individual's health and safety, as well as the safe and sanitary storage of provisions.

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CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)
- Q: What are the requirements for facilities regarding HVAC systems and alternate source energy? (Continued)
- A: During the risk assessment a provider will need to determine how they will be able to maintain temperatures that will protect the health and safety of (patient, resident, participant, client) and the safe and sanitary storage of provisions if their facility loses power. The provider needs to determine how they will provide heating or cooling to their facility, if required, to maintain temperatures during an emergency situation, if they lose power.

CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)
- Q: The regulation states: (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. What is meant by "provisions" in (ii)(a)?
- A: Provisions include: food, water, pharmaceuticals or medications and medical supplies. At §482.15(b)(1)(ii)(D), we proposed that the hospital develop policies and procedures to address the provisions of sewage and waste disposal including solid waste, recyclables, chemical, biomedical waste, and waste water.

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CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)
- Q: Some vendors are telling healthcare facilities that they need to purchase certain quantities of medically related supplies in order to be in compliance with the new Emergency Preparedness rule. What supplies and quantities (if any) do healthcare facilities need to purchase to be in compliance?
- A: The regulation does not require any specific items and quantities that facilities must have to be in compliance with the rule. It is up to each individual facility to conduct an assessment of its facility's supply needs during an emergency and make purchases based on its assessment.

CMS Emergency Preparedness Rule

- Frequently Asked Questions (From CMS resource website)
- Q: Some providers have asked CMS to provide examples for what exercises facilities should consider.
- A: The training and exercise requirements of the regulation call for individual-facility and/or full-scale community-based exercises, the below are some examples of exercise considerations:
    - Earthquakes
    - Tornados
    - Hurricane
    - Flooding
    - Fires
    - Cyber Security Attack
    - Single-Facility Disaster (power-outage)
    - Medical Surge (i.e. community disaster leading to influx of patients)
    - Infectious Disease Outbreak
    - Active Shooter

CMS Emergency Preparedness

- Top 5 EP deficiency tags from November 15, 2017 – August 8, 2018
  - E0026 – Roles Under a Waiver Declared by Secretary
  - E0024 – Policies/Procedures – Volunteers and Staffing
  - E0039 – EP Testing Requirements
  - E0015 – Subsistence Needs for Staff and Patients
  - E0006 – Plan Based on All Hazards Approach

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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.

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>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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CMS Emergency Preparedness

- <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.

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

- E0015 – Subsistence Needs for Staff and Patients Continued
- (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

- E0006 – Plan Based on All Hazards Risk Assessment

- [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]

- (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*

- *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.

- (2) Include strategies for addressing emergency events identified by the risk assessment.

CMS Emergency Preparedness

- 1135 Waiver process guidance: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers.html

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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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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- 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

- 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

- 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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– K363

Subsection

Numerical
Order

Section

system in accordance with 19.3.5.7.

19.3.6.3* Corridor Doors.

19.3.6.3.1* Doors protecting corridor openings in o
required enclosures of vertical openings, exits, or l
areas shall be doors constructed to resist the passage
and shall be constructed of materials such as the fol

– K321

- There are numerous changes to the 2012 codes that were not emphasized by the categorical waiver process

- Some are changes that facilities may find advantageous but others may be found to be more stringent or an increase in workload compared to previous requirements

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Fire-Retardant-Treated Wood (FRT)

- Clarification of use of fire-retardant-treated (FRT) wood
  - Sections 18/19.1.6.6 permits FRT that serves as support for the installation of fixtures and equipment when the FRT is installed behind noncombustible or limited-combustible sheathing
  - Examples would be wall mounted computer kiosks, handrails, etc.

Annual Fire Door Inspection/Testing

- Inspection and testing requirements for fire-rated door assemblies in accordance with NFPA 80

- This is an item that initially became part of the survey process beginning July 5, 2017, but this date was extended to January 1, 2018 per CMS Survey and Certification Letter 17-38-LSC, dated July 28, 2017

- The letter also clarifies that the requirement is specific to fire-rated doors and not smoke doors that are non-rated

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Annual Fire Door Inspection/Testing

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Annual Fire Door Inspection/Testing

- 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
    - Not required to hold a certification although there are classes that are becoming available to obtain a certification
  - Repairs shall be made "without delay"

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- 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-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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Annual Fire Door Inspection/Testing

- 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

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

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 10 – Fire Extinguishers

- 2010 NFPA 10 – Inspection, Maintenance, and Recharging of Portable Fire Extinguishers
- Persons performing maintenance and recharging of extinguishers must be certified
  - The test shall at a minimum be based upon knowledge of NFPA 10
  - Persons passing the test must be issued a document or certificate made available to the AHJ stating that the person was certified based upon NFPA 10 principles.
  - This does **_not_** apply to individuals performing the monthly inspections

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NFPA 10 – Fire Extinguishers

- Formal Interpretations (FI) to Sections 5.5.5 and 6.6.1
  - Fire extinguishers provided for the protection of cooking appliances that use combustible cooking media shall be listed and labeled for Class K fires
  - FI No. 10-02-2:
    - Class K extinguishers are also required to be installed to protect cooking via a griddle or stove top frying pan
    - All cooking kitchen locations, where either a griddle or stove top frying pan is used, must have a Class K extinguisher. This extends from the main kitchen to satellite cooking kitchens

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NFPA 13 – Sprinkler Installation

- Key change from the 1999 edition to the 2010 edition of NFPA 13 with regard to privacy curtains
- Section 8.6.5.2.2.1 – Privacy curtains shall not be considered obstructions where:
    - The curtains are supported by fabric mesh of ceiling track
    - Openings in the mesh are equal to 70 percent or greater
    - The mesh extends to a minimum of **_22_** inches down from the ceiling

NFPA 13 – Sprinkler Installation

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NFPA 13 – Sprinkler Installation

- Note that a minimum ½ diagonal mesh opening is considered meeting 70% or greater

- Section 19.3.5.11 of 2012 LSC states:
  - Newly introduced cubicle curtains in sprinklered areas shall be installed in accordance with NFPA 13

- Is the 18 inch rule now the 22 inch rule?

- No, the 18 inch rule still applies to other obstructions

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NFPA 13 – Sprinkler Installation

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NFPA 99 Receptacle Testing

- NFPA 99, 2012 edition details receptacle testing at patient bed locations

- A technical question was submitted to NFPA to determine whether or not this applied to nursing home resident bed locations, and NFPA responded that it does apply

6.3.4.1 Maintenance and Testing of Electrical System.

6.3.4.1.1

Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device.

6.3.4.1.2

Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data.

6.3.4.1.3

Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.

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- Receptacle testing includes the following:
  - 6.3.3.2 Receptacle Testing in Patient Care Rooms.
  - 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection.
  - 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified.
  - 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed.
  - 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).

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- NFPA 99 requirements changed from Occupancy-Based to Risk-Based in 2012, covered under Chapter 4

- Building systems in health care facilities shall be designed to meet system Category 1 though Category 4 requirements
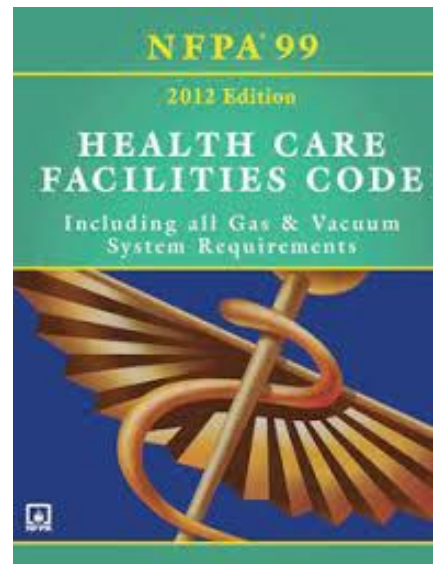
Categories – Based on impact to patients and caregivers

- Category 1: System failure likely to cause major injury or death
- Category 2: System failure likely to cause minor injury
- Category 3: System failure not likely to cause injury (can cause discomfort)
- Category 4: System failure would have no impact

- The facility is responsible to have a "professional" perform a risk assessment for each building system specified in Chapters 5-11 of this code to determine the risk category

- Per CMS Central Office, this risk assessment only applies to new work and new facilities
  - Examples: new replacement generator, addition, renovation of a nursing home wing, etc.

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CMS LTC Regulation 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

CMS LTC Regulation 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

CMS LTC Regulation 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.
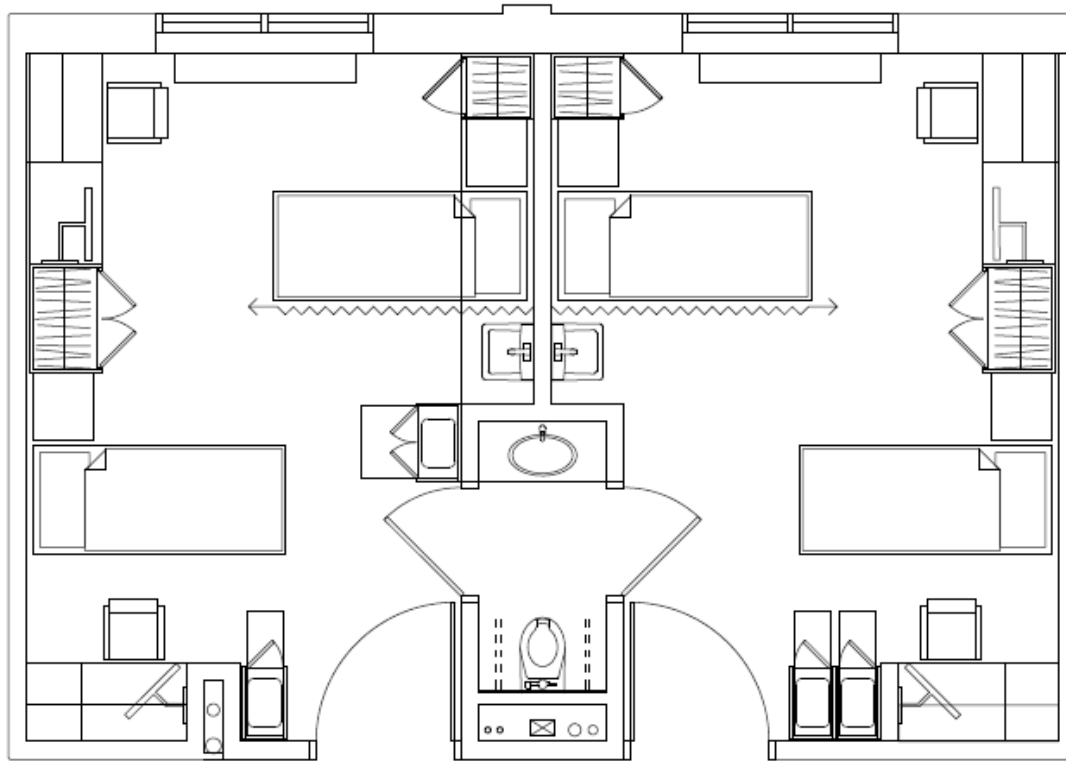
CMS LTC Regulation Update

- 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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# CMS LTC Regulation 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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CMS LTC Regulation Update

EXISTING UNIT

CMS LTC Regulation Update
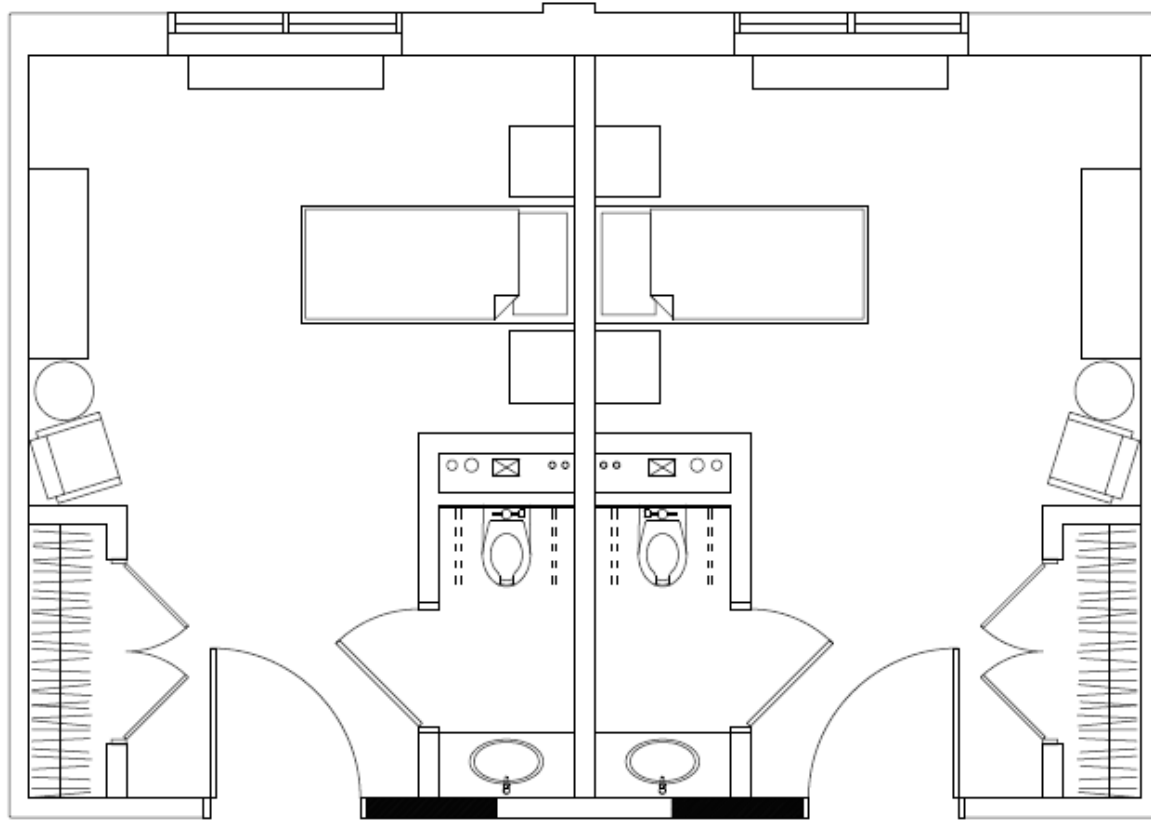
PROPOSED SINGLE OCCUPANCY UNITS

Common LSC Deficiencies

- Top 10 deficiency tags from January 1, 2017 – December 31, 2017
  - K0363 – Corridor Doors
  - K0353 – Sprinkler System Maintenance and Testing
  - K0372 – Subdivision of Building Spaces – Smoke Barriers
  - K0920 – Electrical Equipment – Power Cords and Extension Cords
  - K0161 – Building Construction Type and Height
  - K0321 – Hazardous Areas Enclosure
  - K0100 – General Requirements – Other
  - K0311 – Vertical Openings – Enclosure
  - K0211 – Means of Egress – General
  - K0923 – Gas Equipment – Cylinder and Container Storage

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Common LSC Deficiencies

- K0363 – Corridor Doors
    - Doors do not properly latch in the frame
    - Doors are not smoke tight when closed
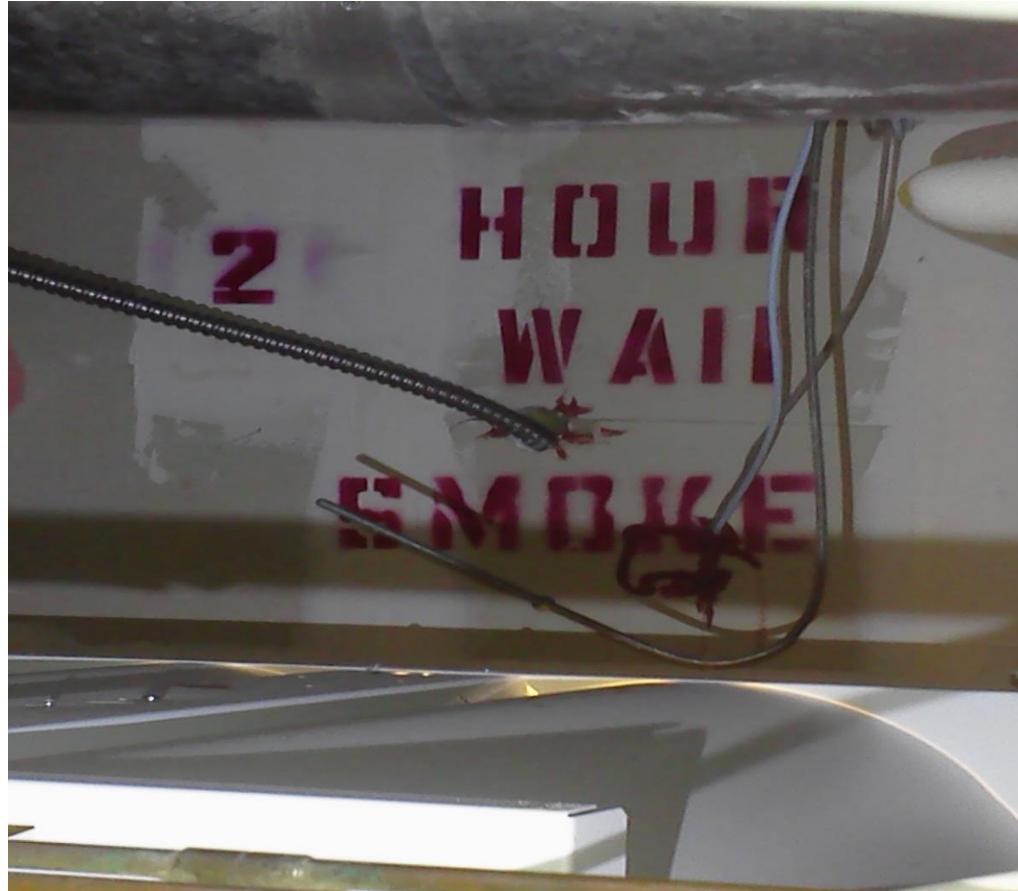   - Impediment to closing the door (wedge, chair, trash can, etc.)

Common LSC Deficiencies

- K0353 – Sprinkler System Maintenance and Testing
  - Documentation to be readily available at the time of the survey
  - Lack of documentation and/or lack of maintenance and testing at required intervals

Common LSC Deficiencies

- K0372 – Subdivision of Building Spaces – Smoke Barriers

  - Unsealed penetrations

  - Doors in the smoke barrier do not close properly and/or are not smoke tight

  - Walls not properly extended or sealed to the deck above

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Common LSC Deficiencies

- K0920 – Electrical Equipment – Power Cords and Extension Cords

    – Permanent use of power and extension cords

    – Misuse of surge protectors – use outside of UL listing

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Common LSC Deficiencies

Common LSC Deficiencies

- K0161 – Building Construction Type and Height
  - Overall construction type is noncompliant
  - Combustible structural materials in noncombustible construction type
  - Lack of fireproofing where required

Common LSC Deficiencies

- K0321 – Hazardous Areas – Enclosure
  - Unsealed penetrations of hazardous area enclosures
  - Non-rated door or frame
  - No self-closing hardware or disabled self-closing hardware on doors
  - Doors improperly held open (wooden wedge, chain, rope, etc.)

Common LSC Deficiencies

- K0100 – General Requirements – Other
  - Deficiencies without a specific tag number
  - Renovations or construction without plans

- K0311 – Vertical Openings – Enclosure
  - Shafts not properly protected (unsealed penetrations, non-rated access doors, self-closing hardware of access doors, etc.)
  - Unsealed penetrations between floors

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Common LSC Deficiencies

- K0211 – Means of Egress – General
  - Dietary carts, soiled linen carts, etc. stored in the corridor
  - Exit doors difficult to open
  - Overgrown vegetation on exterior exit path

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Common LSC Deficiencies

- K0923 – Gas Equipment – Cylinder and Container Storage
  - Unsecure cylinders
  - Full and empty cylinders not segregated
  - Over 300 cubic feet of oxygen stored within a room that does not meet the requirements of an oxygen storage room

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Questions?

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