



WISCONSIN HEALTHCARE ENGINEERING ASSOCIATION
Dedicated to Excellence in Healthcare Engineering

ADOPTION OF 2012 LSC

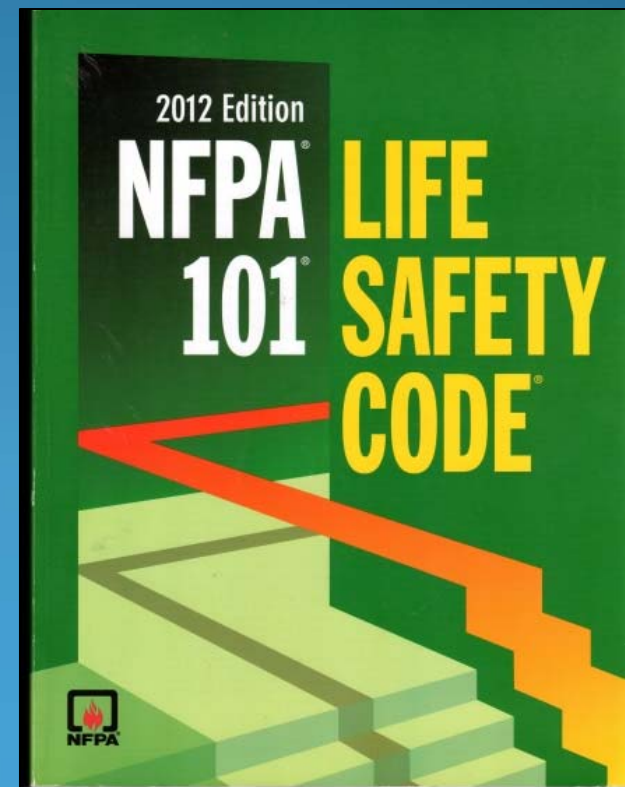
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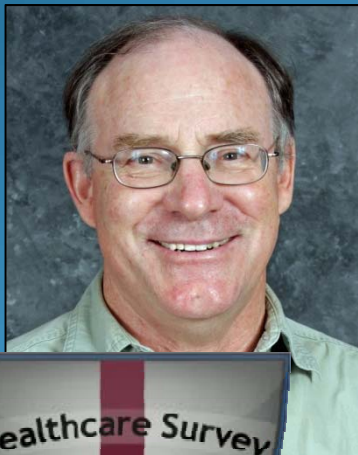




WISCONSIN HEALTHCARE ENGINEERING ASSOCIATION

Dedicated to Excellence in Healthcare Engineering

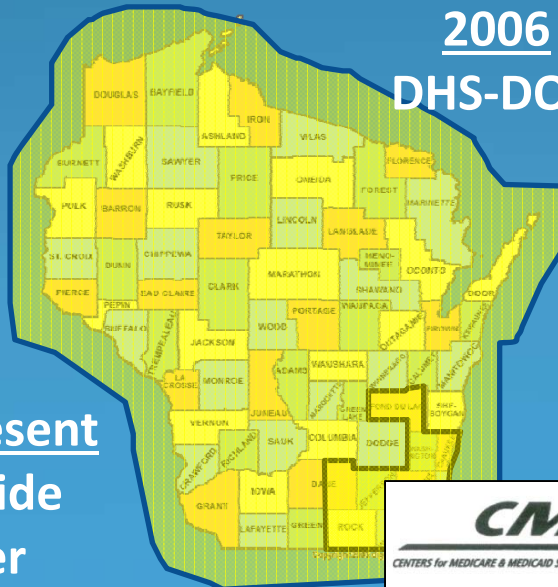
Presented by:
Bill Lauzon, PE
Lauzon Life Safety
Consulting, LLC



2011-present
Statewide
Helper



2006
DHS-DQA



1973-2006
Tomah - Fargo
Madison – Kenosha
Racine

ADOPTION OF 2012 LSC

TOPICS to COVER

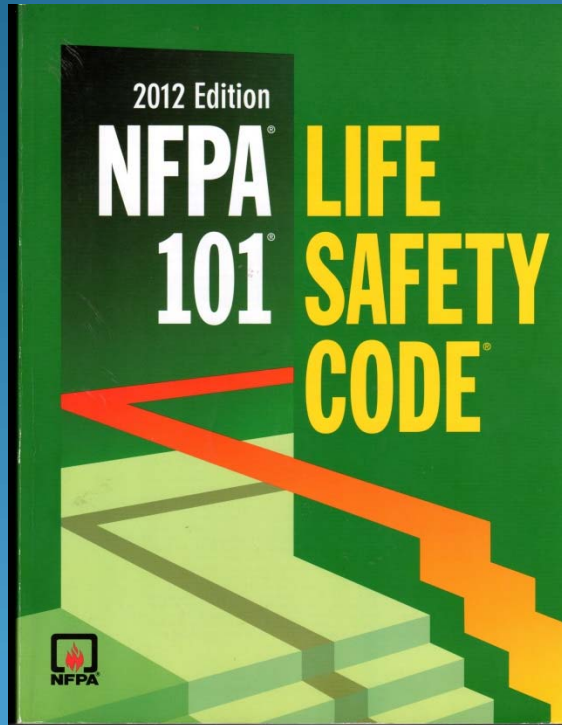
- | | |
|---|-------------------------|
| 1. Adoption Process | (slides 4-12) |
| 2. Conditions of Participation | (slides 13-20) |
| 3. Waivers (General & Categorical) | (slides 21-29) |
| 4. 2012 LSC – Health Care Changes | (slides 30-72) |
| 5. 2012 LSC – Ambulatory Changes | (slides 73-77) |
| 6. 2012 NFPA 99 | (slides 78-106) |
| 7. Recommended Comments | (slides 107-121) |



Adoption Process

Adoption PROCESS for:

2012 Life Safety Code (NFPA 101)



Proposed Rule



FEDERAL REGISTER

The Daily Journal of the United States Government

Published
Wed April 16, 2014

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850



Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 14-21- LSC

April 18, 2014

State Survey Agency Directors
State Fire Authorities

Director
Survey and Certification Group

SUBJECT: Publication of Notice of Proposed Rulemaking (NPRM) for Fire Safety Requirements – *Informational Only*

Memorandum Summary

Publication of NPRM for Fire Safety Requirements: The Centers for Medicare & Medicaid Services (CMS) published a proposed rule that would amend the current fire safety standards for Medicare- and Medicaid-participating providers and suppliers. This proposed rule would adopt the 2012 edition of the Life Safety Code (LSC), National Fire Protection Association, (NFPA) 101. Comments may be accepted until 5 pm EST June 16, 2014.

On April 16, 2014 CMS published a proposal to revise the edition of the LSC referenced in Requirements, Conditions of Participation and Conditions for Coverage for long term care facilities, hospitals, critical access hospitals, ambulatory surgical centers, hospices that provide inpatient services, religious non-medical health care institutions, and programs of all-inclusive care for the elderly facilities. The proposal would eliminate references to all earlier editions of the LSC. CMS also proposes to adopt the 2012 edition of the Health Care Facilities Code, NFPA 99, with some exceptions.

The proposed rule may be viewed at: <https://federalregister.gov/a/2014-08602>, which provides details on how to submit comments. Public comments are due no later than June 16, 2014.

Effective Date: Proposed. Comments may be accepted until 5 pm EST June 16, 2014.

/s/
Thomas E. Hamilton

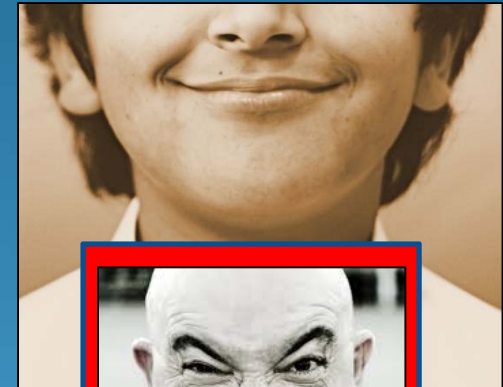
DON'T MISS YOUR RIGHT TO CHALLENGE CMS IF YOU FEEL SOMETHING IS WRONG!

Comments Due: 5 PM JUNE 16, 2014 (Ref CMS-3277-P)

Electronic, Mail, Hand Delivery



You may submit electronic comments on this regulation to *<http://www.regulations.gov>*. Follow the “Submit a comment” instructions.



Contact: Kristin Shifflett (410-786-4133)
Danielle Shearer (410-786-6617)

- **Not able to acknowledge or respond individually**
- **Will consider all comments received**
- **Will respond to comments in preamble of final document**

Proposed Rule



FEDERAL REGISTER

The Daily Journal of the United States Government

**Published
Wed April 16, 2014**



FEDERAL REGISTER

Vol. 79

Wednesday,

No. 73

April 16, 2014

Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 416, 418, et al.

Medicare and Medicaid Programs; Fire Safety Requirements for Certain Health Care Facilities; Proposed Rule

A close-up of a Social Security card. The words "SOCIAL SECURITY" are embossed in large, white, capital letters on a dark blue, textured background. The card has a gold-colored border.

SOCIAL SECURITY

“The STATUTORY BASIS for incorporating NFPA's LSC for our providers and suppliers is the Secretary's authority to stipulate health and safety regulations for each type of Medicare and (if applicable) Medicaid-participating facilities, as well as the Secretary's general rulemaking authority set out at SECTIONS 1102 AND 1871 OF THE SOCIAL SECURITY ACT (the Act).”

The signature strip of a Social Security card. It features a gold-colored background with the word "SIGNATURE" in blue. Below the word is a gold-colored strip with the date "03/20/2009" in blue. The strip is flanked by two gold-colored vertical bars.

SIGNATURE
USA 03/20/2009

[Quote from Federal Register, Published Wed April 16, 2014]



LSC adoption by CMS applies to:

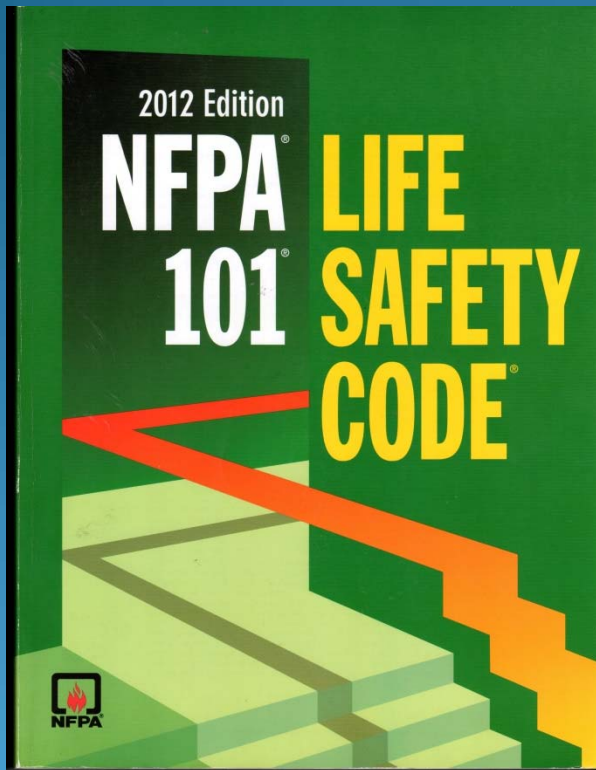
1. Hospitals
2. Long-Term Care facilities (LTC)
3. Critical Access Hospitals (CAH)
4. Ambulatory Surgical Centers (ASC)
5. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs)
6. Hospice inpatient care facilities
7. Programs for All inclusive Care for the Elderly (PACE)
8. Religious Non-medical Health Care Institutions (RNHCIs)

Biggest Question: WHEN will The 2012 LSC be effective?

If the Past is any Indication:

<u>Steps</u>	<u>2000 LSC Adoption</u>	<u>2012 LSC Adoption</u>
1. Proposed Rule	Oct, 2001	Apr 2014
2. Final Rule Action	Nov, 2002	(+13 mo) May 2015
3. S&C Adopt Ltr	Jan, 2003	(+2 mo) Jul 2015
4. Effective Date	Mar, 2003	(+2 mo) <u>Sep 2015</u>
5. Survey Start	Sep, 2003	(+6 mo) Mar 2016

When CMS adopts the LSC,
it adopts the edition as it existed on the
day of publication of the
final rule



Caution: Today's wording
may NOT be the same as
the actual adopted printing

Conditions of Participation



CONDITIONS OF PARTICIPATION (COP)

Your facility's
signed
agreement
with CMS to
abide by
their rules

They become
the AHJ





CONDITIONS OF PARTICIPATION (COP)

<u>Provider Type</u>	<u>SSA Section</u>
• Hospitals	(§ 482.41)
• Critical Access Hospitals	(§ 485.623)
• Long Term Care Facilities	(§ 483.70)
• Ambulatory Surgery Centers	(§ 416.44)
• Hospices	(§ 418.110)
• Intermediate Care Facilities for Individuals With Intellectual Disabilities	(§ 483.470)



CONDITIONS OF PARTICIPATION (COP)

Described in the State Operations Manual (SOM)

<u>TAGS</u>	<u>Hospital</u>	<u>LTC</u>	<u>CAH</u>
Health Care	A	F	C
Life Safety	K	K	K

Even ONE K-Tag Deficiency is an Automatic "COP-OUT"



CONDITIONS OF PARTICIPATION (COP)

“REGARDLESS OF THE
NUMBER OF PATIENTS”



CONDITIONS OF PARTICIPATION (COP)

“REGARDLESS OF THE NUMBER OF PATIENTS”

Both the 2000 and 2012 editions of the LSC classify a “Health Care Occupancy” as a facility having 4 OR MORE PATIENTS on an inpatient basis.

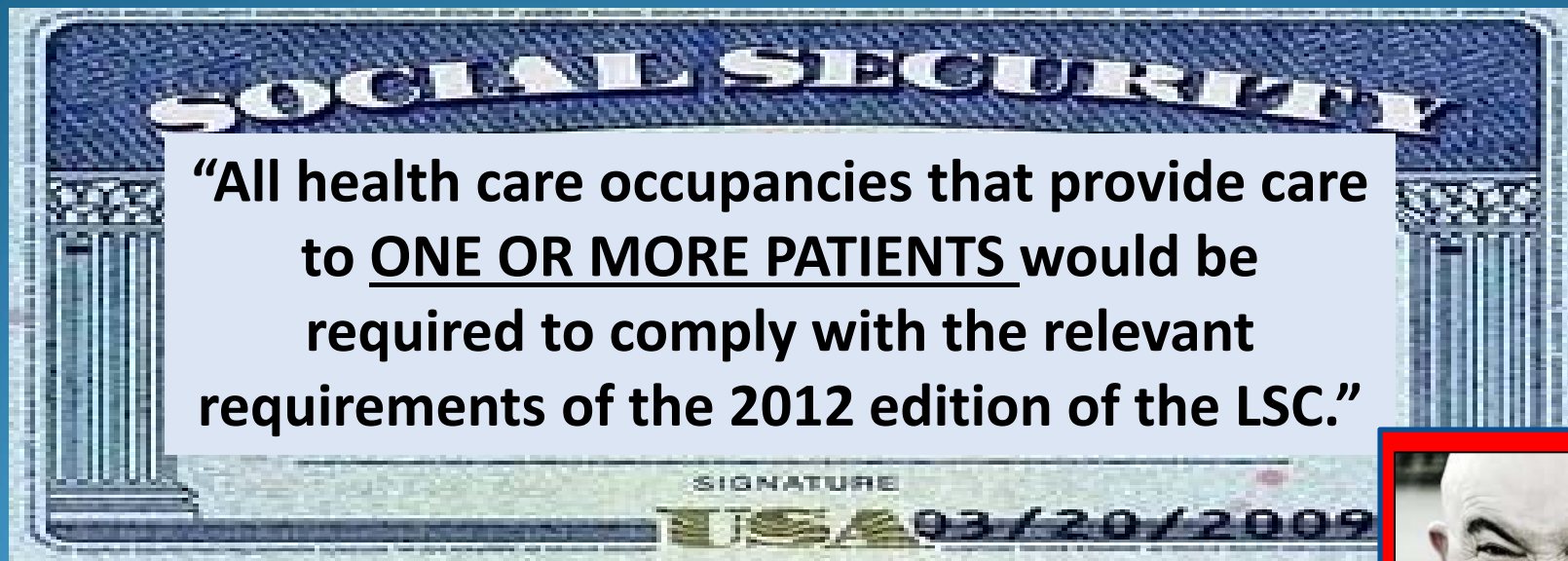
- “CMS DOES NOT APPLY this LSC standard with respect to patient census numbers ...
- Rules would apply on a facility basis, REGARDLESS OF THE SIZE of the facility or the facility's patient census”.

[Quote from Federal Register, Published Wed April 16, 2014]



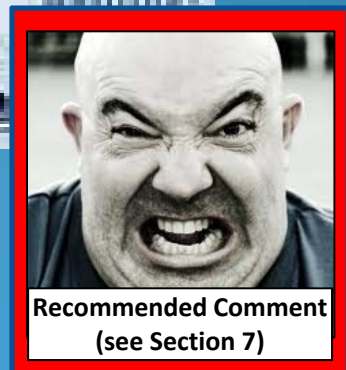
CONDITIONS OF PARTICIPATION (COP)

“REGARDLESS OF THE NUMBER OF PATIENTS”



“All health care occupancies that provide care to ONE OR MORE PATIENTS would be required to comply with the relevant requirements of the 2012 edition of the LSC.”

[Quote from Federal Register, Published Wed April 16, 2014]



**Recommended Comment
(see Section 7)**

ADOPTION OF 2012 LSC



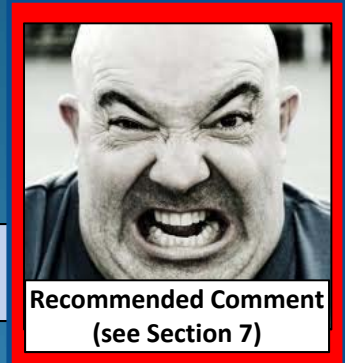


WAIVERS



WAIVER AUTHORITY

TRADITIONAL WAIVER PROCESS



PROVIDER GETS A CITATION when it is surveyed

PROVIDER MAY REQUEST a waiver from its State Survey Agency or Accrediting Organization (AO)

State Agency or AO REVIEWS THE REQUEST and makes a recommendation to the CMS Regional Office

CMS Regional Office would review the waiver request and the recommendation and make a FINAL DECISION.



WAIVER AUTHORITY

CATEGORICAL WAIVER

“We have issued categorical waivers of LSC requirements:

- 1. When NEWER EDITIONS OF THE LSC provided equally effective means of ensuring life safety compared to requirements of earlier LSC editions.**
- 2. When CMS has evaluated the alternative (such as examining the NEW fire safety research and technology),**

[Quote from Federal Register, Published Wed April 16, 2014]



WAIVER AUTHORITY

CATEGORICAL WAIVER

CMS may defer to newer editions of the LSC

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1880



Ref: S&C: 13-58-LSC

Center for Clinical Standards and Quality/Survey & Certification Group

DATE: August 30, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

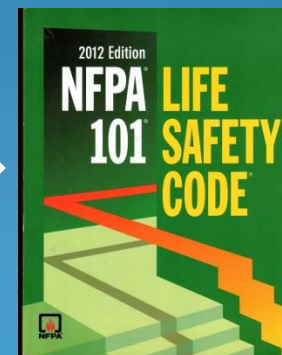
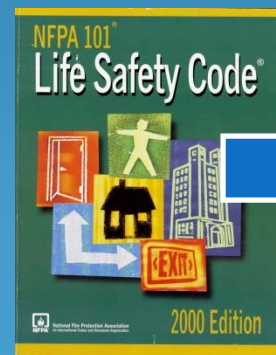
SUBJECT: 2000 Edition National Fire Protection Association (NFPA) 101® Life Safety Code (LSC) Waivers

Memorandum Summary

- **Several Categorical LSC Waivers Permitted:** The Centers for Medicare & Medicaid Services (CMS) has identified several areas of the 2000 edition of the LSC and 1999 edition of NFPA 99 that may result in unreasonable hardship on a large number of certified providers/suppliers and for which there are alternative approaches that provide an equal level of protection. This memorandum specifies the provisions that are available for waiver, including the conditions for the alternative approaches.
- **Providers and Suppliers Must Elect to Use the Waiver:** Individual waiver applications are not required, but providers and suppliers are expected to have written documentation that they have elected to use a waiver and must notify the survey team at the entrance conference for any survey assessing LSC compliance that it has elected the use of a waiver permitted under this guidance and that it meets the applicable waiver requirements. The survey team will review the information and confirm they are meeting the circumstances for the waiver.

Various regulations governing certain certified providers and suppliers require compliance with the 2000 edition of the NFPA 101: LSC. The LSC establishes minimum requirements for the design, operation, and maintenance of buildings and structures to protect individuals from fire and related hazards.

As allowed by the regulations at §482.41(b)(2), §485.623(d)(3), §483.70(a)(2), §416.44(b)(2), and §418.110(d)(2), CMS may waive specific provisions of the 2000 edition of the LSC in hospitals, critical access hospitals, long-term care facilities, ambulatory surgical centers, and inpatient hospice, which, if rigidly applied, would result in unreasonable hardship upon a provider or supplier, but only if the waiver does not adversely affect the health and safety of patients or residents. CMS has determined that the 2000 edition of the LSC contains several provisions that may result in unreasonable hardship for providers/suppliers, for which an adequate alternative level of protection may be achieved. Accordingly, CMS is making available categorical waivers to new and existing providers and suppliers subject to the LSC.





WAIVER AUTHORITY

CATEGORICAL WAIVER

“Advance recommendation from a state survey agency or accrediting organization (as applicable), is not required in order for a waiver to be granted”.



[Quote from Federal Register, Published Wed April 16, 2014]



WAIVER AUTHORITY

CATEGORICAL WAIVER

“Waiver approval subject to:

- **Review of documentation maintained by the facility,**
- **Verification of the applicability of the waiver, and**
- **Confirmation that the terms and requirements of the waiver have been implemented by the facility”.**

In most cases verification occurs when an onsite survey of the facility is conducted.

[Quote from Federal Register, Published Wed April 16, 2014]



WAIVER

**The Need of these Waivers will
"sunset" if the 2012 LSC is
adopted**

CATEGORICAL WAIVERS

- 1. Unoccupied Stair Openings**
- 2. Door Locking**
- 3. Delayed Egress Locking**
- 4. Suite Size & TD**
- 5. Sprinkler Testing**
- 6. Fire Pump Testing**
- 7. OR Humidity**
- 8. Fireplaces-Direct Vent**
- 9. Fireplaces-Solid Fuel**
- 10. Corridor Kitchens**
- 11. Corridor Obstruction**
- 12. Combustible Decorations**
- 13. Waste Container Size**
- 14. Med Gas Alarms**
- 15. Generator Load Banking**



CATEGORICAL WAIVER

WAIVER CHECKLIST

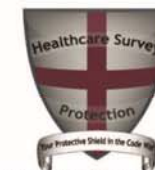
CMS CATEGORICAL WAIVER CHECKLIST

Page 1 of 4

FACILITY NAME:	Waiver Topic, description & location:
CITY:	
Waiver adopted/approved _____ (date) by _____	

If the facility desires to use any of the CMS categorical waivers listed below, it must

- Officially adopt the waiver decision, with written approval of the facility Environment of Care/Safety Committee, or other designee of the board of directors or owner. Approval shown in minutes. Best to have a separate letter for each waiver topic. Best to show the specific location of each occurrence with a "keynote" on the Life Safety Plans
- Have documentation to show compliance with each of the new code requirements (see below at right side of this checklist for each topic),
- Notify (in writing & verbal) surveyors at the start of a survey which waivers have been adopted by the facility (show official adoption documentation from step 1)
- Cautions: a). Facility must also ensure compliance with the Wis Building Codes (IBC, IMC, etc) for any new work. The CMS waivers do NOT apply to those requirements.
b). These categorical waivers do NOT affect any continuing/annual CMS waivers, which must still be adhered to.
- Recommendation: For the sake of organization, it is highly recommended that ALL facility waivers & variances documentation be kept in a single location, such as a "WAVIER" binder, with a separate "tab" for each waiver topic.



Lauzon Life Safety Consulting, LLC

If the facility is Joint Commission surveyed, documentation of categorical waivers MUST be shown in the "additional comments" field of the on-line Basic Building Information (BBI). Best to attach the official adoption documentation from step 1. Also list each situation in the on-line Statement of Conditions (SOC), with the waiver as the Plan for Improvement (PFI).

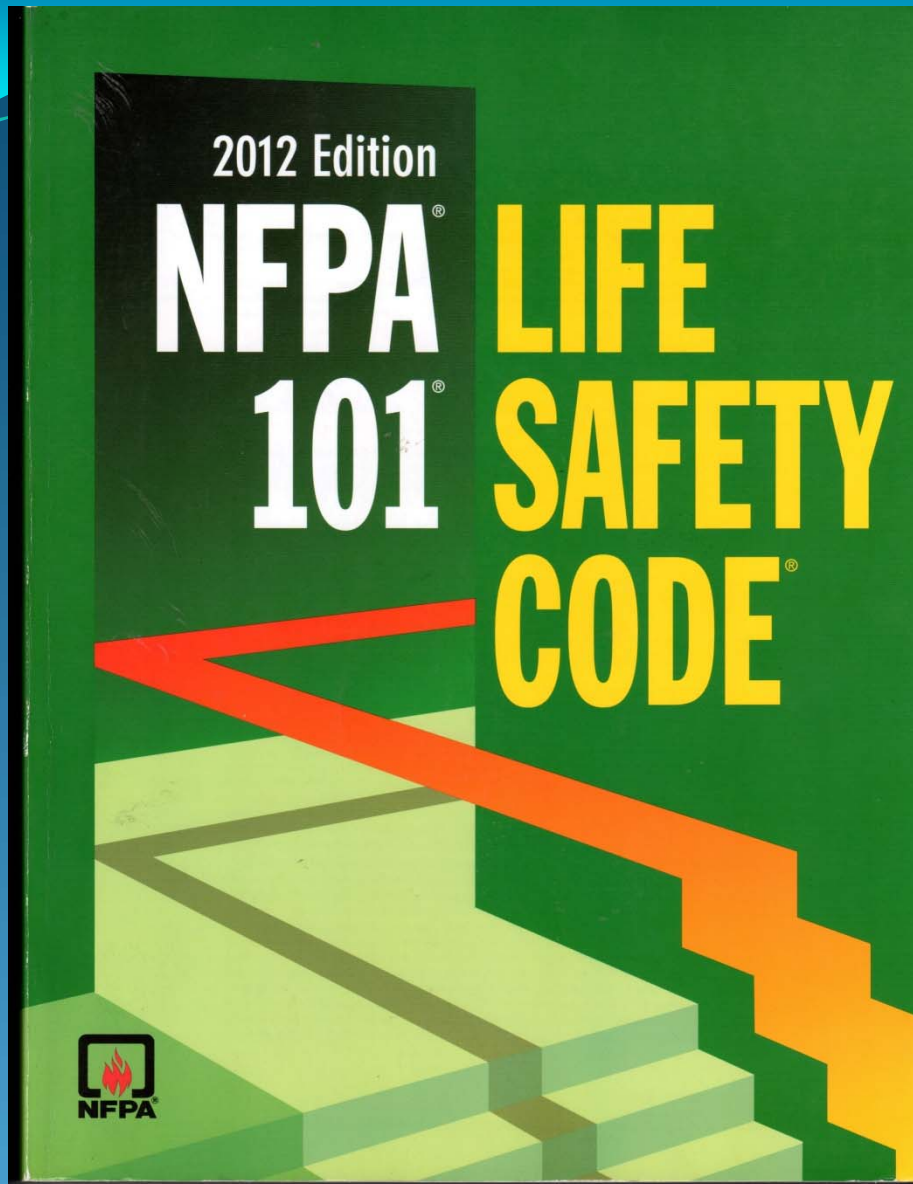
					CURRENT CODE		NEW CODE		
WAIVER TOPIC	K-TAG	TJC STD	S&C Letter	S&C DATE	CODE REF	CURRENT CODE REQUIREMENT	NEW CODE SUMMARY	CODE REF	REQUIREMENTS THAT MUST BE COMPLIED WITH TO USE THE CATEGORICAL WAIVER (i.e., 2012 CODE) (All applicable items must be checked & have documentation to show satisfactory compliance; refer to full code to ensure compliance)
<input type="checkbox"/> 1-Unoccupied Opening in Exit Enclosures	K-033	LS02.01.20 EP 32	13-58	8/30/13	101-2000 §7.1.3.2.1(d)	unoccupied mech equip rooms cannot open into exit enclosures	existing unoccupied mech equip spaces (without fuel-fired equip & no storage) with fire-rated doors may open into exit enclosures (stairs & exit passageways)	101-2012 §7.1.3.2(9)c	<input type="checkbox"/> Apply only to existing stairwell openings <input type="checkbox"/> Existing door must be properly rated <input type="checkbox"/> Used solely for non-fuel fired mechanical equip <input type="checkbox"/> Bldg has full supervised sprinkler sys <input type="checkbox"/> No storage of combustibles
<input type="checkbox"/> 2-Door Locking	K-038	LS02.01.20 EP 1	13-58	8/30/13	101-2000 §18/19.2.2.2	doors may be locked only when the clinical needs of patients require special security measures	doors may be locked only when the clinical, security, safety. Or other special needs of patients require special security measures	1014-2012 §18/19.2.2.2.5	Can lock if Clinical Need: <input type="checkbox"/> The clinical need of patient requires specialized security measures or patient poses a security staff AND <input type="checkbox"/> All staff can readily unlock at all times with keys they carry at all times or via remote control or other reliable means available to all staff, AND <input type="checkbox"/> Only one lock on the door Can lock if Special Need: <input type="checkbox"/> The patient special needs requires specialized protective measures for their own safety, AND <input type="checkbox"/> All staff can readily unlock at all times with keys they carry at all times or via remote control or other reliable means available to all staff, AND <input type="checkbox"/> Only one lock on the door, AND (continued next col) <input type="checkbox"/> Complete smoke detection in locked space; or locked doors remotely unlockable from an approved & constantly attended location within the space, AND <input type="checkbox"/> Building fully sprinkled, AND <input type="checkbox"/> Electric locks open on loss of power, AND <input type="checkbox"/> Locks release by independent, activity of the smoke detector system or water flow of the sprinkler system

ADOPTION OF 2012 LSC





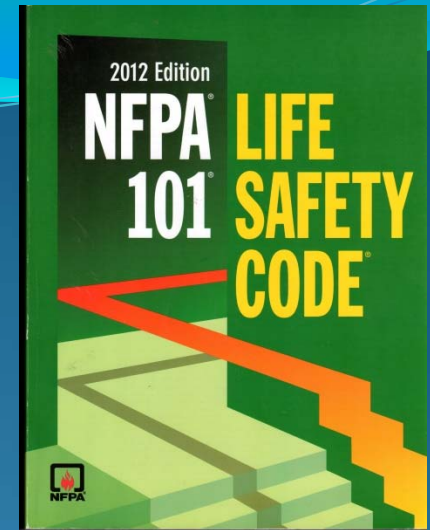
2012 LSC Health Care



- New Look
- New Layout
- New Content

NEW APPEARANCE of 2012 LSC

1. Format of the LSC has been altered.
The LSC has ELIMINATED THE USE OF
“EXCEPTIONS” throughout the entire code
to provide more consistency and easier reading.



2000 LSC, Corridor Separation

18.3.6.1 Corridors shall be separated from all other areas by partitions complying with 18.3.6.2 through 18.3.6.5. (See also 18.2.5.9.)

Exception No. 1: Spaces shall be permitted to be unlimited in area and open to the corridor, provided that the following criteria are met:

- (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. — see p 152 SSD or QF
- (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers.
- (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. SSD or OBS
- (d) The space does not obstruct access to required exits.

Exception No. 2: Waiting areas shall be permitted to be open to the corridor, provided that the following criteria are met:

- (a) The aggregate waiting area in each smoke compartment does not exceed 600 ft² (55.7 m²). SSD or OBS
- (b) Each area is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or each area is arranged and located to allow direct supervision by the facility staff from a nursing station or similar space.
- (c) The area does not obstruct access to required exits.

Exception No. 3:* Spaces for nurses' stations.

Exception No. 4: Gift shops open to the corridor where protected in accordance with 18.3.2.5. p 151

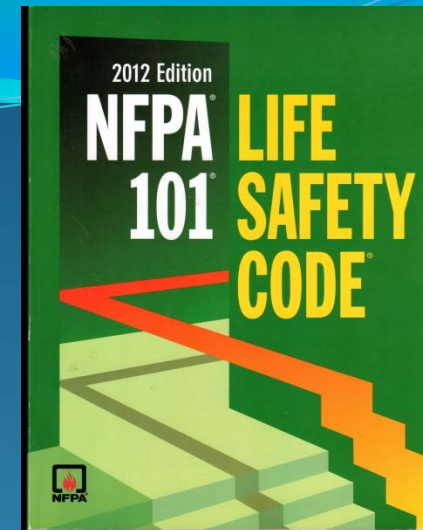
Exception No. 5: In a limited care facility, group meeting or multipurpose therapeutic spaces shall be permitted to open to the corridor, provided that the following criteria are met:

- (a) The space is not a hazardous area.
- (b) The space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the space is arranged and located to allow direct supervision by the facility staff from the nurses' station or similar location.
- (c) The area does not obstruct access to required exits.

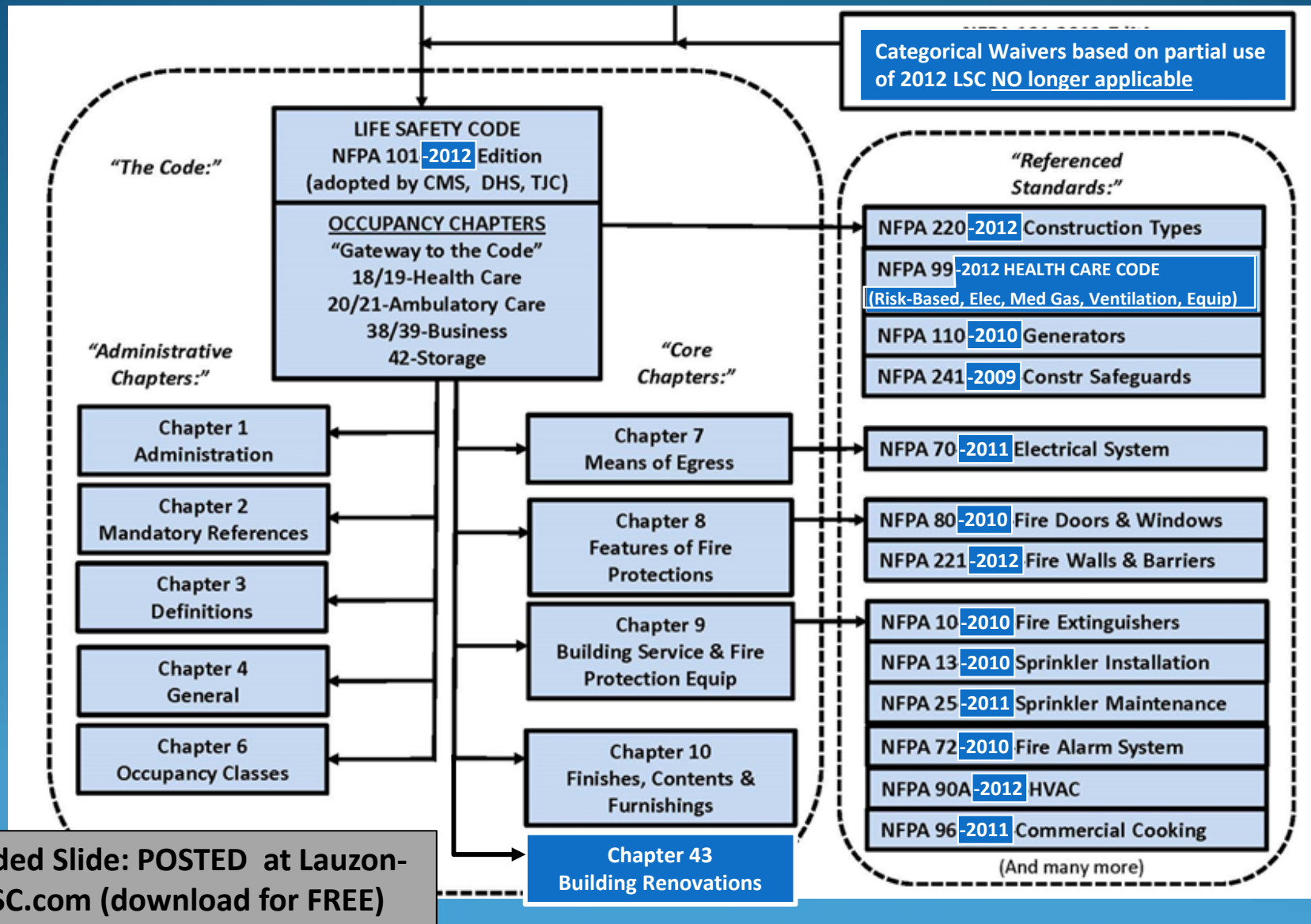
2012 LSC, Corridor Separation

18.3.6.1 Corridor Separation. Corridors shall be separated from all other areas by partitions complying with 18.3.6.2 through 18.3.6.5 (see also 18.2.5.4), unless otherwise permitted by one of the following:

- (1) Spaces shall be permitted to be unlimited in area and open to the corridor, provided that all of the following criteria are met:
 - (a)*The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas.
 - (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers.
 - (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space.
 - (d) The space does not obstruct access to required exits.
- (2) Waiting areas shall be permitted to be open to the corridor, provided that all of the following criteria are met:
 - (a) The aggregate waiting area in each smoke compartment does not exceed 600 ft² (55.7 m²).
 - (b) Each area is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or each area is arranged and located to allow direct supervision by the facility staff from a nursing station or similar space.
 - (c) The area does not obstruct access to required exits.
- (3)*This requirement shall not apply to spaces for nurses' stations.
- (4) Gift shops not exceeding 500 ft² (46.4 m²) shall be permitted to be open to the corridor or lobby.
- (5) In a limited care facility, group meeting or multipurpose therapeutic spaces shall be permitted to open to the corridor, provided that all of the following criteria are met:
 - (a) The space is not a hazardous area.
 - (b) The space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the space is arranged and located to allow direct supervision by the facility staff from the nurses' station or similar location.
 - (c) The space does not obstruct access to required exits.
- (6) Cooking facilities in accordance with 18.3.2.5.3 shall be permitted to be open to the corridor.



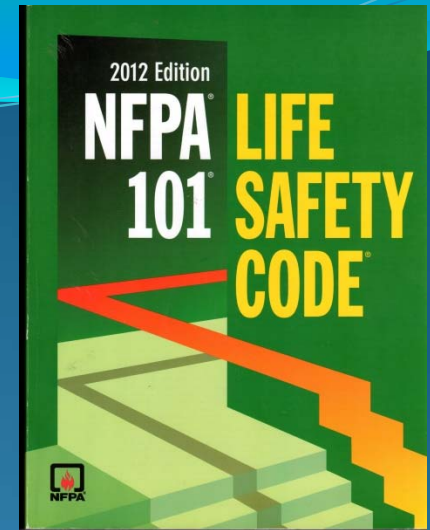
NEW REFERENCED CODES by 2012 LSC



NEW APPEARANCE of 2012 LSC

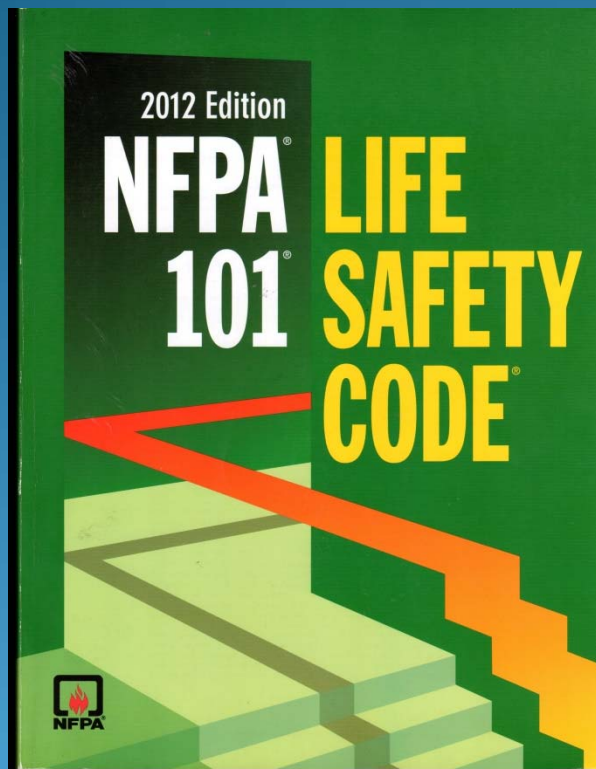
1. Format of the LSC has been altered. The LSC has ELIMINATED THE USE OF “EXCEPTIONS” throughout the entire code to provide more consistency and easier reading.

2. Change in measurement systems, from CENTIMETERS TO MILLIMETERS. Using a smaller unit of measurement allows for more precision and consistency throughout the LSC.





Can Adopt Only Some Parts & Make Revisions to the LSC

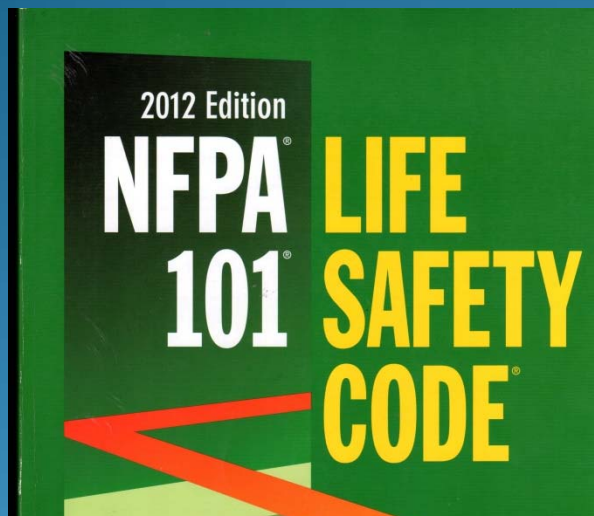


IMPORTANT:

MARK the sections in your
Code Book that

- DO NOT APPLY or
- Have been REVISED

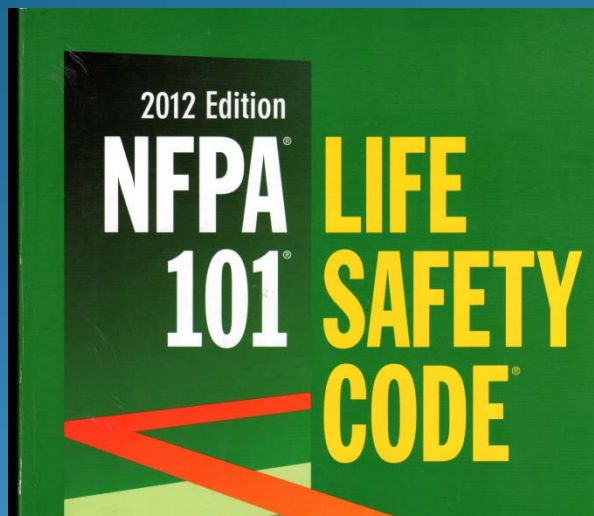
KEY CHANGES & REVISIONS OF 2012 LSC



HEALTHCARE Chapters 18/19

Key Topic	Providers Affected	
	Hosp,CAH,LTC	
1. Chapter 43	x	CMS Adopt As-Is
2. Door Locking	CW	
3. Corridor Obstruct	CW	
4. Corridor Projections	R	CMS Cat. Waiver
5. Sleeping Suite Size	CW	
6. Smoke Control	R	
7. Roller Latches	R	
8. High Rise Sprinklers	x	
9. Corridor Cooking	CW	
10. ABHR	x	CMS Revised 2012 LSC
11. Sprinkler Outage	R	
12. Outside Windows	R	
13. Fireplaces	CW	
14. Furnishings & Décor	CW	
15. Recycle Containers	CW	

KEY CHANGES & REVISIONS OF 2012 LSC



**HEALTHCARE
Chapters 18/19**

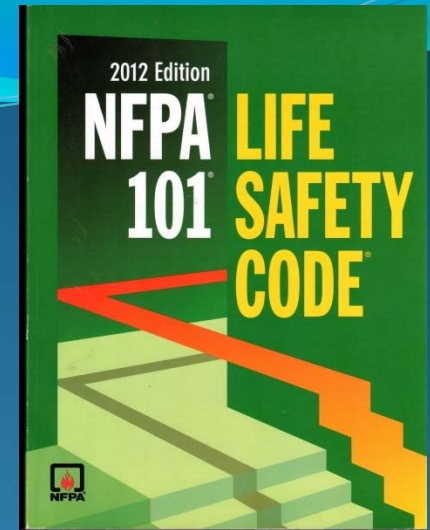
Key Topic		Providers Affected Hosp, CAH, LTC	
1. Chapter 43		X	CMS Adopt As-Is
2. Door Locking		CW	
3. Corridor Obstruct		CW	
4. Corridor Projections		R	
5. Sleeping Suite Size		CW	CMS Cat. Waiver
6. Smoke Control		R	
7. Roller Latches		R	
8. High Rise Sprinklers		X	
9. Corridor Cooking		CW	
10. ABHR		X	
11. Sprinkler Outage		R	CMS Revised 2012 LSC
12. Outside Windows		R	
13. Fireplaces		CW	
14. Furnishings & Décor		CW	
15. Recycle Containers		CW	

New/Revised Provisions of 2012 LSC

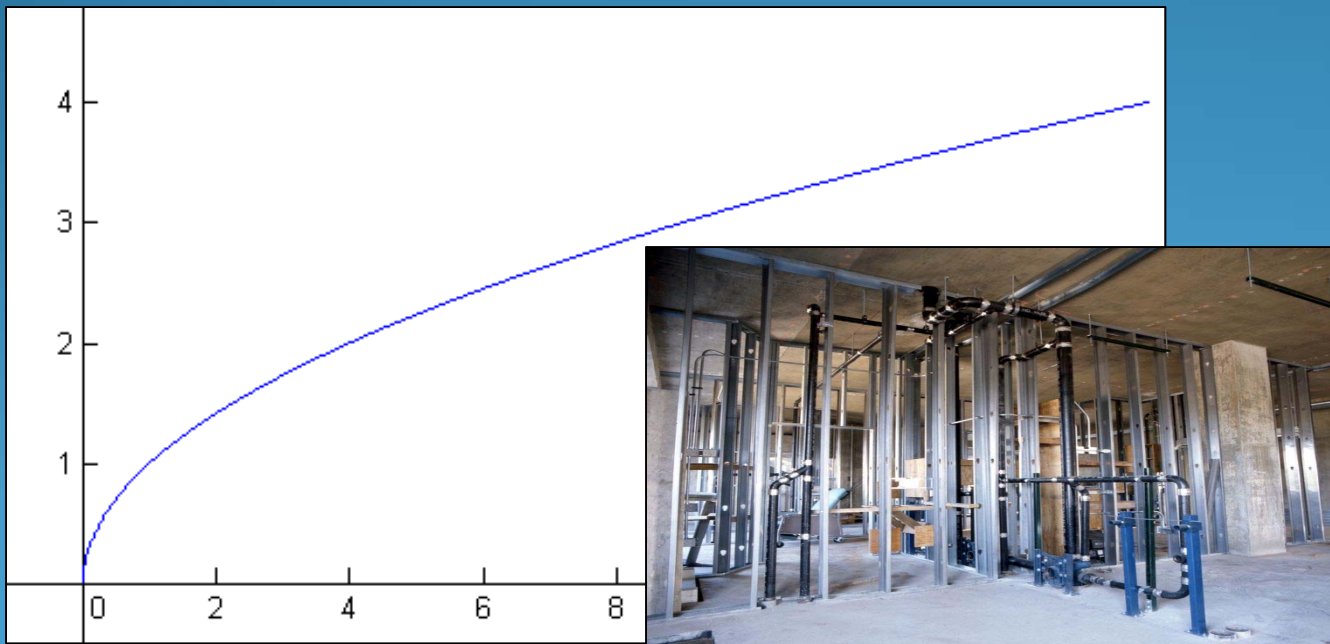
1. NEW Chap. 43 “BUILDING REHABILITATION.”

Code requirements

VARY WITH THE REHABILITATION WORK
CATEGORY.

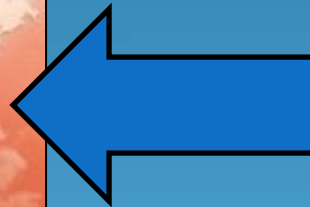
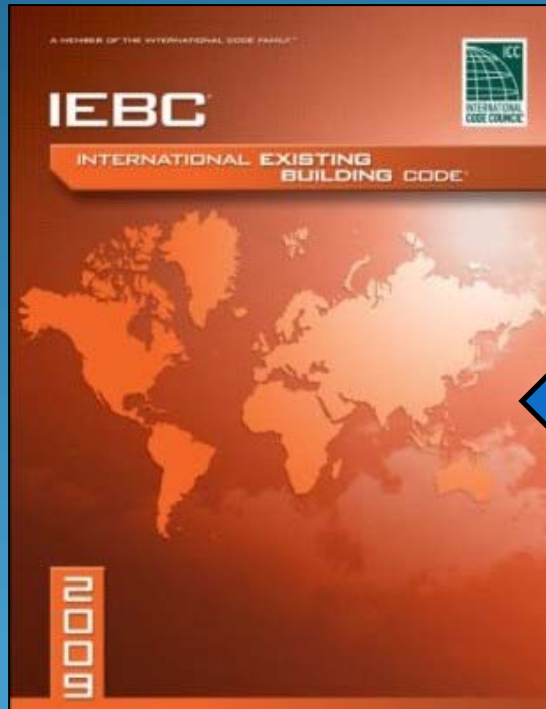
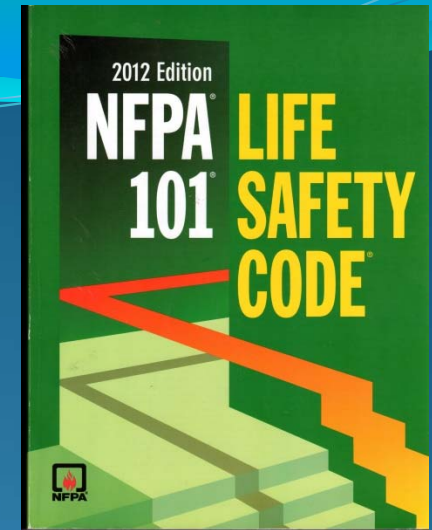


The 2000 LSC requires minor renovation projects to meet the same stringent requirements as those applied to completely new construction.



New/Revised Provisions of 2012 LSC

1. NEW Chap. 43 “BUILDING REHABILITATION.”

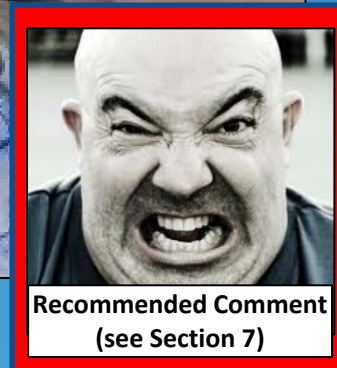
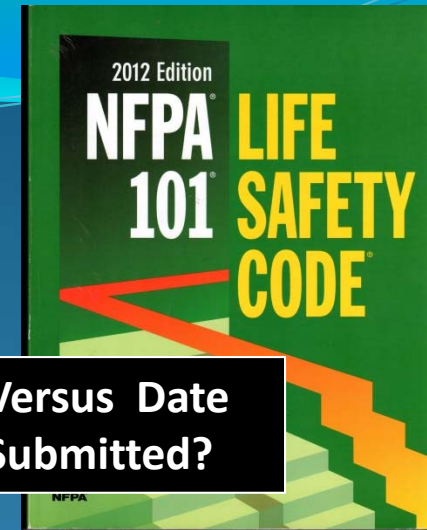


Sound
Familiar?

New/Revised Provisions of 2012 LSC

Chapter 43: Meet 2012 NEW REQUIREMENTS

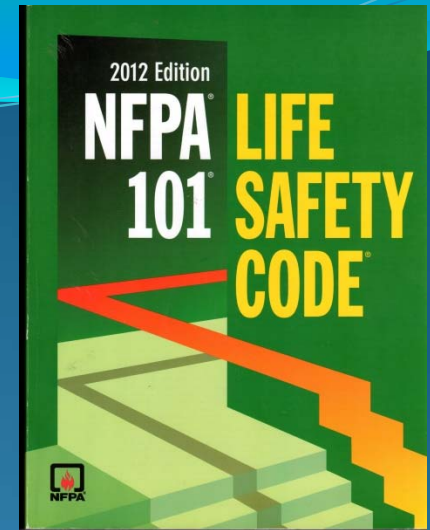
- IF building plans not approved by the rule's effective date
- IF begin construction after the effective date of this regulation



New/Revised Provisions of 2012 LSC

Chapter 43: Meet 2012 EXISTING REQUIREMENTS

- IF constructed before the effective date of this regulation



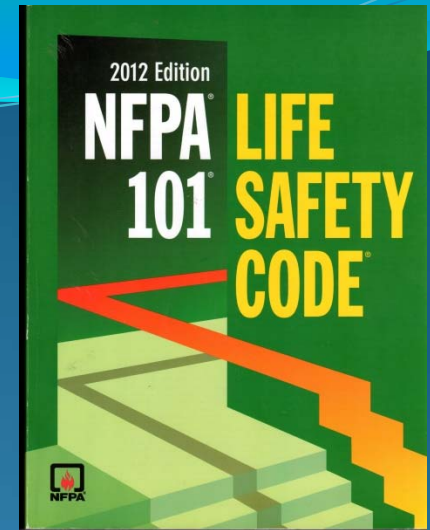
In instances where mandatory LSC references do not include existing chapters, existing occupancies must comply with provisions previously adopted by CMS at the time they were constructed or installed.



New/Revised Provisions of 2012 LSC

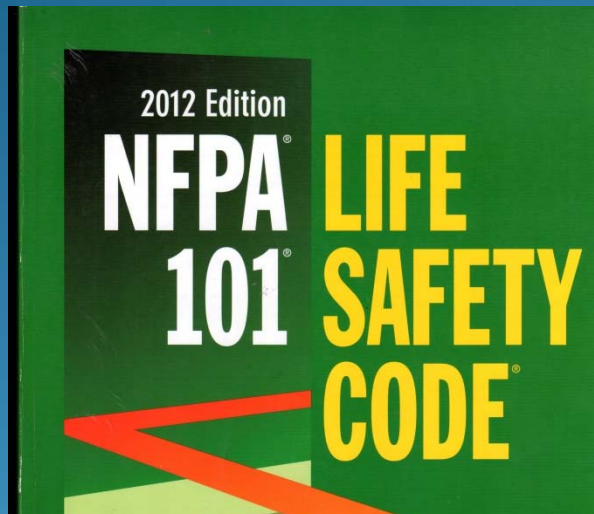
Chapter 43: Meet 2012 REHAB REQUIREMENTS

- IF changes made to existing buildings
 1. Repair
 2. Renovation
 3. Modification
 4. Reconstruction
 5. Change Of Use
 6. Change Of Occupancy
 7. Addition



CMS: “This clarification will assist health care facilities by reducing costs for minor construction projects.”

KEY CHANGES & REVISIONS OF 2012 LSC



HEALTHCARE Chapters 18/19

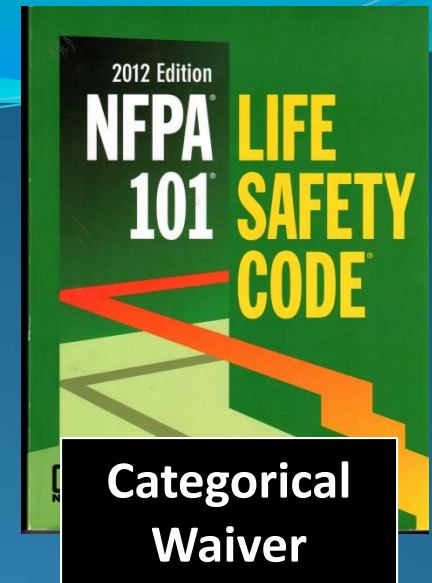
Providers Affected Hosp,CAH,LTC

<u>Key Topic</u>	<u>Hosp,CAH,LTC</u>
1. Chapter 43	x
2. Door Locking	CW
3. Corridor Obstruct	CW
4. Corridor Projections	R
5. Sleeping Suite Size	CW
6. Smoke Control	R
7. Roller Latches	R
8. High Rise Sprinklers	x
9. Corridor Cooking	CW
10. ABHR	x
11. Sprinkler Outage	R
12. Outside Windows	R
13. Fireplaces	CW
14. Furnishings & Décor	CW
15. Recycle Containers	CW

New/Revised Provisions of 2012 LSC

2. Door Locking 18/19.2.2.2.5.2

This new provision PERMITS DOOR LOCKING if the SPECIAL NEEDS of patients require special protective measures for their safety, if:



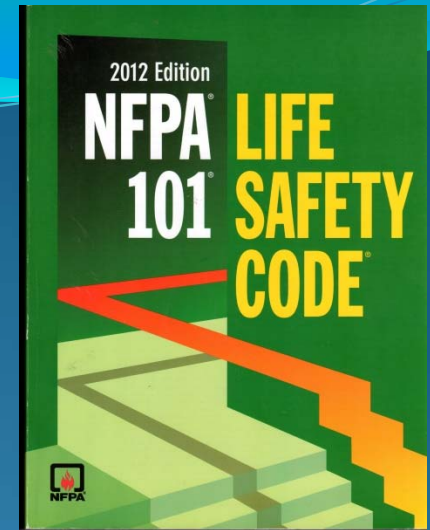
New/Revised Provisions of 2012 LSC

2. Door Locking 18/19.2.2.2.5.2

This new provision PERMITS DOOR LOCKING if the SPECIAL NEEDS of patients require special protective measures for their safety, if:

- (1) All staff must have keys;
- (2) Smoke detection systems must be in place; and
- (3) Facility must be fully sprinkled;
- (4) Electrical locks will release upon loss of power and
- (5) Locks release by independent activation of the smoke detection system and the sprinkler water flow

CMS will require documentation of the
“Special Needs” by the appropriate official



New/Revised Provisions of 2012 LSC

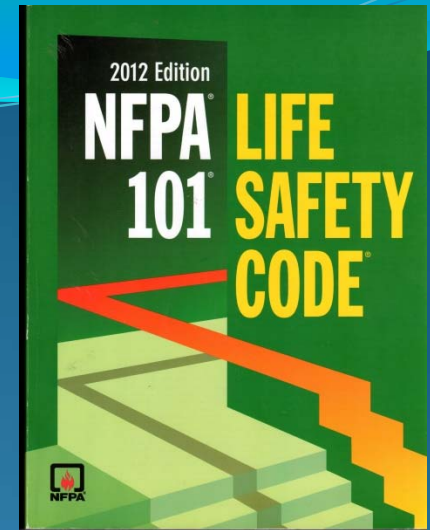
2. Door Locking 18/19.2.2.2.5.2

CMS: “This provision allows interior doors to be locked to reduce the risk of

- **INFANT ABDUCTIONS** and
- **INDIVIDUALS WHO MAY WANDER.**

This provision would improve the security of health care facilities with specialized needs and improve patient safety”.

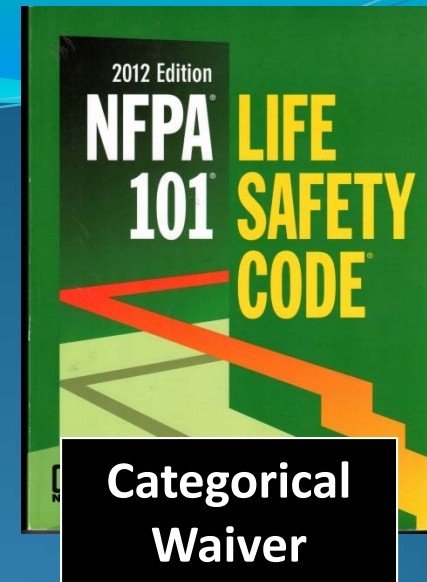
[Quote from Federal Register, Published Wed April 16, 2014]



New/Revised Provisions of 2012 LSC

3. Corridor 18/19.2.3.4

This new provision allows for storage of MEDICAL EQUIPMENT IN THE CORRIDORS.



- Any equipment that is IN USE, including medical emergency equipment, and patient lift and transportation equipment is permitted to be stored in the corridors for more timely patient care.
- FIXED FURNITURE be placed in the corridors (per limits)

CMS: “This creates resting points in the corridors for patients and families in facilities and makes for a more home-like setting”.

[Quote from Federal Register, Published Wed April 16, 2014]

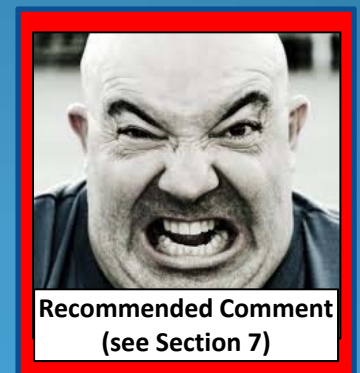
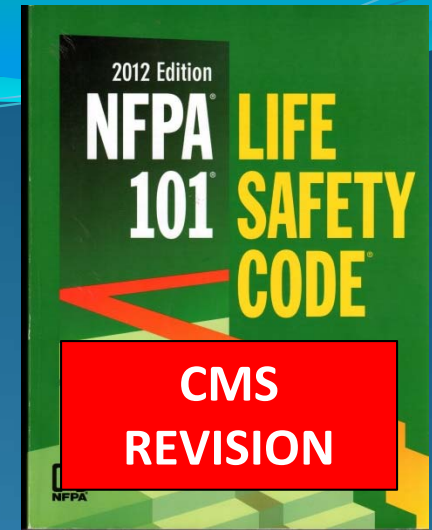
New/Revised Provisions of 2012 LSC

4. Corridor Projections - 18/19.2.3.4(2)

CMS will only permit 4" PROJECTIONS so facilities are compliant with the more stringent requirement set forth by the ADA.

The LSC allows facilities to have 6" projections.

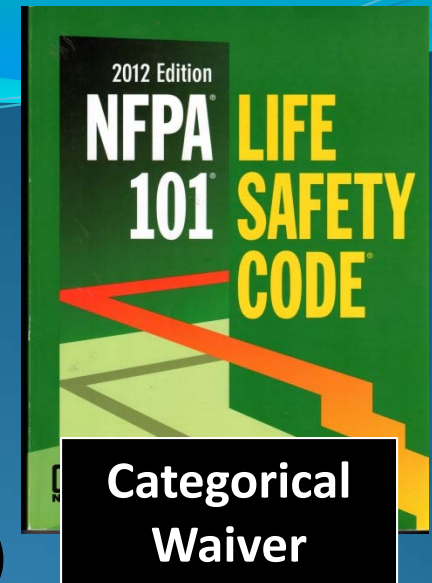
Americans with Disabilities Act (ADA). Section 307 of the "ADA Accessibility Guidelines for Buildings and Facilities"
(<http://www.ada.gov/regs2010/2010ADAStandards/2010ADAstandards.htm#c4>)



New/Revised Provisions of 2012 LSC

5. Sleeping Suites - 18/19.2.5.7

- New construction sleeping suites can have **MAX 7,500 SQ.FT.** (Previous $\leq 5,000$ sq. ft.)
- Sleeping suites 7,501- 10,000 SQ. FT., may be permitted where there is direct VISUAL SUPERVISION and a complete SMOKE DETECTION system.

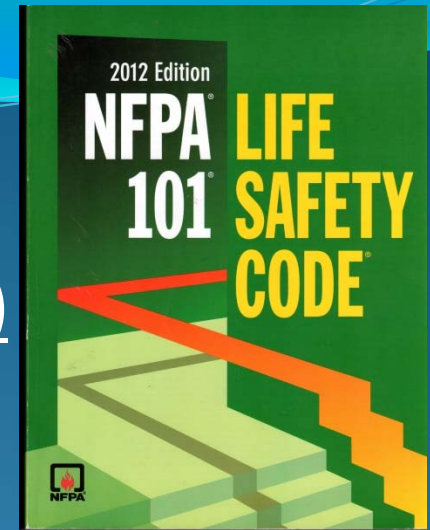


New/Revised Provisions of 2012 LSC

5. Sleeping Suites - 18/19.2.5.7 (Benefits)

CMS: “This allows health care facilities to have more patients in a single area, reducing the number of staff that are necessary to visually monitor patients and allowing facilities to accommodate additional pieces of medical equipment or visitor space. This could improve facility staffing flexibility and reduce costs by allowing this increase in size thereby reducing the number of suites to treat the same number of patients. This potentially allows ‘more comfort and space for patients’ if the facilities choose to use the larger size patient rooms.”

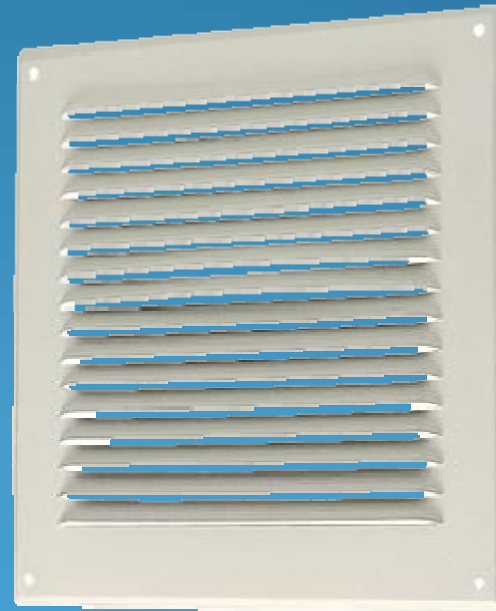
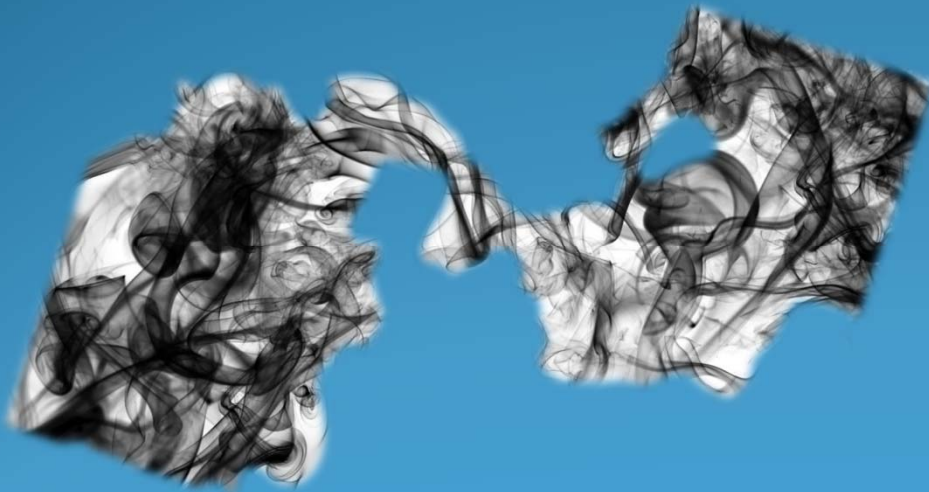
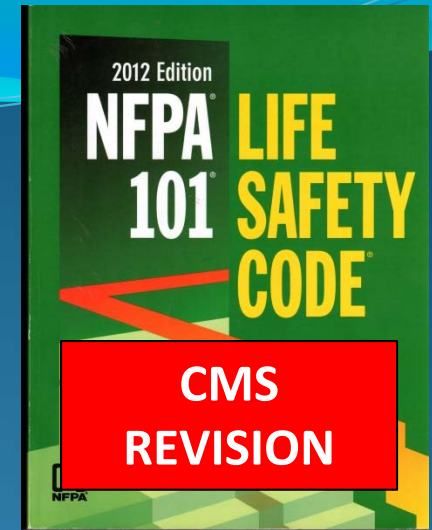
[Quote from Federal Register, Published Wed April 16, 2014]



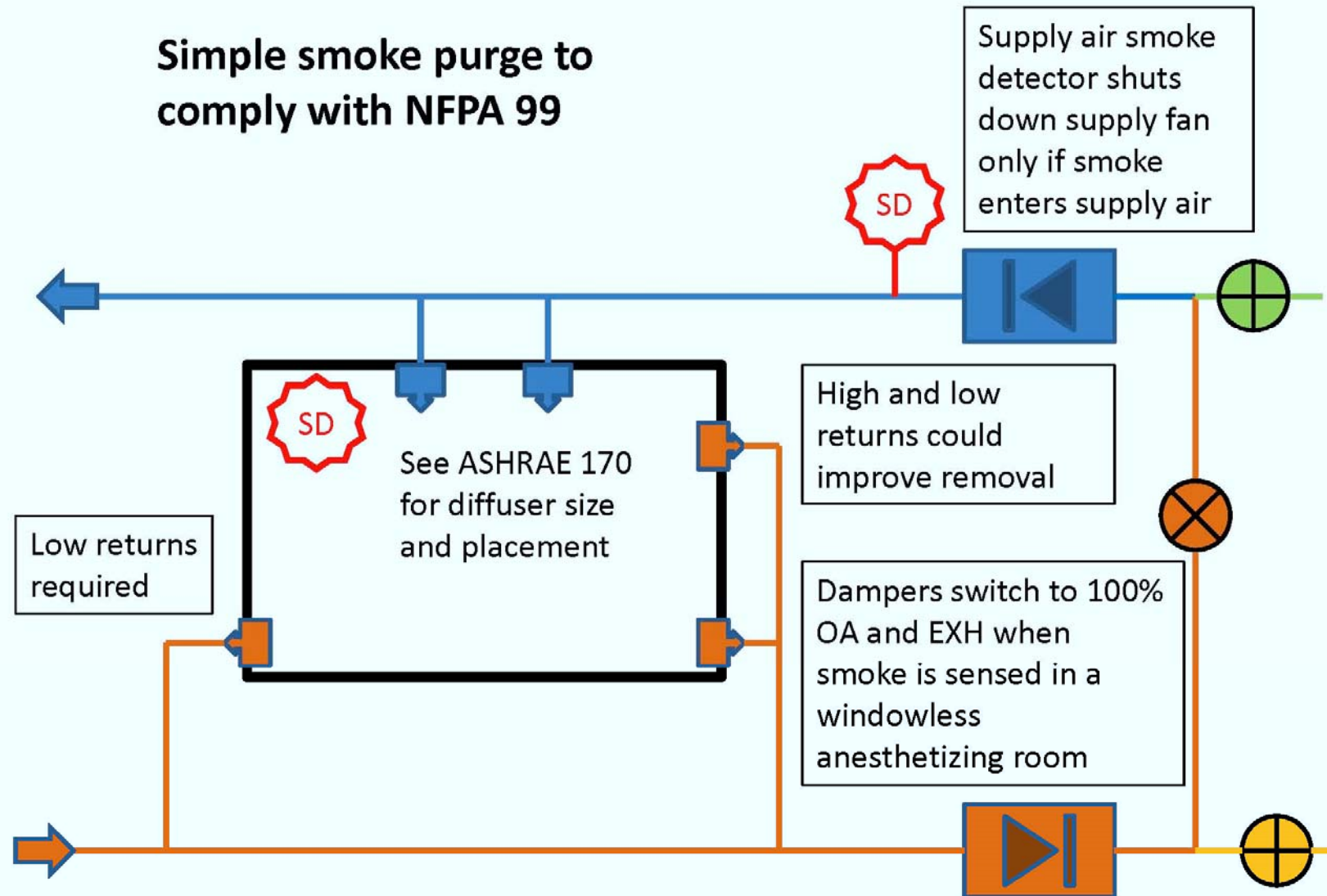
New/Revised Provisions of 2012 LSC

6. OR Smoke Control 18/19.3.2.3

CMS proposes to RETAIN THE REQUIREMENT FOR SMOKE CONTROL in windowless anesthetizing locations.



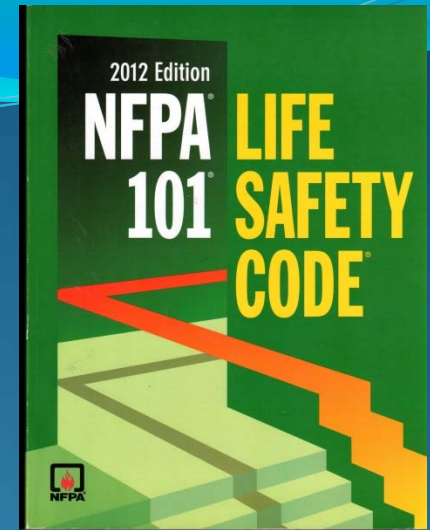
Simple smoke purge to comply with NFPA 99



Drawn by Roger Lautz, PE

New/Revised Provisions of 2012 LSC

6. OR Smoke Control 18/19.3.2.3



The 2012 LSC references the 2012 NFPA 99, which eliminated the smoke control ventilation system in anesthetizing locations

CMS: *“The smoke control protects the anesthetizing location until surgical procedures can be completed. Fires continue to occur in ORs.”*
<http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm282810.htm>.

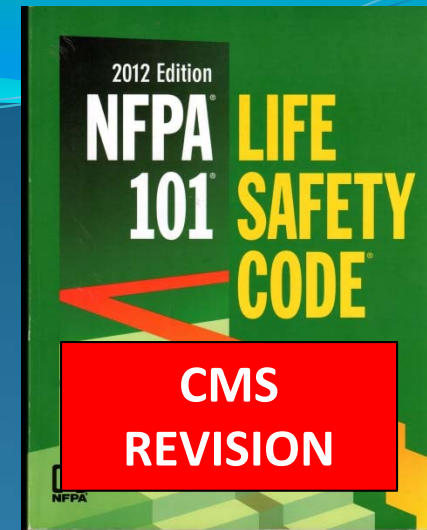


[Quote from Federal Register, Published Wed April 16, 2014]

New/Revised Provisions of 2012 LSC

7. Roller Latches- 18/19.3.6.3.5

**CMS will PROHIBITS ROLLER LATCHES and
Require corridor doors to be positive latching**



The 2012 LSC permits roller latches capable of keeping the door fully closed if a force of 5 pounds is applied at the latch edge or roller latches in fully sprinkled buildings.

CMS: “Through fire investigations, roller latches have proven to be an unreliable door latching mechanism requiring extensive maintenance to operate properly. Many roller latches in fire situations failed to provide adequate protection to residents in their rooms during an emergency”.



[Quote from Federal Register, Published Wed April 16, 2014]

New/Revised Provisions of 2012 LSC

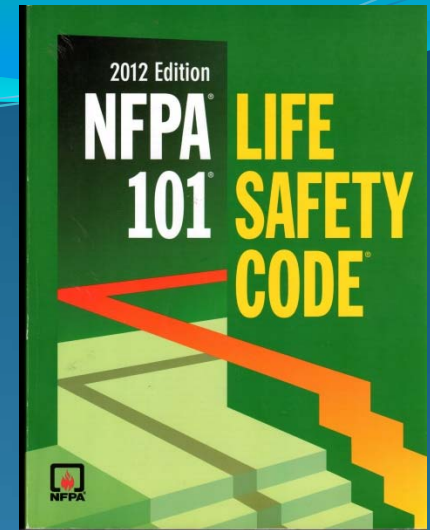
8. High Rise Sprinklers 18/19.4.2

Existing buildings over 75' (generally >7 or 8 stories) in height must have automatic sprinkler systems installed throughout.



CMS: “The 2012 LSC allows 12-years from when the authority having jurisdiction (CMS) officially adopts the 2012 LSC for existing facilities to comply with the sprinkler system installation requirement. We propose to adopt this new provision because high-rise buildings require more time to evacuate, and sprinklers would very likely allow additional time to safely evacuate a facility”.

[Quote from Federal Register, Published Wed April 16, 2014]



New/Revised Provisions of 2012 LSC

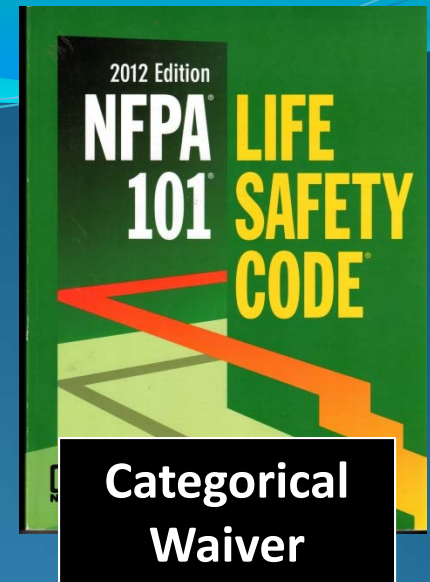
9. Cooking Facilities 18/19.3.2.5.3

Cooking facilities are ALLOWED IN CORRIDORS, provided the following conditions are met:



CMS: *“This provision is a new, and further supports a more home-like setting in health care facilities”.*

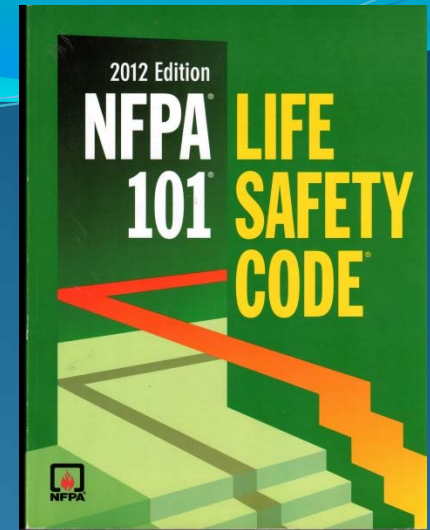
[Quote from Federal Register, Published Wed April 16, 2014]



New/Revised Provisions of 2012 LSC

9. Cooking Facilities 18/19.3.2.5.3

Cooking facilities are ALLOWED IN CORRIDORS, provided the following conditions are met.

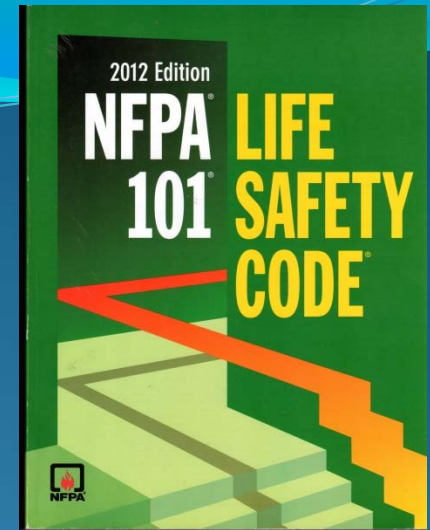


- The area being served is limited to 30 beds or less;
- The area separated from rest of facility by a smoke barrier;
- The range hood and stovetop meet certain standards
- A switch in the area to deactivate equip when area is not under staff supervision & has auto-off timer after 2 hrs
- Two smoke detectors located in a zone 20-25' from the cooktop or range.

New/Revised Provisions of 2012 LSC

10. ABHR 18/19.3.2.6

This provision now explicitly ALLOWS AEROSOL DISPENSERS, in addition to gel hand Rub Dispensers, subject to limitations on size, quantity, and location.

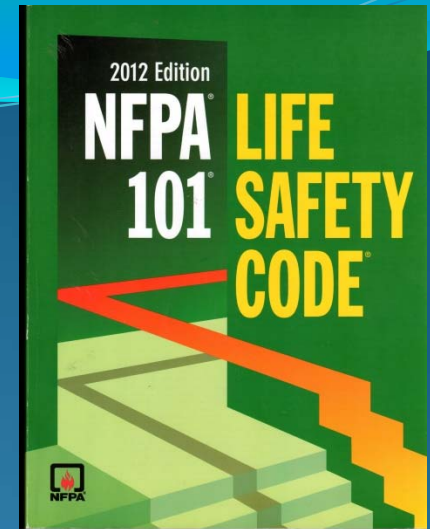


New/Revised Provisions of 2012 LSC

10. ABHR 18/19.3.2.6

AUTOMATIC DISPENSERS ARE PERMITTED, if:

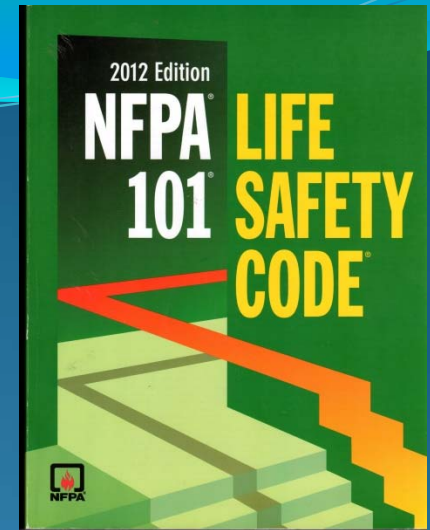
- (1) They do not release contents unless they are activated;**
- (2) the activation occurs only within 4" of the sensing device;**
- (3) any object left near the sensor causes only 1 activation;**
- (4) the dispenser must not dispense more than the amount required for hand hygiene per the label instructions;**
- (5) the dispenser is designed, constructed and operated in a way to minimize accidental or malicious dispensing; and**
- (6) all dispensers are tested per the mfr's instructions each time a new refill is installed.**



New/Revised Provisions of 2012 LSC

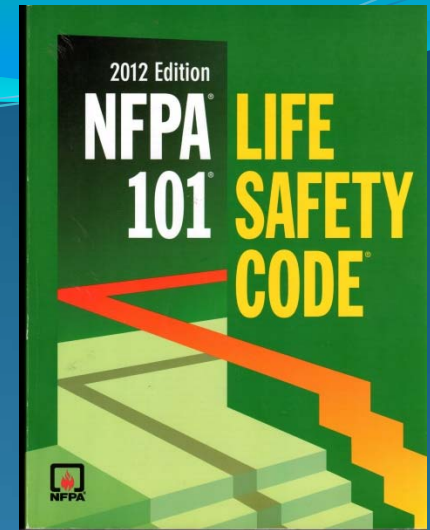
10. ABHR 18/19.3.2.6

The provision refines prior language regarding “above or ADJACENT to an ignition source” as being “WITHIN 1 INCH” of the ignition source.



New/Revised Provisions of 2012 LSC

11. Sprinkler Outages - 18/19.3.5



Section 9.7.5 of the 2012 LSC references NFPA 25, which gives a limit >10 hours in a 24-hour period to implement evacuation or a fire watch.

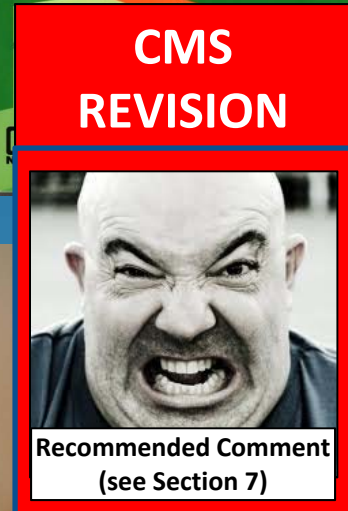
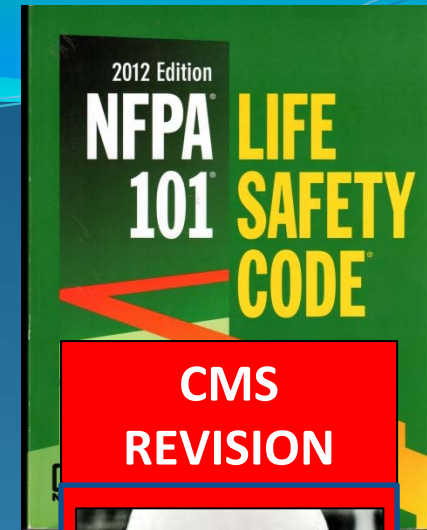
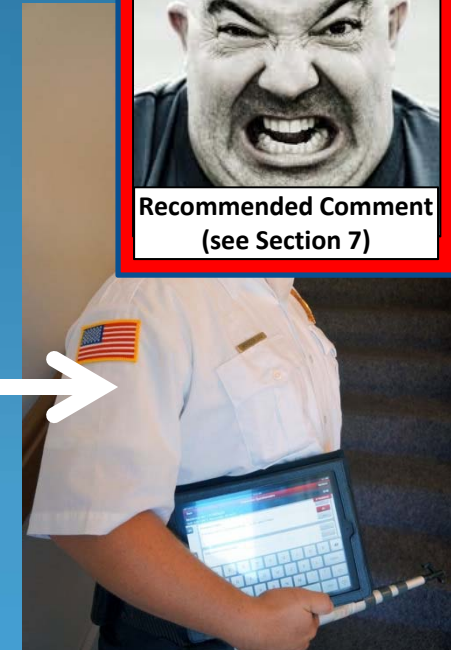
CMS: “retains the prior time frame because of the reliance on facility sprinkler protection system in the LSC, and to ensure a facility is monitored when a sprinkler is out of service”.

[Quote from Federal Register, Published Wed April 16, 2014]

New/Revised Provisions of 2012 LSC

11. Sprinkler Outages - 18/19.3.5

CMS would retain the requirement for EVACUATION OR FIRE WATCH when a sprinkler system is OUT OF SERVICE FOR > 4 HOURS.



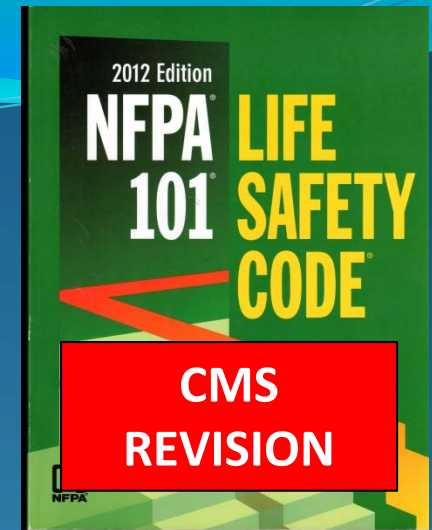
New/Revised Provisions of 2012 LSC

12. Outside Window/Doors – 18/19.3.8

CMS proposes to RETAIN the 2000 LSC requirement that every health care occupancy patient sleeping room have AN OUTSIDE WINDOW OR OUTSIDE DOOR, with new health care occupancies having an allowable sill height not to exceed 36” above the floor with certain exceptions.

This requirement no longer exists in the 2012 LSC.

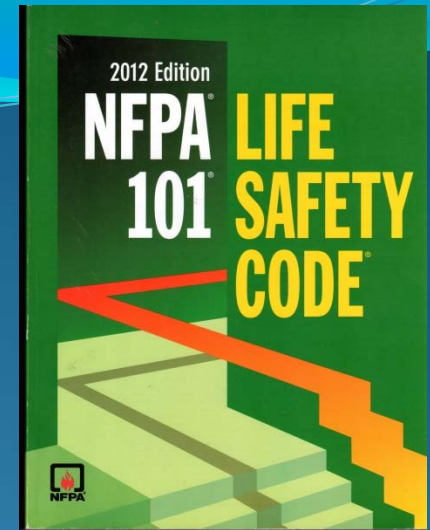
CMS: *“Since outside windows and doors may be used for smoke control, building entry, patient and resident evacuation, we propose to retain this requirement”.*



New/Revised Provisions of 2012 LSC

12. Outside Window/Doors - 18/19.3.8

CMS proposes the following EXCEPTIONS to the outside window or door requirement, as included in the 2000 edition of the LSC:

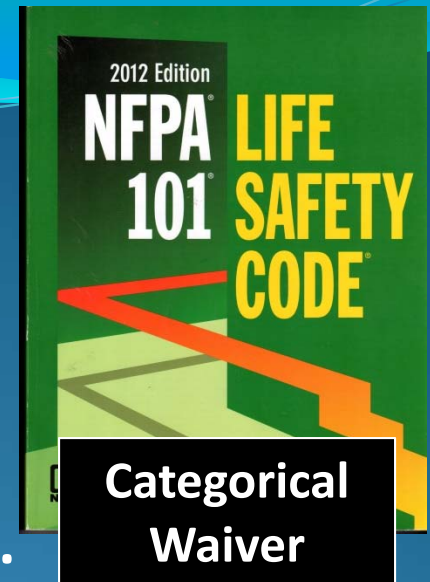


- Newborn nurseries and rooms intended for occupancy for less than 24 hours have no sill height requirements
- Windows in atrium walls shall be considered outside windows for the purposes of this requirement
- The window sill height in special nursing care areas shall not exceed 60 " above the floor.

New/Revised Provisions of 2012 LSC

13. Fireplaces 18/19.5.2.3

Allows DIRECT-VENT GAS FIREPLACES in smoke compartments without the 1 hour fire wall Rating (not inside of any patient sleeping room).



SOLID FUEL-BURNING FIREPLACES are permitted and can be used only in areas other than patient sleeping rooms, and must be separated from sleeping rooms by construction of no less than a 1 hour fire resistance wall rating.

CMS: *“This allows for more options for the location of fireplaces in health care facilities to make the facilities feel more home-like”.*

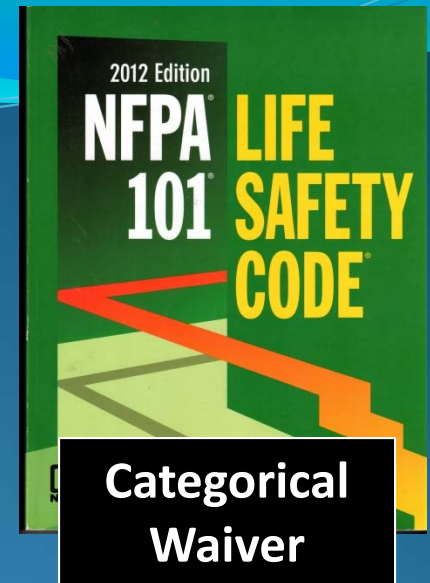
[Quote from Federal Register, Published Wed April 16, 2014]

New/Revised Provisions of 2012 LSC

14. Furnishings & Decorations 18/19.7.5.1

This provision has been revised to ALLOW COMBUSTIBLE DECOR in any health care Occupancy as long as they are flame-retardant or treated with approved fire-retardant coating that is listed and labeled, and meet fire test standards.

The décor (such as photographs, paintings and other art) may be attached directly to the walls, ceilings, and non fire-rated doors as long as it does not interfere with the operation of the doors.

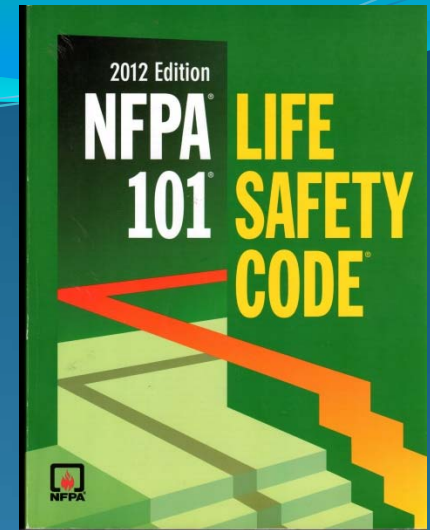


New/Revised Provisions of 2012 LSC

14. Furnishings & Decorations 18/19.7.5.1

Decor may not exceed:

- 1) 20% of the wall, ceiling and door area in a non-sprinkled space
- 2) 30% of the wall, ceiling and doors, in a sprinkled space;
- 3) 50 percent of the wall, ceiling and doors, in any room with a capacity of 4 people (the actual number of occupants in the room may be less than its capacity) in a fully sprinkled smoke compartment



CMS: *“These changes would allow persons to bring their own décor & furnishings, which helps to provide a more home-like setting”.*

[Quote from Federal Register, Published Wed April 16, 2014]

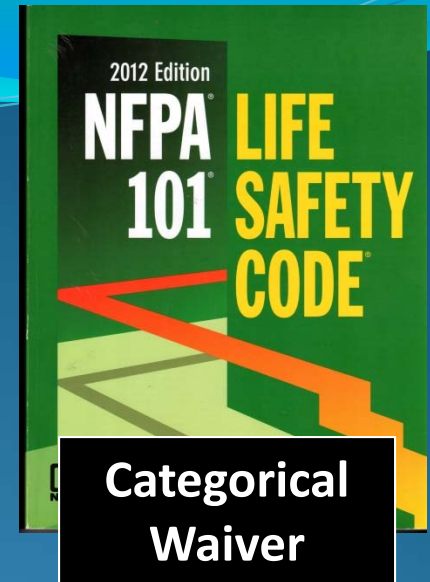
New/Revised Provisions of 2012 LSC

15. Recycling Containers - 18/19.7.5.7.2

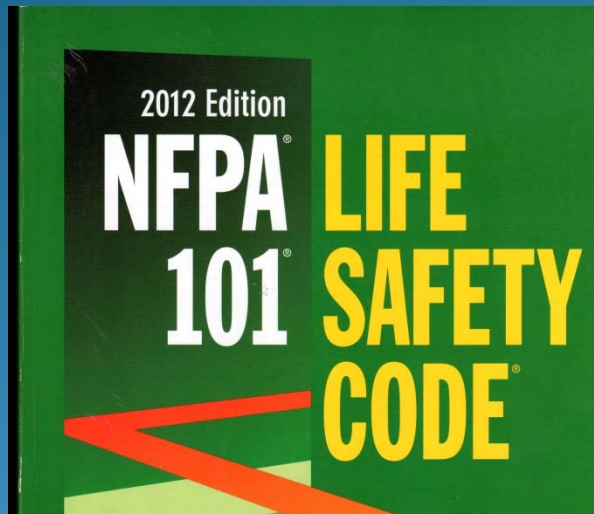
This new provision requires containers used solely for RECYCLING CLEAN WASTE To have a capacity of a MAX 96 GALLONS.

CMS: “In the 2000 edition of the LSC, the container size was limited to 32 gallons. The larger containers allowed in the 2012 edition of the LSC require less frequent emptying, which could reduce housekeeping costs”.

[Quote from Federal Register, Published Wed April 16, 2014]



KEY CHANGES & REVISIONS OF 2012 LSC



HEALTHCARE Chapters 18/19

Key Topic	Providers Affected	
	Hosp,CAH,LTC	
1. Chapter 43	X	Comment
2. Door Locking	CW	
3. Corridor Obstruct	CW	
4. Corridor Projections	R	Comment
5. Sleeping Suite Size	CW	
6. Smoke Control	R	Comment
7. Roller Latches	R	Comment
8. High Rise Sprinklers	X	Comment
9. Corridor Cooking	CW	
10. ABHR	X	Comment
11. Sprinkler Outage	R	Comment
12. Outside Windows	R	Comment
13. Fireplaces	CW	
14. Furnishings & Décor	CW	
15. Recycle Containers	CW	

DON'T MISS YOUR RIGHT TO CHALLENGE CMS IF YOU FEEL THEIR PROPOSAL IS WRONG!

Comments Due: 5 PM JUNE 16, 2014 (Ref CMS-3277-P)

Electronic, Mail, Hand Delivery



You may submit electronic comments on this regulation to *<http://www.regulations.gov>*. Follow the “Submit a comment” instructions.



Contact: Kristin Shifflett (410-786-4133)
Danielle Shearer (410-786-6617)

ADOPTION OF 2012 LSC



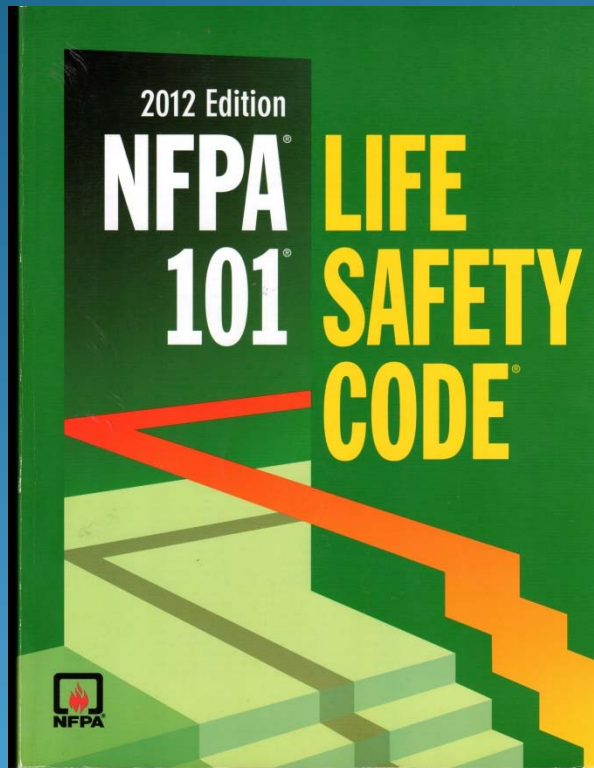


2012 LSC Ambulatory

KEY CHANGES & REVISIONS OF 2012 LSC



AMBULATORY CARE Chapter 20/21



Providers Affected	
Key Topic	Ambul Care
1. Chapter 43	x
2. Interior Doors	x
3. Hazardous Doors	x
4. ABHR	x
5. Sprinkler Outage	R
6. Smoke Control	R

CMS Adopt As-Is

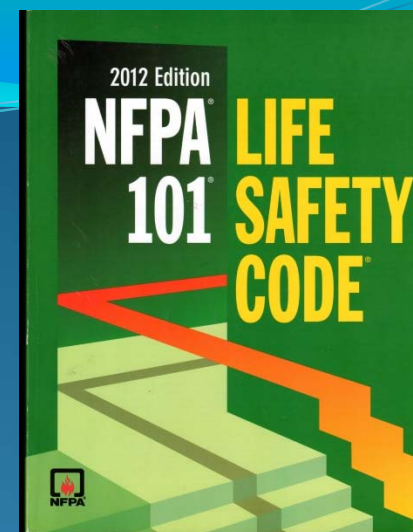
CMS Revised 2012 LSC

AMBULATORY CARE

New/Revised Provisions of 2012 LSC

2. Interior Nonbearing Walls

20.1.6.4 & 21.1.6.5



This new provision allows all interior nonbearing walls that are required to have a minimum 2 hour fire resistance rating to be **CONSTRUCTED OF FIRE-RETARDANT TREATED WOOD** enclosed within noncombustible or limited combustible materials provided that these walls

← "drywall"

← i.e. exit enclosures; occupancy separations.

CMS: "The use of fire-retardant treated wood allows for more flexibility during construction and could reduce the cost of construction."

AMBULATORY CARE

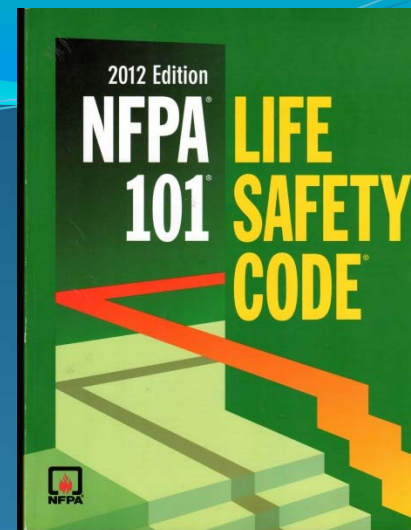
New/Revised Provisions of 2012 LSC

3. Hazardous Doors - 20/21 3.2.1

This new provision requires all doors to hazardous areas to be SELF-CLOSING OR CLOSE AUTOMATICALLY.

CMS: “This provision was added to provide an extra level of protection for all patients. Adding this provision aligns the requirements for both ASCs and Health care occupancies to assure the same basic level of protection for all patients”.

[Quote from Federal Register, Published Wed April 16, 2014]



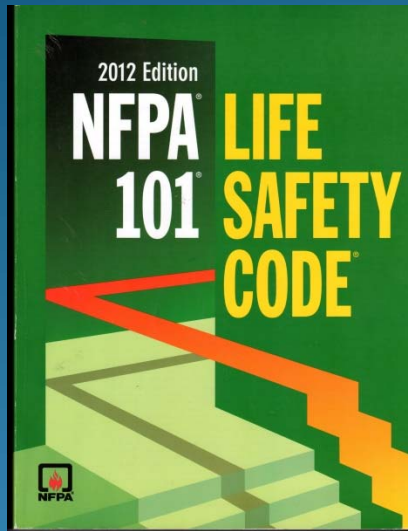
ADOPTION OF 2012 LSC





2012
NFPA 99

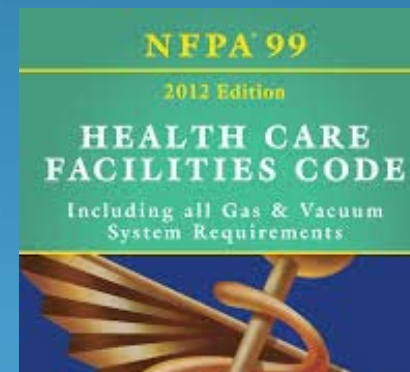
Adoption of:



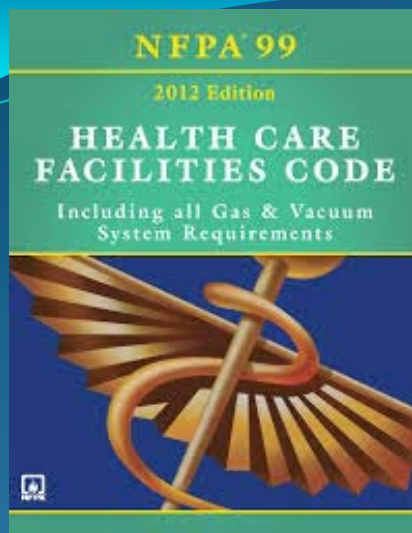
2012
Life Safety Code
(NFPA 101)



2012
Health Care
Facilities Code
(NFPA 99)



CMS: “The 2012 LSC health care occupancy chapters do not reference NFPA 99 requirements for all areas within a health care facility.”



HEALTH CARE

Overview of 2012 NFPA 99

NFPA 99 provides minimum requirements for the installation, inspection, testing, maintenance, performance, and safe practices for health care facility materials, equipment and appliances.

The NFPA 99 has been upgraded from a standard to a code.
CODES describe what to do; **STANDARDS** describe how to comply

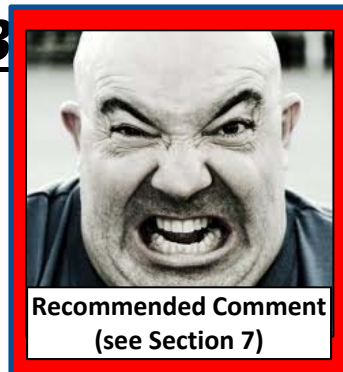
CMS: Adopt NFPA 99, except Chapters 7, 8, 12, & 13

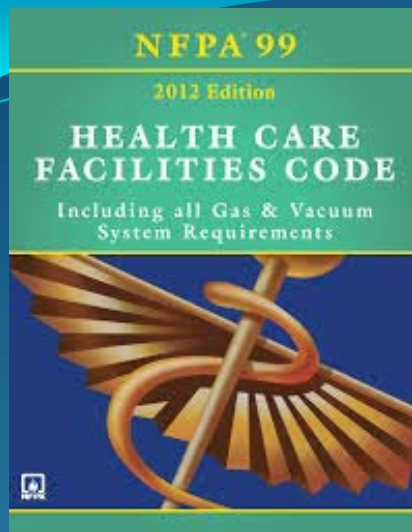
Chapter 7 - Telecommunication

Chapter 8 - Plumbing

Chapter 12 – Emergency Prep

Chapter 13 – Security





HEALTH CARE CODE

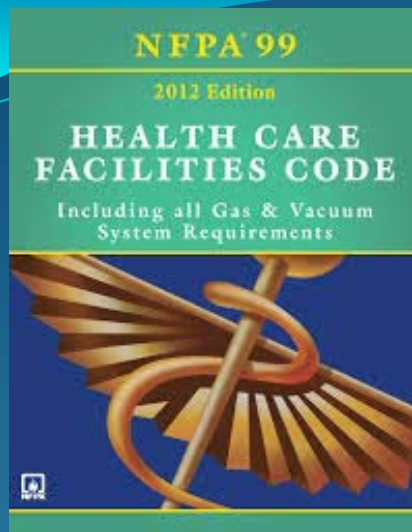
Chapter 4 - Fundamentals

Chapter 4 is new to the 2012 edition and provides guidance on how to apply NFPA 99 requirements to health care facilities based on “categories” determined by a risk-based methodology

A risk-based approach offers requirements based on the types of treatment and services being provided to patients or residents, rather than the type of facility in which they are being performed



The Joint Commission



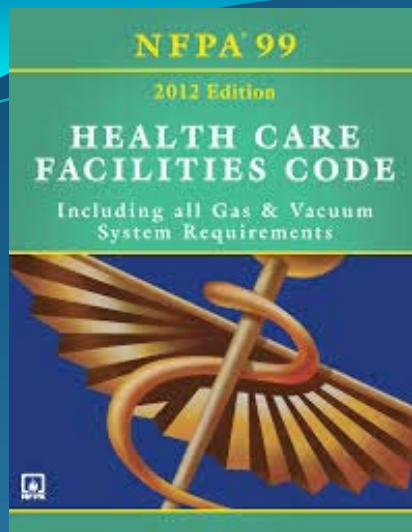
HEALTH CARE CODE

Chapter 4 - Fundamentals

The risk-based approach allows a facility to **CUSTOMIZE** the level of protection for individual areas based on its risk to patients, and no longer applies the same requirements throughout an entire facility.

- Risk assessment conducted by qualified facility personnel
- Implement less stringent requirements in areas of lower risk
- Implement more stringent requirements higher risk areas

CMS: “This allows facilities to apply the most appropriate level of protection in an efficient and economical manner”



HEALTH CARE CODE

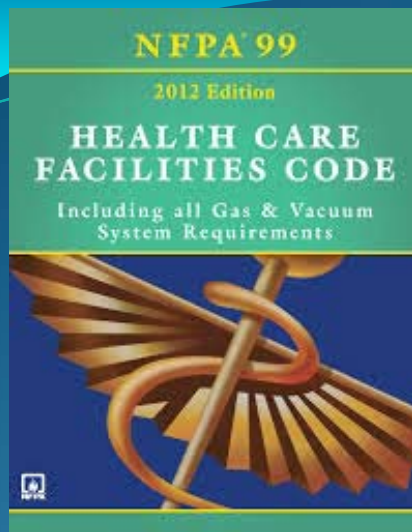
Chapter 4 - Fundamentals

4 categories risk, based on the types of treatment and services being provided to patients or residents.

CATEGORY 1 (Section 4.1.1) : “Facility systems in which failure of such equipment or system is likely to cause MAJOR INJURY OR DEATH of patients or caregivers”

Examples of what a major injury could include:

- amputation or
- burn to the eye



HEALTH CARE CODE

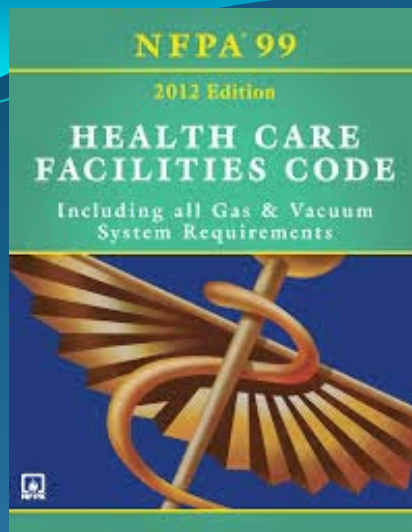
Chapter 4 - Fundamentals

4 categories risk, based on the types of treatment and services being provided to patients or residents.

CATEGORY 2 (Section 4.1.2): “Facility systems in which failure of such equipment is likely to cause MINOR INJURY to patients or caregivers”

Examples of what a minor injury could include:

- as one that is not serious or involving risk of life.

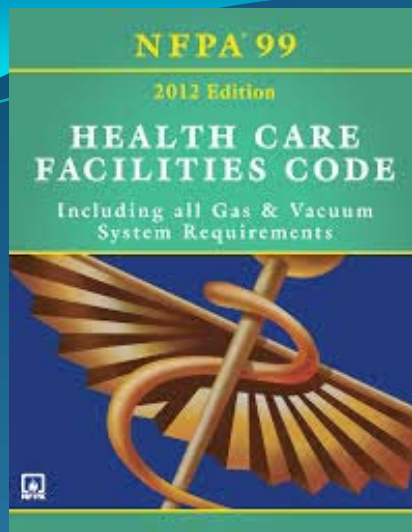


HEALTH CARE CODE

Chapter 4 - Fundamentals

4 categories risk, based on the types of treatment and services being provided to patients or residents.

CATEGORY 3 (Section 4.1.3): “Facility systems in which failure of such equipment is NOT LIKELY TO CAUSE INJURY to patients or caregivers, but can cause patient discomfort”

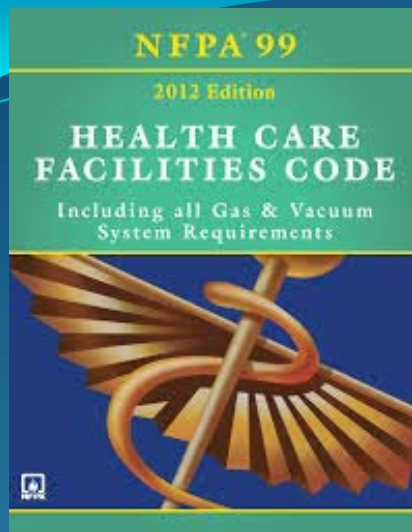


HEALTH CARE CODE

Chapter 4 - Fundamentals

4 categories risk, based on the types of treatment and services being provided to patients or residents.

CATEGORY 4 (Section 4.1.4): “Facility systems in which failure of such equipment would have NO IMPACT on patient care”



HEALTH CARE CODE

Chapter 4 - Fundamentals

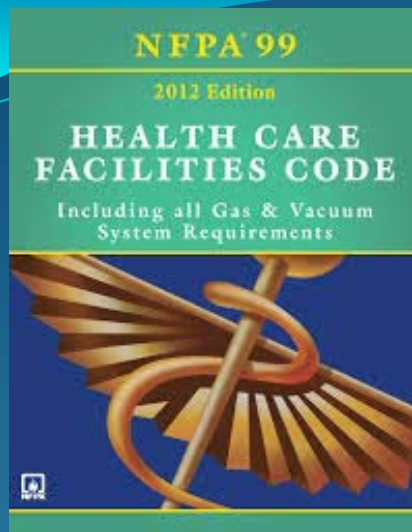
Section 4.2 requires each health care or ambulatory occupancy to define its risk assessment methodology, implement the methodology and document the results.

CMS does not require any particular risk assessment procedure.

Section A.4.2 provides EXAMPLES OF APPROPRIATE RISK ASSESSMENT PROCEDURES, such as

- **ISO/IEC31010, *Risk management—Risk Assessment*, or**
- **NFPA 551, *Guide for the Evaluation of Fire Risk Assessments*.**

Recommend: Buy NOW & implement



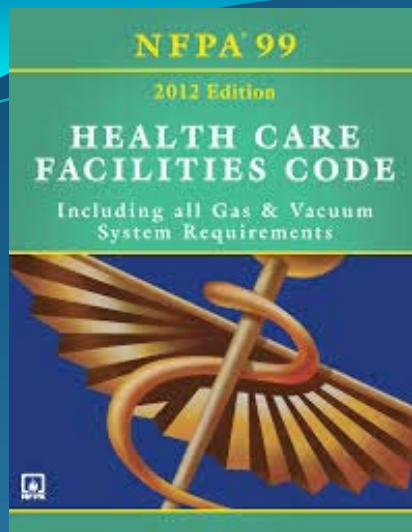
HEALTH CARE CODE

Chapter 5 – Gas & Vacuum

Section 5.1.14—Category 1 Op & Management

Includes information on the operation and maintenance of medical gas, vacuum, WAGD and support gas systems. Covers:

- **System limitations, maintenance programs, inspection and testing, management of flexible connections,**
- **Piping and valve labeling, and recordkeeping**
- **Allows flexibility in the maintenance program by focusing on the basic goals, timing, and qualifications for the work**
- **Does not require a specific schedule; Facility to determine the frequency of maintenance based on the original quality, age and longevity, and known characteristics of the equipment**



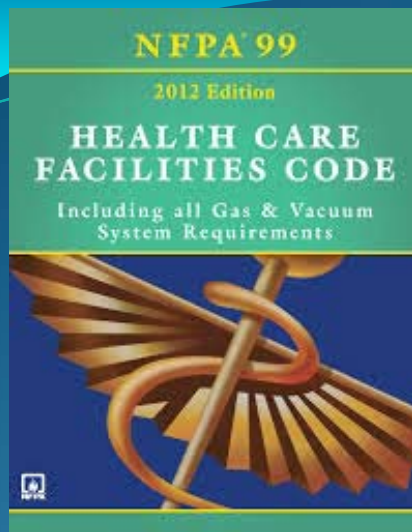
HEALTH CARE CODE

Chapter 5 – Gas & Vacuum

Section 5.2 Category 2 Piped Gas and Vacuum

Apply to patients who might require the gases occasionally, but ordinarily would not require them & short term use. Covers:

- **Virtually the same requirements as for Category 1, except some equipment is permitted to be simplex rather than duplex.**



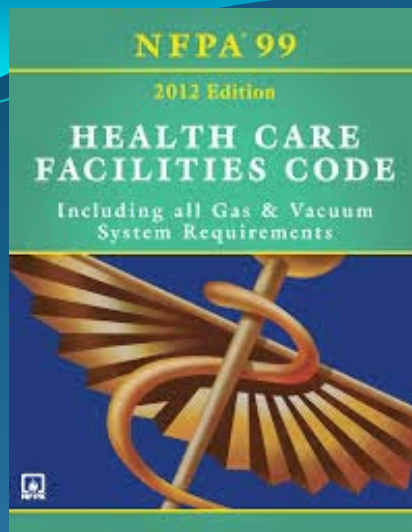
HEALTH CARE CODE

Chapter 6 – Electrical

Section 6.3.3—Performance Criteria and Testing

Covers performance criteria. Electrical systems that support patient rooms are required to be **TESTED** to ensure that they are safe and reliable. Includes:

- Grounding system testing
- Voltage measurements
- Impedance measurements
- Testing equipment
- Receptacle testing
- Isolated power systems testing
- Ground-fault protection testing



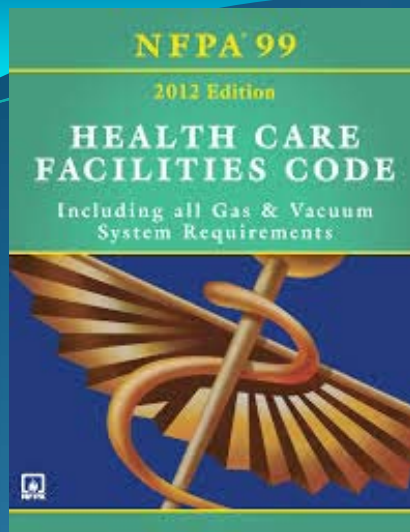
HEALTH CARE CODE

Chapter 6 – Electrical

Section 6.3.4—Administration

includes information on the frequency of electrical system component testing and record keeping requirements. Includes:

- HOSPITAL-GRADE RECEPTACLES are required at patient bed locations and in locations where deep sedation or general anesthesia is administered; testing must be performed after initial installation, replacement, or servicing of the device
- Receptacles NOT LISTED AS HOSPITAL-GRADE must be tested in intervals not exceeding 12 months
- Minimum acceptable DOCUMENTATION must identify what was tested, when it was tested & if it performed successfully



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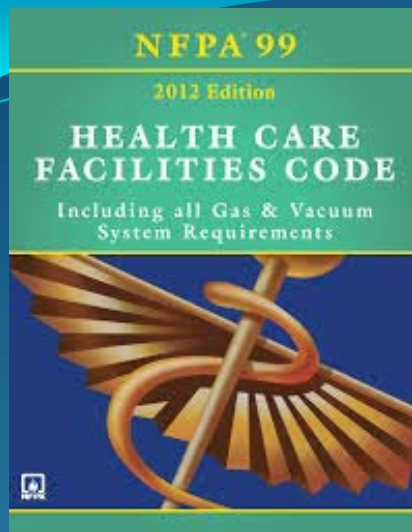
Chapter 6 – Electrical

Section 6.4.3—Performance Criteria & Testing

Covers EES Type 1 performance criteria to assure that the EES is safe and reliable.

Includes:

- Maintenance, inspection and testing of the EES alternate power source, including generator testing criteria, test conditions, and testing personnel qualifications
- Specific maintenance, inspection and testing requirements are also required through reference to NFPA 110, Standard for Emergency and Standby Power Systems
- Maintenance & testing of EES circuitry
- Record keeping requirements.

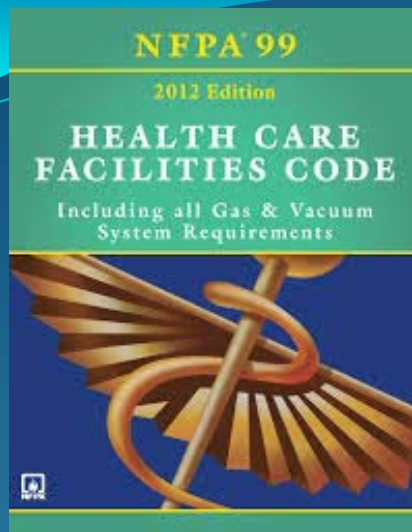


HEALTH CARE CODE

Chapter 9 – HVAC

New chapter requires HVAC systems to be in accordance with ASHRAE STANDARD 170 – 2008, Ventilation of Health Care Facilities, to create acceptable indoor air quality.

- Does not apply to existing HVAC systems, but would apply to the construction of new health care facilities, and the altered, renovated, or modernized portions of existing systems or individual components.
- Ensure minimum levels of heating, ventilation and air conditioning performance in patient and resident care areas.



HEALTH CARE CODE

Chapter 9 – HVAC

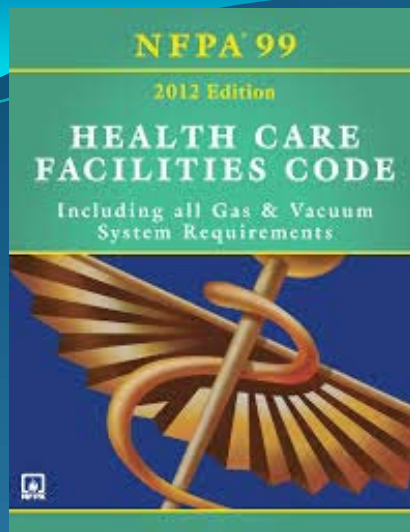
Section 9.3.1 – HVAC & Process Systems

Defines design requirements for ventilation systems to assure a clean & comfortable environment that minimizes odors

- **Apply to patient care areas and other related support areas within a health care facility**
- **Considers chemical, physical and biological contaminants that can affect the delivery of medical care to patients, the recovery of patients, and the safety of patients, health care workers, and visitors.**

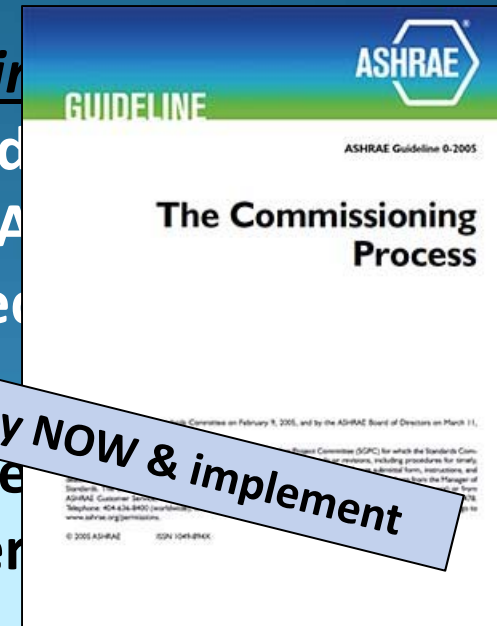
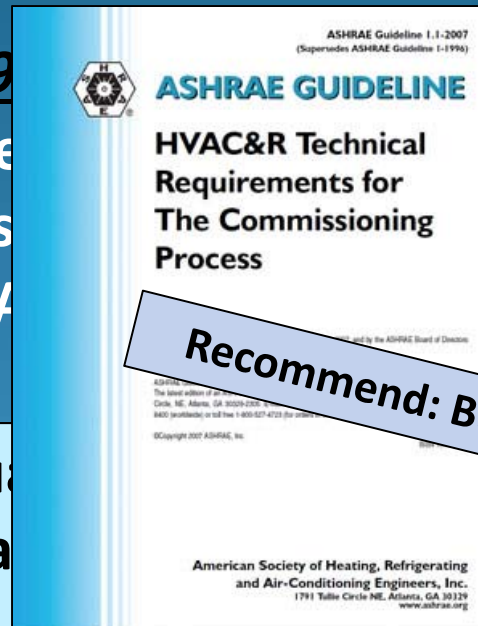
HEALTH CARE CODE

Chapter 9 – HVAC



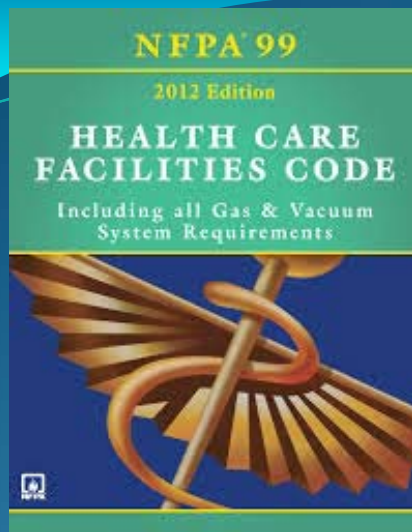
Section 9

Performance Commissioning 1.1, "HVAC"



Recommend: Buy NOW & implement

- **COMMISSIONING** is a quality assurance process for new HVAC systems and a set of objectives and criteria.
- CMS considers **ASHRAE Guideline 0 & Guideline 1.1** as the only acceptable documents guiding the commissioning process.

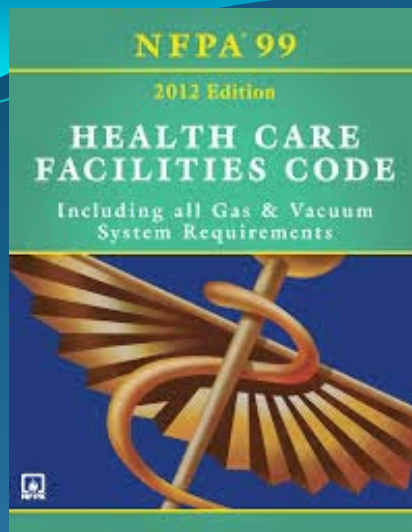


HEALTH CARE CODE

Chapter 10 – Elec Equipment

Covers the performance, maintenance, and testing of electrical equipment, fixed & portable electrical equipment , and information on administrative issues.

CMS: “There has been an increased need for electrical safety requirements due to the increase in the use of electrical circuits and multiple appliances that are located close to the patient's body, including situations where they enter the patient's body (such as internal defibrillators, and neurostimulators).”



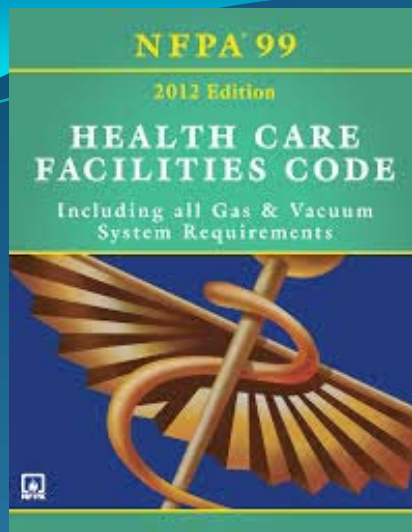
HEALTH CARE CODE

Chapter 10 – Elec Equipment

Section 10.4—Non-patient Electrical Equipment
Discusses proper **TESTING** of equipment that may not be patient care related, but may be in the **VICINITY OF THE PATIENT** and could pose an electrical hazard to the patient

Non-patient electrical appliances may include:

- Entertainment devices
- Computers
- Displays and such



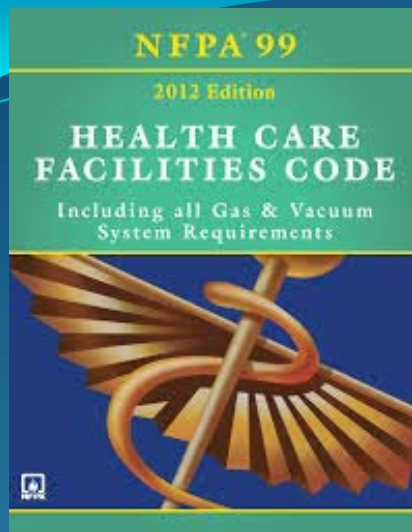
HEALTH CARE CODE

Chapter 10 – Elec Equipment

Section 10.5—Administration

Requires policies for testing of equipment, proper use of elec equip during O2 therapy & oxygen enriched environment. Covers:

- **Lab equipment use, inspection, and maintenance**
- **Records on performance testing and repairs of patient care equipment**
- **Equipment used/maintained by qualified/trained personnel.**



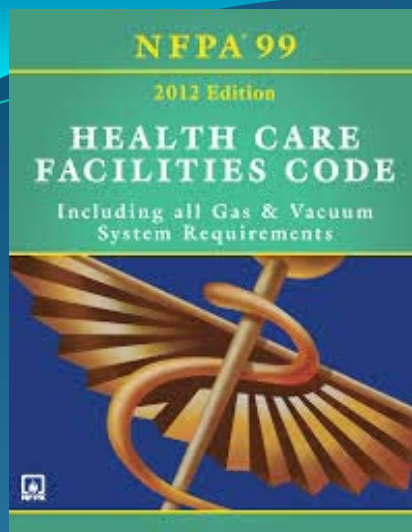
HEALTH CARE CODE

Chapter 11 – Gas Equipment

Section 11.4—Performance Criteria and Testing

Includes:

- Testing of portable patient gas equipment
- Proper handling of gas containers for respiratory therapy
- Safety procedures for non-patient gas equipment
- Laboratory proper handling of gas equipment



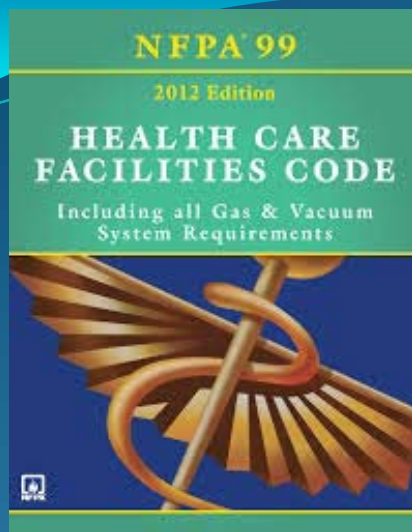
HEALTH CARE CODE

Chapter 14 – Hyperbaric Equip

Section 14.3—Administration and Maintenance

Administration and maintenance of hyperbaric facilities and hyperbaric chambers

- Designate a Safety Director
- Develop management policies and emergency procedures
- Fire training of operating personnel
- Policies on types of medical devices or equipment can be used in the chamber,
- Policies on safe use of medical gases, electrical equipment, and fire protection equipment used in the chamber

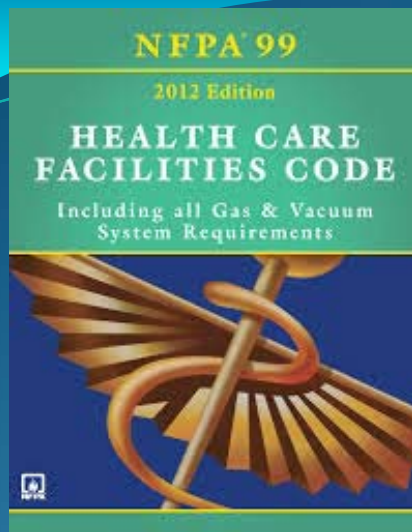


HEALTH CARE CODE

Chapter 15 – Features of Fire Protection

Covers the performance, maintenance, and testing of fire protection equipment in health care facilities

- **Requirements for inspection, testing and maintenance apply to all facilities**
- **Issues addressed range from the use of flammable liquids in an operating room to special sprinkler protection**
- **Fire protection requirements are independent of the risk-based approach, as they are applicable to all patient care areas in both new and existing facilities.**

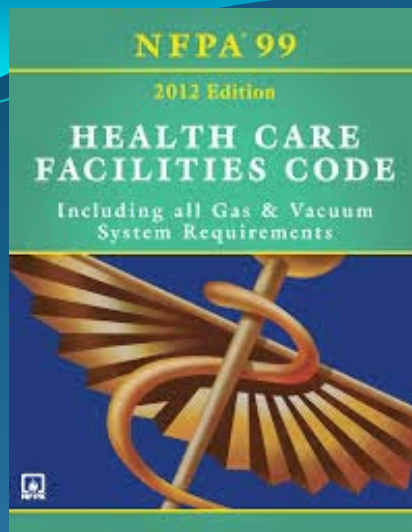


HEALTH CARE CODE

Chapter 15 – Features of Fire Protection

Has several sections taken directly from the NFPA 101, including requirements for the following:

- **Construction and compartmentalization**
- **Laboratories**
- **Utilities**
- **Elevators & Escalators & Conveyors**
- **Incinerators, Rubbish & Laundry Chutes**
- **Fire detection, alarm and communication systems**
- **Automatic sprinklers and other extinguishing equipment**
- **Compact storage (mobile storage and maintenance)**
- **Testing of water based fire protection systems**



HEALTH CARE CODE

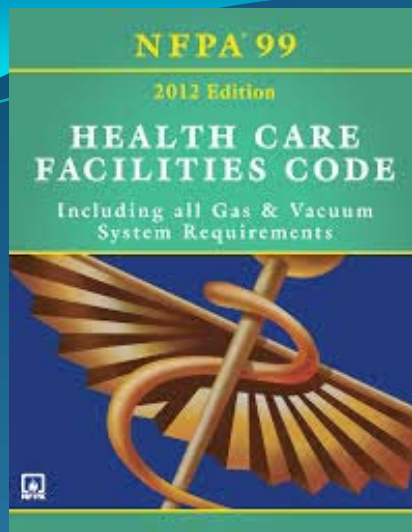
Chapter 15 – Features of Fire Protection

Section 15.13 - Operating rooms

Covers hazard assessment, fire prevention, handling flammable germicides and antiseptics, emergencies, and orientation and training.

Section 15.13.1—Hazard Assessment

Assessment of hazards that a facility could encounter during a surgical procedure, and the periodic review of surgical operations and procedures.



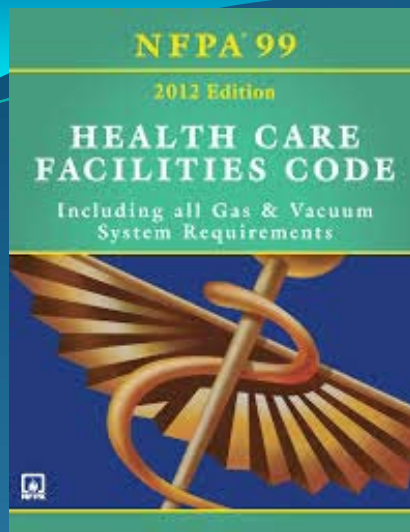
HEALTH CARE CODE

Chapter 15 – Features of Fire Protection

Section 15.13.3—Germicides and Antiseptics

Covers procedures for the safe handling of flammable materials in operating rooms.

- **Operational procedures on the fire hazards of flammable materials, packaging and material handling, removing solution-soaked materials, preventing pooling of material**
- **Preoperative “time-out” period to allow for drying before patient draping**
- **Policies and procedures to outline safety precautions.**



HEALTH CARE CODE

Chapter 15 – Features of Fire Protection

Section 15.13.3.9—Emergency Procedures

Requires emergency procedures in case of fire, or chemical spills in the operating room, alarm activation, evacuation and equipment shutdown.

ADOPTION OF 2012 NFPA 99



Recommended Comments to CMS

The following recommendations are solely those of Lauzon Life Safety Consulting, LLC, and do not reflect an official opinion of WHEA. Participants are urged to submit their own comments to CMS prior to 5 pm on June 16, 2014 . You are free to copy any of these recommendations or scan and submit “as-is” under your cover e-mail. Doing nothing will ensure the creation of code requirements that all will have to contend with for the next 15 years. Act NOW.

It is best for comments to be original; however, if you do not have the time to generate your own comments, feel free to copy & edit the following pages so they reflect your concerns. Include information on how the rule would affect your facility and support your claims with facts, data, and science. Public comments are not votes. One well supported comment can be more influential than a thousand form letters

If you are commenting on a particular sentence in the rule, provide the page number, column, and paragraph citation from the federal register.

**DON'T MISS YOUR RIGHT TO CHALLENGE CMS
IF YOU FEEL SOMETHING IS WRONG!**

Comments Due: 5 PM JUNE 16, 2014 (Ref CMS-3277-P)

Electronic



**You may submit electronic comments on this
regulation to *<http://www.regulations.gov>*.
Follow the “Submit a comment” instructions.**

Recommended Comments to CMS

1. CMS Adoption Process
2. Waiver Without a Citation
3. Corridor Projections
4. Roller Latches
5. High-Rise Sprinklers
6. ABHR
7. Sprinkler Outages
8. Adoption of NFPA 99
9. Chapter 43 – Renovation
10. Windowless Smoke Control
11. Window Requirements in ER Observation Rooms
12. One Patient Definition of Healthcare



**MS Word Versions Have been POSTED
at Lauzon-LSC.com (download for FREE) & SUBMIT!**

FACILITY COMMENT ON: **CMS ADOPTION PROCESS**

CMS Statement in Proposal, 4/16/2014: *No comments*

Facility Comment: We support the CMS proposal to update life safety standards and believes CMS should keep standards current in the future. We support changes to NFPA 101, NFPA 99, and the International Codes that reduce conflicts between various requirements and are appropriate to health care delivery models. The 2012 editions of NFPA 101 and NFPA 99 reflect this work as well as other initiatives that promote greater flexibility in applying codes and standards appropriately to health care facilities.

It is important for CMS to adopt the latest codes without modification to ensure consistency between the multiple regulations enforced in health care. We have identified a few concerns with the proposed CMS rule because the proposed rule makes substantial changes to these two codes.

NFPA, like other standards making organizations, uses a public consensus process to debate points and ensure that provisions of the codes are appropriate for health care facilities. We have an overarching expectation of the various NFPA technical committees responsible for the changes in codes and standards to make changes that are backed by good science, defensible economics, informed policy making, and clear decision authority.

Our fundamental disagreement with the proposed CMS rule is the lack of open, transparent discussion and lack of evidence or good science to warrant the proposed deviations from the codes that so many of our nation's experts reviewed, debated, studied, and researched.

Facility Recommendation: We strongly encourage CMS to adopt the LSC in its entirety, without modification.

FACILITY COMMENT ON: **WAIVER WITHOUT A CITATION**

CMS Statement in Proposal, 4/16/2014: *"We do not consider it always necessary for a facility to be cited before it can apply for or receive a waiver. This is particularly the case when we have evaluated specific provisions of the LSC, determined that a waiver would arguably apply to all similarly-situated facilities with respect to the LSC requirement in question, and issued a public communication describing the specifics of such a categorical waiver, including any particular requirements that must be met in order for the waiver to apply to a facility."*

Facility Comment: We recognize CMS as the sole authority to grant waivers, and support and encourage CMS to continue their review of newer codes and standards that may lead to future categorical waivers to the benefit of all health care providers with similar circumstances. However, it has been the standard practice of CMS to decline to review waiver requests for specific LSC deficiencies that health care providers may have, since they have not been cited during an accreditation survey or a state agency survey on behalf of CMS.

Most health care facility managers are conscientious individuals who seek to perform a credible performance in maintaining their facility safe for their patients. When confronted with a LSC deficiency that presents an unreasonable hardship and cannot be resolved (or would take multiple years to resolve) they seek alternative methods to achieve compliance. For the sake of this discussion, and assuming a Fire Safety Evaluation System (FSES) equivalency is not a valid alternative, a waiver request is the facilities manager last option. It would be advantageous to the health care provider if CMS would allow them to submit waiver requests through their accreditation organization or state agency on behalf of CMS, to the respective CMS regional office for their review and approval.

CMS may consider it acceptable for facility managers to wait until their triennial survey, and then identify the LSC deficiency for which they seek a waiver so it can be cited on the survey report. This is contrary to the way that most (if not all) facility managers reason and operate. First, most facility managers would not identify LSC deficiencies to a surveyor or inspector during a survey. Secondly, many facility managers performance reviews are tied to the quantity and type of deficiencies cited during an accreditation survey or a validation survey. It is natural for these facility managers to remain silent if presented the opportunity to identify LSC deficiencies to a surveyor or inspector.

By not permitting health care providers with the opportunity to submit waiver requests prior to the LSC deficiency being cited during a survey, CMS is inadvertently creating an environment whereby facility managers are becoming passive about LSC compliance, and may likely take the attitude of not attempting to self-identify LSC deficiencies and implement alternative life safety measures.

CMS has already set a precedent of approving categorical waivers for specific issues prior to a health care provider being cited during a survey. While these categorical waivers are based on newer editions of the NFPA codes and standards, the precedent is set where CMS has granted waivers before the organization was cited.

Facility Recommendation: We strongly encourage CMS to consider this request to allow health care providers the ability to submit waiver requests before they are cited during a survey.

FACILITY COMMENT ON: **CORRIDOR PROJECTIONS**, 18/19.2.3.4(2)

CMS Statement in Proposal, 4/16/2014: *"...while the LSC allows facilities to have 6 inch projections, so long as the ADA standard is 4 inches then facilities should only have 4 inch projections to comply with the more stringent requirement set forth by the ADA."*

Facility Comment: The Americans with Disabilities Act (ADA) is only applicable to new construction or renovation of existing conditions, and is not retroactive to existing conditions. Many health care facilities were constructed prior to the enforcement of the ADA, and have corridor projections that exceed the ADA limit of 4 inches.

Facility Recommendation: We strongly encourage CMS to consider requiring health care providers to comply with the ADA corridor projection limits of 4 inches for new construction and renovation of existing areas only.

FACILITY COMMENT ON: **ROLLER LATCHES**, 18.3.6.3.9.1 & 19.3.6.3.5

CMS Statement in Proposal, 4/16/2014: *“Many roller latches in fire situations failed to provide adequate protection to residents in their rooms during an emergency. Therefore, roller latches would be prohibited in existing and new Health Care Occupancies, and corridor doors would be required to have positive latching devices.”*

Facility Comment: We agree with the concept that roller latches are a safety hazard on corridor doors that are required to latch. However, some corridor doors are not required to latch, such as doors to toilet rooms, shower rooms, and bath tub rooms, where no combustibles are stored. There should be no penalty if an organization wants to use roller latches in situations where corridor doors are not required to latch. Also, doors to patient rooms inside a sleeping suite are not required to latch either, and similarly, roller latches should be permitted inside a suite if the organization chooses to use them.

Facility Recommendation: We strongly encourage CMS to alter their final rule to distinguish that roller latches are not permitted on corridor doors that are required to latch.

FACILITY COMMENT ON: **HIGH-RISE SPRINKLERS**, 18/19.4.2

CMS Statement in Proposal, 4/16/2014: *"We would like to solicit public comments regarding the phase-in period of 12 years, including if 12 years is enough time for the installation of sprinklers in high-rise buildings."*

Facility Comment: As CMS pointed out in their proposed rule, the 2012 LSC allows a 12-year period from the time the authority having jurisdiction adopts the 2012 LSC for existing high-rise healthcare facilities to comply with the requirement to become fully protected with automatic sprinklers. Automatic sprinklers are the number one most effective fire-safety measure an organization can provide that will save lives in the event of a fire. A healthcare facility that qualifies as a high-rise building will need additional time to evacuate their patients (compared to a non-high-rise healthcare facility) in the event of a fire, and sprinklers can contain and/or extinguish a fire and provide the much needed extra time.

Facility Recommendation: We believe 12 years is more than sufficient time to become fully sprinkled for high-rise healthcare facilities, and encourage CMS to consider a more reasonable time period of 6 to 8 years.

FACILITY COMMENT ON: **ABHR**, 18/19.3.2.6

CMS Statement in Proposal, 4/16/2014: *no comments*

Facility Comment: The 2012 edition of the LSC provides for changes in how health care providers use alcohol based hand-rub (ABHR) dispensers in their facility. The 2012 edition of the LSC only discusses healthcare occupancies and ambulatory health care occupancies when it addresses ABHR dispensers, but the 2012 LSC seems to have omitted allowing ABHR dispensers in corridors of business occupancies.

Section 38/39.3.2 of the 2012 edition of the LSC references section 8.7 on the protection of hazards. Section 8.7.3.2 states: *“No storage or handling of flammable liquids or gases shall be permitted in any location where such storage would jeopardize egress from the structure, unless otherwise permitted by 8.3.7.1.”* Thus, the mounting of ABHR dispensers in corridors of business occupancies could be considered handling of flammable liquids, and according to the 2012 LSC, is not permitted.

Many health care facilities have multiple occupancy types in their facility, including business occupancy, and according to this section of the LSC, ABHR dispensers would not be permitted in the corridors.

Facility Recommendation: We strongly encourage CMS to address this apparent oversight by the NFPA technical committee(s) who omitted allowing ABHR dispensers in business occupancies of healthcare facilities. Whatever risk there is of ABHR dispensers mounted in the corridors of healthcare occupancies, it is the same and no greater risk when mounted in the corridors of business occupancies.

FACILITY COMMENT ON: **SPRINKLER OUTAGES**, 18/19.3.5

CMS Statement in Proposal, 4/16/2014: *“Because of the increased reliance upon a facility sprinkler protection system in the 2012 edition of the LSC, and to ensure a facility is adequately monitored when a sprinkler system is out of service, we propose to retain the requirement for evacuation or a fire watch when a sprinkler system is out of service for more than 4 hours.”*

Facility Comment: We fail to see the increased reliance on the sprinkler system that CMS refers to, other than high-rise buildings required to be fully sprinkled. To the contrary, NFPA has indicated a lessening on the reliance of the building sprinkler system as indicated by the changes made to the 2011 edition of NFPA 25 which has reduced the requirement to test vane-style water flow switches from quarterly to semi-annually; and the same standard reduced the requirement to test electric driven fire pumps from weekly to monthly.

The NFPA technical committee’s rationale to increase the required time period from 4 hours to 10 hours to either evacuate the building or conduct a fire watch when the sprinkler system is impaired, is based on the belief that sprinkler contractors will be working on the sprinkler system during a normal weekday 8-hour daytime work shift. With the extra manpower that contractors can offer, and the maximum staffing that weekday day-time shifts can provide, it makes perfect sense to allow a 10-hour window that the sprinkler system is impaired before a fire watch is required. Otherwise, if the 4-hour time period is retained, then unnecessary extra staff will have to perform a fire watch that is not necessary during the daytime shift.

2012 LSC, 9.6.1.6 retains the 4-hr outage criteria for the fire alarm system. If the fire alarm is operational when the sprinkler system is impaired, the code recognizes that the available smoke detection system and staff awareness are sufficient safeguards to provide a safe environment during a 10 hour sprinkler outage.

Facility Recommendation: We strongly encourage CMS to allow the 10-hour window before a fire watch is required for daytime staffing periods during a normal weekday 1st & second shifts. For third shift, and when staffing levels are lower, such as weekends and holidays, then the 4-hour window before a fire watch is required makes more sense. The majority of work conducted on sprinkler systems in healthcare facilities is conducted during the weekday 1st shift.

FACILITY COMMENT ON: ADOPTION OF 2012 NFPA 99

CMS Statement in Proposal, 4/16/2014: “In order to ensure the minimum level of protection afforded by NFPA 99 is applicable to all patient and resident care areas within a health care facility, CMS is proposing the adoption of the 2012 edition of NFPA 99, with the exception of chapters 7, 8, 12, and 13.”

Facility Comment: In another section of the proposed rule, CMS states the reason to not adopt chapters 7, 8, and 13 is because CMS believes these chapters are not within the scope of the conditions of participation and conditions for coverage. Chapter 7 is on Information Technology and Communication Systems; chapter 8 is on Plumbing; and chapter 13 is on Security Management. Chapter 12 is on Emergency Management and that subject is already covered by a CMS proposed rule issued in December, 2013.

Chapter 7 on “Information Technology and Communication” primarily concerns itself with telecommunications, which is critically important when patients need to communicate with nurses through nurse call systems; physicians need to communicate with health care providers; and incident commanders need to communicate with their regional emergency operations centers. Chapter 7 includes:

- Not less than two physically separate service entrance pathways into the facility are required;
- Electronic storage with a minimum capacity to store all inpatient records shall be provided at the building
- Further restrictions and location requirements on the entrance facility for telecommunication and equipment room including: Power requirements, environmental requirements, fire suppression, nurse call systems.

Chapter 13 is titled “Security Management” and while the initial content of this chapter appears to be a duplication of another accreditation organization’s standards, the chapter does provide significant guidance and standards on critically important security elements and measures that provide a safe environment for the patients, includes: Security management plan, Security vulnerability assessment, Identification of responsible person to manage security activities by leadership, Identifying and protecting security sensitive areas, Ingress and egress control, Media control Crowd control, Security equipment, Security operations, and Program evaluation. This chapter covers more content than any accreditation organization standard on security management, and is very useful and appropriate in the overall plan to provide a safe environment for the patients.

We understand CMS’s reluctance to adopt chapter 8 on plumbing, since it appears to be a duplication of state and local codes. it has very little content to offer. We understand that CMS has their own proposed rule on Emergency Management that makes chapter 12 a duplication.

We disagree with CMS in regards to not adopting chapters 7 and 13. The subject matter in these chapters is very much within the scope of the conditions for participation in regards to hospital health care facilities providing a safe environment for patients. The content of chapter 7 and 13 can be very helpful to hospital health care organizations as the accreditation organizations do not have standards on all of this information.

Facility Recommendation: We strongly encourage CMS to reconsider and adopt chapters 7 and 13 in their final rule.

FACILITY COMMENT ON: CHAPTER 43 - RENOVATION

CMS Statement in Proposal, 4/16/2014: “This clarification will assist health care facilities by reducing costs for minor construction projects.”

Facility Comment: We applaud CMS and NFPA for recognizing that renovations in existing buildings are not always a major overhaul of an entire area and that the degree of changes should dictate the degree of implementing new code requirements. However, we disagree with the implementation trigger for when Chapter 43 takes effect:

- Follow new code requirements IF building plans not approved by the rule's effective date
- Follow new code requirements IF begin construction after the effective date of this regulation
- Follow existing code requirements IF constructed before the effective date of this regulation

The facility and designer has no control over the date of when the plan review authority having jurisdiction will actually approve a set of plans for construction. In Wisconsin, this may be anywhere from 30 to 130 days after submittal. If a building plan is designed under the current code and submitted prior to the effective date, it may be found to be out of compliance if the actual date of AHJ approval is even one day past the code adoption date. Similarly, if a set of plans is approved just prior to the effective date of the regulation, but construction is not able to start prior to the effective date, the design may be found to be out of compliance since work could not be immediately mobilized. Also, if a construction project is not fully completed prior to the effective date, it may be found out of compliance with new requirements.

Facility Recommendation: We strongly encourage CMS to use the submittal date of construction plans for plan review to be the “trigger” to apply Chapter 43.

FACILITY COMMENT ON: **WINDOWLESS SMOKE CONTROL** 18/19.3.2.3

CMS Statement in Proposal, 4/16/2014: ““The smoke control protects the anesthetizing location until surgical procedures can be completed. Fires continue to occur in ORs.” <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm282810.htm>.

Facility Comment: We applaud NFPA for recognizing that smoke control systems do not any degree of safety in windowless anesthesia locations. The original smoke control requirement appeared in the 1960 version of NFPA 56A. The technical committee on Mechanical Systems revised the code language to specifically state that smoke purge is not required in windowless anesthetizing locations. The requirement was considered to be a relic left over from when it was first incorporated into an NFPA requirement at a time when the use of flammable anesthetics was common and therefore the fire hazards in these rooms was much higher.

FDA documents that there are about 2260 hospital fires a year, with 1 death and about 130 injuries. Operating Rooms account for about 20-30 fire, with no deaths, in about 65 million surgeries per year. There is no doubt significant risk of fires in a surgical environment due to the oxygen rich atmosphere, paper drapes, combustible skin agents, electro-cautery and laser devices. However, most surgical fires are in the immediate proximity of the patient, rather than the general room and the appropriate control measure should be localized prevention and response, rather than trying to stay in the same room as a fire situation. A report by Dr. Yale Podnos of the American College of Surgeons states that “In case of a fire, all persons in the operating room should know the location of fire extinguishers and how to use them. Fire alarm pull stations and emergency exits should be conveniently situated to facilitate orderly evacuation and extinguishing.” FDA or ACS documentation on controlling fire risks in anesthesia locations does not cite the need for smoke removal systems.

The Risk-based approach to 2012 NFPA 99 requires facilities to consider the hazard risks of their activities and take the appropriate preventive and response actions. Section 15.13 specifically requires a surgical hazard assessment. CMS points out in their proposal statement that Section A.4.2 provides an example of appropriate risk assessment procedures, such as NFPA 551, *Guide for the Evaluation of Fire Risk Assessments*. IF the risk assessment points to the need for a smoke removal system, then one must be provided.

Facility Recommendation: We strongly encourage CMS to adopt NFPA 99, as published, without retaining the relic smoke control requirement, and rely on the risk-based assessment processes that are established in the revised code.

FACILITY COMMENT ON: WINDOW REQUIREMENTS FOR ER OBSERVATION ROOMS- 18/19

CMS Statement in Proposal, 4/16/2014(@Fed Reg: Page 21566, Col 1, top): *“We also propose to add a new requirement at §482.41(b) (10) that would retain the majority of the 36 inch window sill requirement that was in the 2000 edition of the LSC. Newborn nurseries and rooms intended for occupancy for less than 24 hours, such as those housing obstetrical labor beds, and recovery beds would be exempt from the window sill height. The 2000 edition of the LSC allowed for observation beds in the emergency department to be exempt from the 36 inch window sill requirement. However, we do not propose to incorporate an exemption for observation beds, because they are frequently occupied for greater than 24 hours. Therefore, observation beds would be required to meet the 36 inch window sill requirement.”*

Facility Comment: The physical environment of the ER consists of as many exam rooms and treatment rooms as the space would allow, and still meet applicable codes and standards. Many ERs extend into the interior areas of the facility since windows to the outdoors are not required in exam and treatment rooms. However, if CMS does not allow an exemption for window sill height in rooms containing observation beds, then healthcare facilities will have difficulty in finding space in the emergency department on outside walls for observation beds that will allow a window to the exterior.

Facility Recommendation: We strongly encourage CMS to reconsider their position and include rooms containing observation beds in the exemption for window sill height.

FACILITY COMMENT ON: ONE PATIENT DEFINITION OF HEALTH CARE

CMS Statement in Proposal, 4/16/2014 (@Fed Reg: Page 21554, Col 2, middle): *“Both the 2000 and 2012 editions of the LSC classify a “Health Care Occupancy” as a facility having 4 or more patients on an inpatient basis. However, CMS does not apply this LSC standard with respect to patient census numbers. Unless specifically noted, the requirements, conditions of participation, and conditions for coverage for all Medicare and Medicaid participating health care providers and suppliers subject to these rules would apply on a facility basis, regardless of the size of the facility or the facility’s patient census. These basic requirements are established to assure a core level of safety and quality for all patients, regardless of where they receive health care services. We believe that patients in small facilities should be assured the same level of fire safety as those in larger facilities. Therefore, the LSC exception for health care occupancy facilities with fewer than four occupants/patients would be inapplicable to the Medicare and Medicaid facilities affected by this proposed rule. All health care occupancies that provide care to one or more patients would be required to comply with the relevant requirements of the 2012 edition of the LSC.”*

Facility Comment: We recognize the need for quality health care to be provided by all health care facilities regardless of the number of patients they serve. The application of the “one patient” rule has led to SA requiring that any building that an inpatient even walks into must be classified as a hospital or nursing home, even if they do not receive treatment or overnight stay. The “customary access” wording in 18/19.1.3.3 has been broadly interpreted to mean a building must be classified as health care even if it is used once a year by an inpatient on a temporary basis, for even a cup of coffee in a café. On a regular basis, long term care residents are signed-out of their facility (NOT discharged) by relatives and transported to dentist offices, restaurants, doctor clinics, etc. The single inpatient rule does not require these facilities to be constructed as health care occupancies. It is a waste of health care dollars to require such non-treatment functions to be built to health care standards just because they are placed in an adjacent building that is operated by the facility.

Facility Recommendation: We strongly encourage CMS to reconsider their position and use the occupancy definitions of NFPA 101. If a single inpatient receives “treatment” the minimum occupancy should be as an ambulatory care facility, but merely transporting a single inpatient through a business space should not trigger the need for full health care construction rules.



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