# HFMADV Spring Conference 2017


Presented by:

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Division of Safety Inspection

PA Department of Health

# Overview

- Fire Door Maintenance
- NFPA 99 Risk Assessment
- CMS Rules Update
  - Recent Emergency Preparedness Guidance
- Electronic Plan Review
- Online Occupancy Request Form

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# Fire Door Maintenance

- Inspection and testing requirements for fire-rated door assemblies in accordance with NFPA 80
- This is an item that will be part of the survey process beginning November 1, 2016

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# Fire Door Maintenance

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# Fire Door Maintenance

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

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# Fire Door Maintenance

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

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# Fire Door Maintenance

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

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# Fire Door Maintenance

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

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# Fire Door Maintenance

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

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# Fire Door Maintenance



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# Fire Door Maintenance

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

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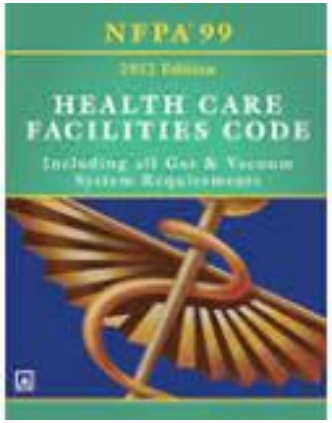
# NFPA 99 Risk Assessment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# NFPA 99 Risk Assessment

## NFPA 99-2012 Risk Assessment Tool

**Instructions for Using the ASHE NFPA 99 Risk Assessment Tool**

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

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

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

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

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

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# NFPA 99 Risk Assessment

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

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# NFPA 99 Risk Assessment

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

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# NFPA 99 Risk Assessment

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

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# NFPA 99 Risk Assessment

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

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

- Definitions (From CMS resource website)
- Facility-Based: When discussing the terms “all-hazards approach” and facility-based risk assessments, we consider the term “facility-based” to mean that the emergency preparedness program is specific to the facility. Facility-based includes, but is not limited to, hazards specific to a facility based on the geographic location; Patient/Resident/Client population; facility type and potential surrounding community assets (i.e. rural area versus a large metropolitan area).

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# CMS Emergency Preparedness

- Definitions (From CMS resource website)
- Full-Scale Exercise: A full scale exercise is a multi-agency, multijurisdictional, multi-discipline exercise involving functional (for example, joint field office, emergency operation centers, etc.) and ‘‘boots on the ground’’ response (for example, firefighters decontaminating mock victims).

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

- Definitions (From CMS resource website)
- Risk Assessment: This is general terminology that is within the emergency preparedness regulations and preamble to the Final Rule (81 Fed. Reg. 63860, Sept. 16, 2016) which describes a process facilities are to use to assess and document potential hazards within their areas and the vulnerabilities and challenges which may impact the facility. Additional terms currently used by the industry are all-hazards risk assessments are also referred to as Hazard Vulnerability Assessments (HVAs) , or all-hazards self-assessments. For the purposes of these guidelines, we are using the term “risk assessment,” which may include a variety of current industry practices used to assess and document potential hazards and their impacts. This guidance is not specifying which type of generally accepted emergency preparedness risk assessment facilities should have, as the language used in defining risk assessment activities is meant to be easily understood by all providers and suppliers that are affected by this final rule and is aligned with the national preparedness system and terminology (81 Fed. Reg. 63860, at 63875). However, facilities are expected to conduct a full assessment of hazards based on geographical location and the individual facility dynamics, such as patient population.

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# CMS Emergency Preparedness

- Definitions (From CMS resource website)
- Staff: The term "staff" refers to all individuals that are employed directly by a facility. The phrase "individuals providing services under arrangement" means services furnished under arrangement that are subject to a written contract conforming with the requirements specified in section 1861(w) of the Social Security Act.

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# CMS Emergency Preparedness

- Definitions (From CMS resource website)
- Table-top Exercise (TTX): A table-top exercise is a group discussion led by a facilitator, using narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. It involves key personnel discussing simulated scenarios, including computer-simulated exercises, in an informal setting. TTXs can be used to assess plans, policies, and procedures.

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  Can continuity of operations, delegations of authority, succession planning be included in the Emergency Operations Plan, or do you expect to see separate plans?
- A:  We are not requiring a specific format for how a facility should have their Emergency Plans documented and in which order.  Upon survey, a facility must be able to provide documentation of these requirements in the plan and show where the plans are located.

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  For formatting of the documentation, the standard state policies & procedures are required.  Our documents are structured as an Emergency Operations Plan with addendums.  Is this allowable?
- A:  We are not requiring a specific format for the manner in which a facility should have their Emergency Plans documented.  Upon survey, a facility must be able to provide documentation of the policies and procedures and show surveyors where the policies and procedures are located.

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q: There are repeated references in the rule to business continuity, business resilience and continuity of operations, but not much clarity is provided as to how the rule differentiates these things or specific requirements. Can you provide more detail as to what will be surveyed?
- A: We did not find any references to the term "business resilience" in the Final Rule. Business continuity and continuity of operations have the same meaning in the context of this rule. The Assistant Secretary for Preparedness and Response has developed a document that includes information to assist facilities in planning for continuity of operations. The document may be found at: http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/hc-coop2-recovery.pdf

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  How does this regulation affect facilities participating in the Hospital Preparedness Program (HPP)?
- A:  The regulation does not affect providers and suppliers participating in the HPP.  There is no relationship between the HPP and the regulation.

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  CMS does not require an approved emergency preparedness plan from the local emergency official but must show coordination with local emergency management officials.  What level of coordination will be considered acceptable for the facility emergency plan approval.  Will a facility only  need an approval for their emergency plan from the CMS servicing agency?
- A:  Facilities must document efforts made byt the facility to cooperate and collaborate with emergency preparedness officials… the rule states that facilities must document efforts made by the facility to cooperate and collaborate with emergency preparedness officials…  We are not requiring official “sign-off” from local emergency management officials.

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  What is the regulation's definition or intent behind the word "community"?
- A:  We did not define community, to afford providers the flexibility to develop disaster drills and exercises that are realistic and reflect their risk assessments…. In the proposed rule, we indicated that we expected hospitals and other providers to participate in the healthcare coalitions in their area for additional assistance in effectively meeting this requirement.

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  What are the consequences for not meeting these new requirements?  Will any leniency be given for organization that have started this type of planning but didn't complete by 11/15/2017?  Will any warnings be issued before any actions taken against a particular organization?
- A:  Facilities have one year to implement the emergency preparedness requirements… There will be no exceptions for the requirements and non-compliance will follow the same process….

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  Will this be an incentive-penalty such as those associated with Meaningful Use?  Will it just be a penalty?  How will surveys be conducted?  When will we have access to the survey tool?
- A:  The implementation of this new regulation is not linked to an incentive program… same enforcement process as with any other Condition that is found to be out of compliance… We anticipate releasing the Interpretive Guidelines and Survey Procedures in spring of 2017….

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  What process/documentation/resources will SA surveyors use to assure compliance with the various facility types?
- A:  As always, surveyors will use the Interpretive Guidelines and Survey Procedures in the State Operations Manual.  Surveyors will also be trained on the requirements before implementation.

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  If an Accrediting Organization already has emergency preparedness standards or emergency preparedness program requirements, how does the new rule affect their current standards?
- A:  AOs will need to submit their emergency preparedness standards/programs to CMS for review. AOs are required to meet or exceed the CMS requirements; therefore the AOs must demonstrate to CMS that their standards meet or exceed all CMS new emergency preparedness requirements.

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  What does the term “training” encompass? Is the content and the extent of the training at the discretion of the facility?
- A:  A well organized, effective training program must include initial training for new and existing staff in emergency preparedness policies and procedures as well as annual refresher trainings. The facility must offer annual emergency preparedness training in which staff can demonstrate knowledge of emergency procedures. The facility must also conduct drills and exercises to test the emergency plan to identify gaps and areas for improvement. We expect facilities to delineate responsibilities for all of their facility’s workers in their emergency preparedness plans and to determine the appropriate level of training for each professional role. Therefore facilities will have discretion in determining what encompasses appropriate training for the different staff positions/roles.

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  Does this regulation apply to physician offices?
- A:  The new Emergency Preparedness requirements do not apply to physician offices that are not part of a certified Medicare participating facility. Physicians' offices or practices that are considered part of a certified Medicare participating facility would be required to meet the regulations.

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  Are there specific Memorandum of Understanding (MOU) requirements in the new guidelines such as a required MOUs list to be sure all the bases are covered?
- A:  The regulation does not specify provider and supplier MOUs; however, the regulation does speak to the need for transfer agreements depending on the facility type. For example, during an emergency, if a patient requires care that is beyond the capabilities of the ASC, we would expect that ASCs would transfer patients to a hospital with which the ASC has a written transfer agreement, as required by existing § 416.41(b), or to the local hospital, that meets the requirements of §416.41(b)(2), where the ASC physicians have admitting privileges.

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  Are all Nursing Homes required to have a generator? What if the Nursing Home doesn't currently have a generator? Must they install one? Is compliance with NFPA 70 & NFPA 110 sufficient, or are there additional requirements regarding the generator and/or fuel capacity?
- A:  The emergency preparedness rule requires long term care (LTC) facilities to have a generator. The regulation also requires LTC facilities to have alternate sources of energy to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. If a facility needs a generator to meet the temperature requirement then it must provide the necessary level of generator with a capacity to run a HVAC. There may be state and local regulations that have additional requirements regarding the generator and any required fuel capacity.

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  If a large health system has operating guidelines which include language described in the policies and procedures section, but does not have formal policies as approved by the hospital board etc., are healthcare facilities required to have formal policies or are official operating guidelines sufficient?
- A:  The regulation is clear that facilities must have “policies and procedures” in place as opposed to “operating guidelines.” Policies are considered a more formal, definite method or course of action to be adhered to. Therefore facilities must develop and maintain “policies” and procedures to meet the requirements of the regulation. Facilities may choose to include relevant language from their “operating guidelines” in their policies and procedures as appropriate. Facilities should be aware that surveyors may ask to see a copy of the facilities “policies” and not “operating guidelines.”

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q:  The rule implies that facilities need to ensure their vendors have a business continuity plan to continue to provide a supply source during times of emergency. Do you have any guidance as to what vendors need to have or what they should provide to these facilities that will make the facilities compliant?
- A:  Facilities are required to provide subsistence needs for staff and patients, whether they evacuate or shelter in place. Those provisions include but are not limited to: food, water, medical supplies and pharmaceutical supplies.

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

- Frequently Asked Questions (From CMS resource website)
- Q: The regulation states: (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. What is meant by "provisions" in (ii)(a)?
- A: Provisions include: food, water, pharmaceuticals or medications and medical supplies. At §482.15(b)(1)(ii)(D), we proposed that the hospital develop policies and procedures to address the provisions of sewage and waste disposal including solid waste, recyclables, chemical, biomedical waste, and waste water.

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# CMS Emergency Preparedness

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

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# CMS Emergency Preparedness

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

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# Electronic Plan Review

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

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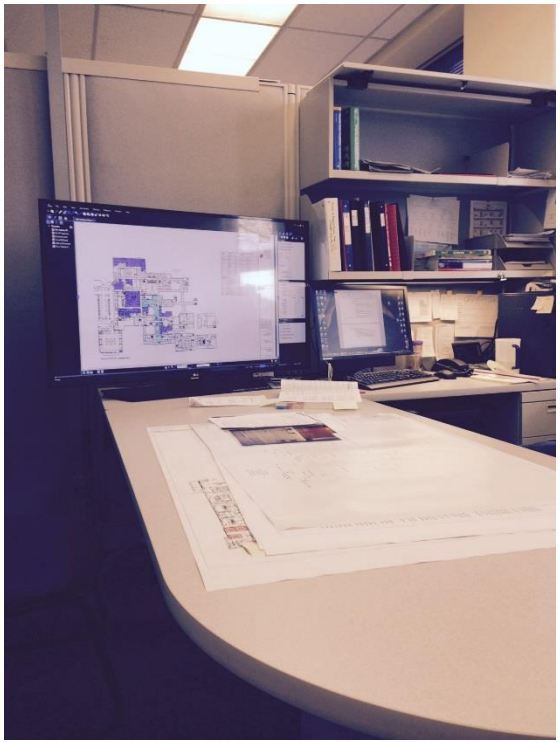
# Electronic Plan Review

– This…

To this…



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# Electronic Plan Review

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

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# Electronic Plan Review

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

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# Safety Risk Assessment

- SRA is new to the 2014 FGI Guidelines
- Includes:
  - Infection Control Risk Assessment
  - Patient Handling and Movement Assessment
  - Patient Fall Prevention
  - Medication Safety
  - Behavioral and Mental Health (Psychiatric Patient Injury and Suicide Prevention)
  - Patient Immobility
  - Security Risks

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# Occupancy Surveys

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

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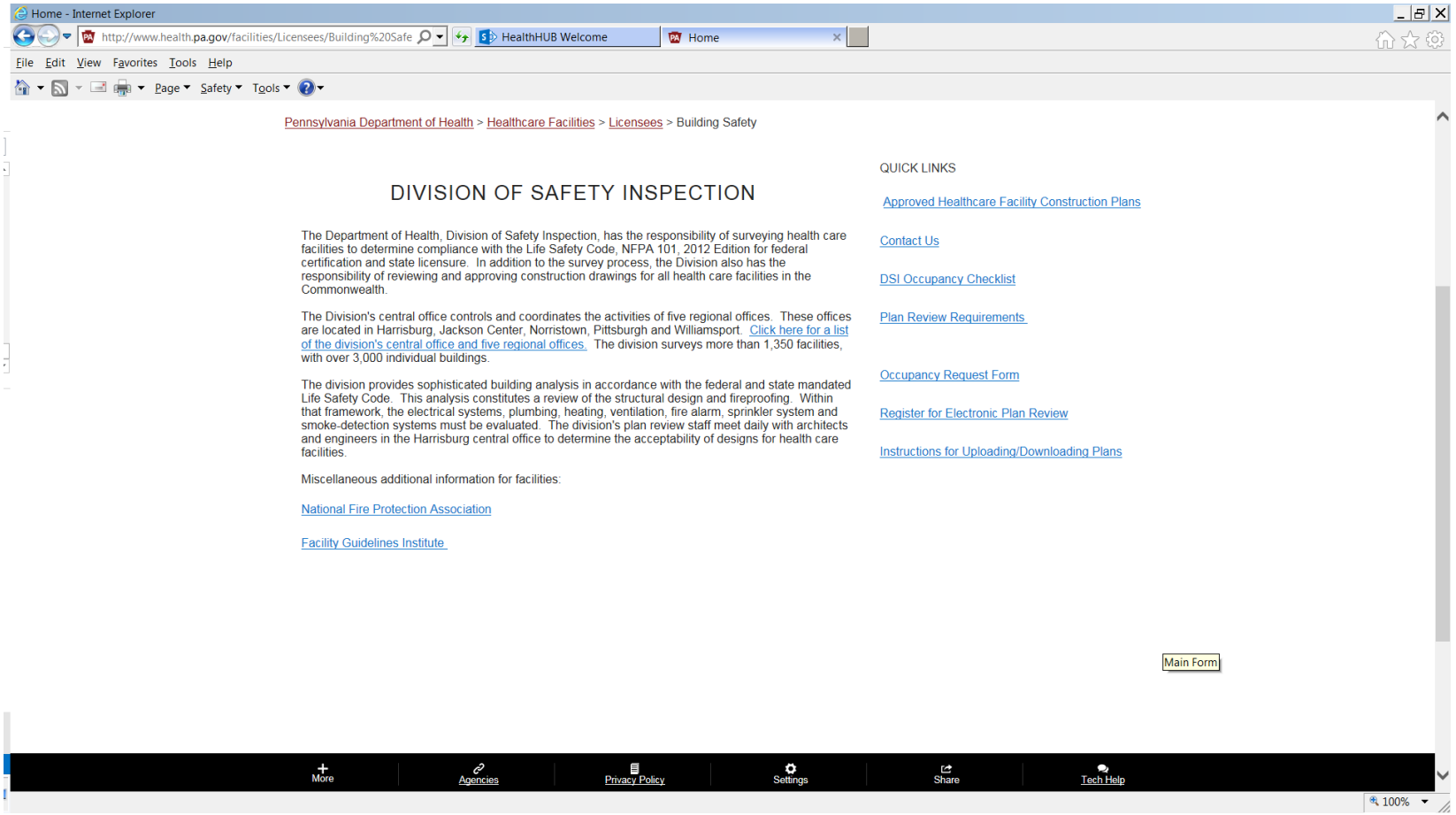
# Occupancy Surveys

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# FSES Update

- CMS S&C Letter 17-15-LSC
- Updates FSES requirements from 2001 NFPA 101A to 2013 NFPA 101A to reflect adoption of the 2012 LSC
- FSES can be completed by the facility, a trained consultant or the SA at their discretion
- FSES is submitted to the SA for review
- New requirement:
  - The SA must send the FSES to the CMS RO for final approval as part of the Plan of Correction
  - FSES must be completely new at each annual (or other survey frequency depending on facility type) survey and must reflect the results of the SA LSC survey

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# FSES Update

- New 2013 NFPA 101A mandatory values for existing high rise buildings and existing nursing homes have created issues with facilities failing to comply
- Note that even though the facility may have complied with previous versions of the FSES, the facility may still fail the 2013 version, especially for multi-story Type of Construction issues
- S&C 17-15-LSC provides the opportunity for existing Long Term Care Facilities (Nursing Homes) to request and receive a time-limited waiver for up to 5 years to correct certain deficiencies

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**WORKSHEET 4.7.7 INDIVIDUAL SAFETY EVALUATIONS**

| Safety Parameters | Containment Safety ($S_1$) | Extinguishment Safety ($S_2$) | People Movement Safety ($S_3$) | General Safety ($S_4$) |
|---|---|---|---|---|
| 1. Construction | | | | |
| 2. Interior Finish (Corr. and Exit) | | | | |
| 3. Interior Finish(Rooms) | | | | |
| 4. Corridor Partitions/Walls | | | | |
| 5. Doors to Corridor | | | | |
| 6. Zone Dimensions | | | | |
| 7. Vertical Openings | | | | |
| 8. Hazardous Areas | | | | |
| 9. Smoke Control | | | | |
| 10. Emergency Movement Routes | | | | |
| 11. Manual Fire Alarm | | | | |
| 12. Smoke Detection and Alarm | | | | |
| 13. Automatic Sprinklers | | | + 2 = | |
| Total Value | $S_1$ = | $S_2$ = | $S_3$ = | $S_4$ = |

**WORKSHEET 4.7.8A MANDATORY SAFETY REQUIREMENTS — NEW HOSPITALS, EXISTING HOSPITALS, OR NEW NURSING HOMES**

| Zone Location | Containment ($S_a$) | | Extinguishment ($S_b$) | | People Movement ($S_c$) | |
|---|---|---|---|---|---|---|
| | New | Exist. | New | Exist. | New | Exist. |
| 1st story | 11 | 5 | 15(12)[a] | 4 | 8(5)[a] | 1 |
| 2nd or 3rd story[b] | 15 | 9 | 17(14)[a] | 6 | 10(7)[a] | 3 |
| 4th story or higher but not high rise | 18 | 9 | 19(16)[a] | 6 | 11(8)[a] | 3 |
| High rise | 18 | 17 | 19(16)[a] | 16 | 11(8)[a] | 7 |

[a] Use ( ) in zones that do not contain patient sleeping rooms.

[b] For a 2nd story zone location in a *sprinklered* EXISTING hospital, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values set shall be permitted to be used: $S_a = 7$, $S_b = 10$, and $S_c = 7$.

**WORKSHEET 4.7.8B MANDATORY SAFETY REQUIREMENTS — EXISTING NURSING HOMES**

| Zone Location | Containment ($S_a$) | Extinguishment ($S_b$) | People Movement ($S_c$) |
|---|---|---|---|
| 1st story | 0 | 10 | 0 |
| 2nd story | 2 | 10 | 2 |
| 3rd story | 6 | 14 | 2 |
| 4th story or higher | 8 | 16 | 2 |

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# Questions?

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