COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

The Trump Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers contain the spread of 2019 Novel Coronavirus Disease (COVID-19). CMS is empowered to take proactive steps through 1135 waivers as well as, where applicable, authority granted under section 1812(f) of the Social Security Act (the Act) and rapidly expand the Administration's aggressive efforts against COVID-19. As a result, the following blanket waivers are in effect, with a retroactive effective date of March 1, 2020 through the end of the emergency declaration. For general information about waivers, see Attachment A to this document. **These waivers DO NOT require a request to be sent to the 1135waiver@cms.hhs.gov mailbox or that notification be made to any of CMS's regional offices.**

Flexibility for Medicare Telehealth Services

- **Eligible Practitioners.** Pursuant to authority granted under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that broadens the waiver authority under section 1135 of the Social Security Act, the Secretary has authorized additional telehealth waivers. CMS is waiving the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.

- **Audio-Only Telehealth for Certain Services.** Pursuant to authority granted under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services (see designated codes https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes). Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs), including Cancer Centers and Long-Term Care Hospitals (LTCHs)

- **Emergency Medical Treatment & Labor Act (EMTALA).** CMS is waiving the enforcement of section 1867(a) of the Act. This will allow hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan.

- **Verbal Orders.** CMS is waiving the requirements of 42 CFR §482.23, §482.24 and §485.635(d)(3) to provide additional flexibility related to verbal orders where read- back verification is required, but authentication may occur later than 48 hours. This will allow more efficient treatment of patients in surge situations. Specifically, the following requirements are waived:
    - §482.23(c)(3)(i) - If verbal orders are used for the use of drugs and biologicals (except immunizations), they are to be used infrequently.
    - §482.24(c)(2) - All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient.
    - §482.24(c)(3) - Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders. This would include all subparts at §482.24(c)(3).
    - §485.635(d)(3) - Although the regulation requires that medication administration be based on a written, signed order, this does not preclude the CAH from using verbal orders. A practitioner responsible for the care of the patient must authenticate the order in writing as soon as possible after the fact.

- **Reporting Requirements**. CMS is waiving the requirements at 42 CFR §482.13(g) (1)(i)-(ii), which require that hospitals report patients in an intensive care unit whose death is caused by their disease, but who required soft wrist restraints to prevent pulling tubes/IVs, no later than the close of business on the next business day. Due to current hospital surge, CMS is waiving this requirement to ensure that hospitals are focusing on increased patient care demands and increased patient census, provided any death where the restraint may have contributed is still reported within standard time limits (i.e., close of business on the next business day following knowledge of the patient's death).

- **Patient Rights.** CMS is waiving requirements under 42 CFR §482.13 **only for hospitals that are considered to be impacted by a widespread outbreak of COVID-19**. Hospitals that are located in a state which has widespread confirmed cases (i.e., 51 or more confirmed cases*) as updated on the CDC website, CDC States Reporting Cases of COVID-19, at https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html, would not be required to meet the following requirements:

- §482.13(d)(2) - With respect to timeframes in providing a copy of a medical record.
- §482.13(h) - Related to patient visitation, including the requirement to have written policies and procedures on visitation of patients who are in COVID-19 isolation and quarantine processes.
- §482.13(e)(1)(ii) - Regarding seclusion.

*The waiver flexibility is based on the number of confirmed cases as reported by CDC and will be assessed accordingly when COVID-19 confirmed cases decrease.

- **Sterile Compounding.** CMS is waiving requirements (also outlined in USP797) at 42 CFR §482.25(b)(1) and §485.635(a)(3) in order to allow used face masks to be removed and retained in the compounding area to be re-donned and reused during the same work shift in the compounding area only. This will conserve scarce face mask supplies. CMS will not review the use and storage of face masks under these requirements.

- **Detailed Information Sharing for Discharge Planning for Hospitals and CAHs.** CMS is waiving the requirement 42 CFR §482.43(a)(8), §482.61(e), and §485.642(a)(8) to provide detailed information regarding discharge planning, described below:
  - The hospital, psychiatric hospital, and CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures. The hospital must ensure that the post-acute care data on quality measures and resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.
  - CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care as described in 42 CFR §482.43(a)(1)-(7) and (b).

- **Limiting Detailed Discharge Planning for Hospitals.** CMS is waiving all the requirements and subparts at 42 CFR §482.43(c) related to post-acute care services so as to expedite the safe discharge and movement of patients among care settings, and to be responsive to fluid situations in various areas of the country. CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care as described in 42 CFR §482.43(a)(1)-(7) and (b). CMS is waiving the more detailed requirement that hospitals ensure those patients discharged home and referred for HHA services, or transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services, must:
  - §482.43(c)(1): Include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient.
  - §482.43(c)(2): Inform the patient or the patient's representative of their freedom to

choose among participating Medicare providers and suppliers of post-discharge services.

  - §482.43(c)(3): Identify in the discharge plan any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

- **Medical Staff.** CMS is waiving requirements under 42 CFR §482.22(a)(1)-(4) to allow for physicians whose privileges will expire to continue practicing at the hospital and for new physicians to be able to practice before full medical staff/governing body review and approval to address workforce concerns related to COVID-19. CMS is waiving §482.22(a) (1)-(4) regarding details of the credentialing and privileging process. **(Please also refer to Practitioner Locations Blanket Waiver listed below.)**

- **Medical Records.** CMS is waiving requirements under 42 CFR §482.24(a) through (c), which cover the subjects of the organization and staffing of the medical records department, requirements for the form and content of the medical record, and record retention requirements, and these flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. CMS is waiving §482.24(c)(4)(viii) related to medical records to allow flexibility in completion of medical records within 30 days following discharge from a hospital. This flexibility will allow clinicians to focus on the patient care at the bedside during the pandemic.

- **Flexibility in Patient Self Determination Act Requirements (Advance Directives).** CMS is waiving the requirements at sections 1902(a)(58) and 1902(w)(1)(A) of the Act (for Medicaid); 1852(i) of the Act (for Medicare Advantage); and 1866(f) of the Act and 42 CFR §489.102 (for Medicare), which require hospitals and CAHs to provide information about their advance directive policies to patients. CMS is waiving this requirement to allow staff to more efficiently deliver care to a larger number of patients.

- **Physical Environment.** ***(Modified since 5/11 Release)*** CMS is waiving certain physical environment requirements under the Medicare conditions of participation at 42 CFR §482.41 and 42 CFR §485.623 to allow for increased flexibilities for surge capacity and patient quarantine at hospitals, psychiatric hospitals, and critical access hospitals (CAHs) as a result of COVID-19. CMS will permit facility and non-facility space that is not normally used for patient care to be utilized for patient care or quarantine, provided the location is approved by the state (ensuring that safety and comfort for patients and staff are sufficiently addressed) and is consistent with the state's emergency preparedness or pandemic plan. This allows for increased capacity and promotes appropriate cohorting of COVID-19 patients. States are still

subject to obligations under the integration mandate of the Americans with Disabilities Act, to avoid subjecting persons with disabilities to unjustified institutionalization or segregation [1].

- **Telemedicine.** CMS is waiving the provisions related to telemedicine at 42 CFR §482.12(a) (8)–(9) for hospitals and §485.616(c) for CAHs, making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital. This allows for increased access to necessary care for hospital and CAH patients, including access to specialty care.

- **Physician Services.** CMS is waiving requirements under 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4), which requires that Medicare patients be under the care of a physician. This waiver may be implemented so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. This allows hospitals to use other practitioners to the fullest extent possible.

- **Anesthesia Services.** CMS is waiving requirements under 42 CFR §482.52(a)(5), §485.639(c) (2), and §416.42 (b)(2) that a certified registered nurse anesthetist (CRNA) is under the supervision of a physician in paragraphs §482.52(a)(5) and §485.639(c)(2). CRNA supervision will be at the discretion of the hospital and state law. This waiver applies to hospitals, CAHs, and Ambulatory Surgical Centers (ASCs). These waivers will allow CRNAs to function to the fullest extent of their licensure, and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

- **Utilization Review.** CMS is waiving certain requirements under 42 CFR §482.1(a)(3) and 42 CFR §482.30 which address the statutory basis for hospitals and includes the requirement that hospitals participating in Medicare and Medicaid must have a utilization review plan that meets specified requirements.
    - CMS is waiving the entire utilization review condition of participation Utilization Review (UR) at §482.30, which requires that a hospital must have a UR plan with a UR committee that provides for a review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. Removing these administrative requirements will allow hospitals to focus more resources on providing direct patient care.

[1]Please note that consistent with the integration mandate of Title II of the ADA and the *Olmstead vs LC* decision, States are obligated to offer/ provide discharge planning and/or case management/ transition services, as appropriate, to individuals who are removed from their Medicaid home and community based services under these authorities during the course of the public health emergency as well as to individuals with disabilities who may require these services in order to avoid unjustified institutionalization or segregation. Transition services/ case management and/or discharge planning would be provided to facilitate these individuals in their return to the community when their condition and public health circumstances permit.

- **Written Policies and Procedures for Appraisal of Emergencies at Off Campus Hospital Departments**. CMS is waiving 42 CFR §482.12(f)(3), emergency services, with respect to surge facilities **only**, such that written policies and procedures for staff to use when evaluating emergencies are not required for surge facilities. This removes the burden on facilities to develop and establish additional policies and procedures at their surge facilities or surge sites related to the assessment, initial treatment, and referral of patients. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

- **Emergency Preparedness Policies and Procedures.** CMS is waiving 42 CFR §482.15(b) and §485.625(b), which requires the hospital and CAH to develop and implement emergency preparedness policies and procedures, and §482.15(c)(1)–(5) and §485.625(c)(1)–(5) which requires that the emergency preparedness communication plans for hospitals and CAHs to contain specified elements with respect to the surge site. The requirement under the communication plan requires hospitals and CAHs to have specific contact information for staff, entities providing services under arrangement, patients' physicians, other hospitals and CAHs, and volunteers. This would not be an expectation for the surge site. This waiver applies to both hospitals and CAHs, and removes the burden on facilities to establish these policies and procedures for their surge facilities or surge sites.

- **Quality Assessment and Performance Improvement Program.** CMS is waiving 42 CFR §482.21(a)–(d) and (f), and §485.641(a), (b), and (d), which provide details on the scope of the program, the incorporation, and setting priorities for the program's performance improvement activities, and integrated Quality Assurance & Performance Improvement programs (for hospitals that are part of a hospital system). These flexibilities, which apply to both hospitals and CAHs, may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain. This waiver applies to both hospitals and CAHs.

- **Nursing Services.** CMS is waiving the requirements at 42 CFR §482.23(b)(4), which requires the nursing staff to develop and keep current a nursing care plan for each patient, and §482.23(b)(7), which requires the hospital to have policies and procedures in place establishing which outpatient departments are not required to have a registered nurse present. These waivers allow nurses increased time to meet the clinical care needs of each patient and allow for the provision of nursing care to an increased number of patients. In addition, we expect that hospitals will need relief for the provision of inpatient services and as a result, the requirement to establish nursing-related policies and procedures for outpatient departments is likely of lower priority. These flexibilities apply to both hospitals and CAHs §485.635(d)(4), and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

- **Food and Dietetic Services.** CMS is waiving the requirement at paragraph 42 CFR §482.28(b) (3), which requires providers to have a current therapeutic diet manual approved by the dietitian and medical staff readily available to all medical, nursing, and food service personnel. Such manuals would not need to be maintained at surge capacity sites. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. Removing these administrative requirements will allow hospitals to focus more resources on providing direct patient care.

- **Respiratory Care Services.** CMS is waiving the requirements at 42 CFR §482.57(b)(1) that require hospitals to designate in writing the personnel qualified to perform specific respiratory care procedures and the amount of supervision required for personnel to carry out specific procedures. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. Not being required to designate these professionals in writing will allow qualified professionals to operate to the fullest extent of their licensure and training in providing patient care.

- **Expanded Ability for Hospitals to Offer Long-term Care Services ("Swing-Beds") for Patients Who do not Require Acute Care but do Meet the Skilled Nursing Facility (SNF) Level of Care Criteria as Set Forth at 42 CFR 409.31.** Under section 1135(b)(1) of the Act, CMS is waiving the requirements at 42 CFR 482.58, "*Special Requirements for hospital providers of long-term care services ("swing-beds")"* subsections (a)(1)-(4) *"Eligibility"*, to allow hospitals to establish SNF swing beds payable under the SNF prospective payment system (PPS) to provide additional options for hospitals with patients who no longer require acute care but are unable to find placement in a SNF.

  In order to qualify for this waiver, hospitals must:

  - Not use SNF swing beds for acute level care.
  - Comply with all other hospital conditions of participation and those SNF provisions set out at 42 CFR 482.58(b) to the extent not waived.
  - Be consistent with the state's emergency preparedness or pandemic plan.

  Hospitals must call the CMS Medicare Administrative Contractor (MAC) enrollment hotline to add swing bed services. The hospital must attest to CMS that:

  - They have made a good faith effort to exhaust all other options;
  - There are no skilled nursing facilities within the hospital's catchment area that under normal circumstances would have accepted SNF transfers, but are currently not willing to accept or able to take patients because of the COVID-19 public health emergency (PHE);

- The hospital meets all waiver eligibility requirements; and
- They have a plan to discharge patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.

This waiver applies to all Medicare enrolled hospitals, except psychiatric and long term care hospitals that need to provide post-hospital SNF level swing-bed services for non-acute care patients in hospitals, so long as the waiver is not inconsistent with the state's emergency preparedness or pandemic plan. The hospital shall not bill for SNF PPS payment using swing beds when patients require acute level care or continued acute care at any time while this waiver is in effect. This waiver is permissible for swing bed admissions during the COVID-19 PHE with an understanding that the hospital must have a plan to discharge swing bed patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.

- **CAH Personnel Qualifications.** CMS is waiving the minimum personnel qualifications for clinical nurse specialists at paragraph 42 CFR §485.604(a)(2), nurse practitioners at paragraph §485.604(b)(1)–(3), and physician assistants at paragraph §485.604(c)(1)–(3). Removing these Federal personnel requirements will allow CAHs to employ individuals in these roles who meet state licensure requirements and provide maximum staffing flexibility. These flexibilities should be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

- **CAH Staff Licensure.** CMS is deferring to staff licensure, certification, or registration to state law by waiving 42 CFR §485.608(d) regarding the requirement that staff of the CAH be licensed, certified, or registered in accordance with applicable federal, state, and local laws and regulations. This waiver will provide maximum flexibility for CAHs to use all available clinicians. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

- **CAH Status and Location.** CMS is waiving the requirement at 42 CFR §485.610(b) that the CAH be located in a rural area or an area being treated as being rural, allowing the CAH flexibility in the establishment of surge site locations. CMS is also waiving the requirement at §485.610(e) regarding the CAH's off-campus and co-location requirements, allowing the CAH flexibility in establishing temporary off-site locations. In an effort to facilitate the establishment of CAHs without walls, these waivers will suspend restrictions on CAHs regarding their rural location and their location relative to other hospitals and CAHs. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.

- **CAH Length of Stay.** CMS is waiving the requirements that CAHs limit the number of beds to 25, and that the length of stay be limited to 96 hours under the Medicare conditions of participation for number of beds and length of stay at 42 CFR §485.620.

- **Temporary Expansion Locations:** For the duration of the PHE related to COVID-19, CMS is waiving certain requirements under the Medicare conditions of participation at 42 CFR §482.41 and §485.623 (as noted elsewhere in this waiver document) and the provider- based department requirements at §413.65 to allow hospitals to establish and operate as part of the hospital any location meeting those conditions of participation for hospitals that continue to apply during the PHE. This waiver also allows hospitals to change the status of their current provider-based department locations to the extent necessary to address the needs of hospital patients as part of the state or local pandemic plan. This extends to any entity operating as a hospital (whether a current hospital establishing a new location or an Ambulatory Surgical Center (ASC) enrolling as a hospital during the PHE pursuant to a streamlined enrollment and survey and certification process) so long as the relevant location meets the conditions of participation and other requirements not waived by CMS. This waiver will enable hospitals to meet the needs of Medicare beneficiaries.

- **Responsibilities of Physicians in Critical Access Hospitals (CAHs).** 42 CFR § 485.631(b)(2). CMS is waiving the requirement for CAHs that a doctor of medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH at § 485.631(b)(2). CMS is retaining the regulatory language in the second part of the requirement at § 485.631(b)(2) that a physician be available "through direct radio or telephone communication, or electronic communication for consultation, assistance with medical emergencies, or patient referral." Retaining this longstanding CMS policy and related longstanding subregulatory guidance that further described communication between CAHs and physicians will assure an appropriate level of physician direction and supervision for the services provided by the CAH. This will allow the physician to perform responsibilities remotely, as appropriate. This also allows CAHs to use nurse practitioners and physician assistants to the fullest extent possible, while ensuring necessary consultation and support as needed.

- **Long Term Care Hospitals - Site Neutral Payment Rate Provisions.** Also as required by section 3711(b) of the CARES Act, during the Public Health Emergency (PHE) due to COVID-19, the Secretary has waived section 1886(m)(6) of the Social Security Act relating to certain site neutral payment rate provisions for long-term care hospitals (LTCHs).
    - Section 3711(b)(1) of the CARES Act waives the payment adjustment under section 1886(m)(6)(C)(ii) of the Act for LTCHs that do not have a discharge payment percentage (DPP) for the period that is at least 50 percent during the COVID-19 public health emergency period. Under this provision, for the purposes of calculating an LTCH's DPP, all admissions during the COVID-19 public health emergency period will be counted in the numerator of the calculation, that is, LTCH cases that were admitted during the COVID-19 public health emergency period will be counted as discharges paid the LTCH PPS standard Federal payment rate.
    - Section 3711(b)(2) of the CARES Act provides a waiver of the application of the site neutral payment rate under section 1886(m)(6)(A)(i) of the Act for those LTCH admissions that are in response to the public health emergency and occur during the

COVID-19 public health emergency period. Under this provision, all LTCH cases admitted during the COVID-19 public health emergency period will be paid the relatively higher LTCH PPS standard Federal rate. A new LTCH PPS Pricer software package will be released in April 2020 to include this temporary payment policy effective for claims with an admission date occurring on or after January 27, 2020 and continuing through the duration of the COVID-19 public health emergency period. Claims received on or after April 21, 2020, will be processed in accordance with this waiver. Claims received April 20, 2020, and earlier will be reprocessed. LTCHs should add the "DR" condition code to applicable claims.

Hospitals Classified as Sole Community Hospitals (SCHs)

- CMS is waiving certain eligibility requirements at 42 CFR § 412.92(a) for hospitals classified as SCHs prior to the PHE. Specifically, CMS is waiving the distance requirements at paragraphs (a), (a)(1), (a)(2), and (a)(3) of 42 CFR § 412.92, and is also waiving the "market share" and bed requirements (as applicable) at 42 CFR § 412.92(a)(1)(i) and (ii). CMS is waiving these requirements for the duration of the PHE to allow these hospitals to meet the needs of the communities they serve during the PHE, such as to provide for increased capacity and promote appropriate cohorting of COVID-19 patients. MACs will resume their standard practice for evaluation of all eligibility requirements after the conclusion of the PHE period.

Hospitals Classified as Medicare-Dependent, Small Rural Hospitals (MDHs)

- For hospitals classified as MDHs prior to the PHE, CMS is waiving the eligibility requirement at 42 CFR § 412.108(a)(1)(ii) that the hospital has 100 or fewer beds during the cost reporting period, and the eligibility requirement at 42 CFR § 412.108(a)(1)(iv)(C) that at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the specified hospital cost reporting periods. CMS is waiving these requirements for the duration of the PHE to allow these hospitals to meet the needs of the communities they serve during the PHE, such as to provide for increased capacity and promote appropriate cohorting of COVID-19 patients. MACs will resume their standard practice for evaluation of all eligibility requirements after the conclusion of the PHE period.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- **Certain Staffing Requirements.** 42 CFR 491.8(a)(6). CMS is waiving the requirement in the second sentence of § 491.8(a)(6) that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the RHC operates. CMS is not waiving the first sentence of § 491.8(a)(6) that requires a physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center

operates. This will assist in addressing potential staffing shortages by increasing flexibility regarding staffing mixes during the PHE.

- **Physician Supervision of NPs in RHCs and FQHCs.** 42 CFR 491.8(b)(1). We are modifying the requirement that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.

- **Temporary Expansion Locations.** CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement removing the location restrictions to allow flexibility for existing RHCs/FQHCs to expand services locations to meet the needs of Medicare beneficiaries. This flexibility includes areas which may be outside of the location requirements 42 CFR §491.5(a)(1) and (2) but will end when the HHS Secretary determines there is no longer a PHE due to COVID-19.

Housing Acute Care Patients in the IRF or Inpatient Psychiatric Facility (IPF) Excluded Distinct Part Units

- CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, such as excluded distinct part unit IRFs or IPFs, where the distinct part unit's beds are appropriate for acute care inpatients. The Inpatient Prospective Payment System (IPPS) hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the disaster or emergency.

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital

- CMS is allowing acute care hospitals with excluded distinct part inpatient psychiatric units to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit as a result of a disaster or emergency. The hospital should continue to bill for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System for these patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the COVID-19 emergency. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe

care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital

- CMS is allowing acute care hospitals with excluded distinct part inpatient rehabilitation units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit as a result of this PHE. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for these patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

Flexibility for Inpatient Rehabilitation Facilities Regarding the "60 Percent Rule"

- CMS is allowing IRFs to exclude patients from the freestanding hospital's or excluded distinct part unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergencyand the patient's medical record properly identifies the patient as such. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

Inpatient Rehabilitation Facility – Intensity of Therapy Requirement ("3-Hour Rule")

- As required by section 3711(a) of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, during the COVID-19 public health emergency, the Secretary has waived 42 CFR § 412.622(a)(3)(ii) which provides that payment generally requires that patients of an inpatient rehabilitation facility receive at least 15 hours of therapy per week. This waiver clarifies information provided in "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency" (CMS-1744-IFC). (85 Federal Register 19252, 19287, April 6, 2020). The information in that rulemaking (CMS-1744-IFC) about Inpatient Rehabilitation Facilities was contemplated prior to the passage of the CARES Act.

Extension for Inpatient Prospective Payment System (IPPS) Wage Index Occupational Mix Survey Submission

- CMS collects data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. Completed 2019 Occupational Mix Surveys, Hospital Reporting Form CMS-10079, for the Wage Index Beginning FY 2022, are due to the Medicare Administrative Contractors (MACs) on the Excel hospital reporting form available at **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html** by July 1, 2020. CMS is currently granting an extension for hospitals nationwide affected by COVID-19 until August 3, 2020. If hospitals encounter difficulty meeting this extended deadline date, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCHs)

- CMS has determined it is appropriate to issue a blanket waiver to long-term care hospitals (LTCHs) to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement, which allows these facilities to be paid as LTCHs. In addition, during the applicable waiver time period, we would also apply this waiver to facilities not yet classified as LTCHs, but seeking classification as an LTCH.

Care for Patients in Extended Neoplastic Disease Care Hospitals

- CMS is allowing extended neoplastic disease care hospitals to exclude inpatient stays where the hospital admits or discharges patients in order to meet the demands of the emergency from the greater than 20-day average length of stay requirement, which allows these facilities to be excluded from the hospital inpatient prospective payment system and paid an adjusted payment for Medicare inpatient operating and capital-related costs under the reasonable cost-based reimbursement rules as authorized under Section 1886(d)(1)(B)(vi) of the Act and §42 CFR 412.22(i).

Long-Term Care Facilities and Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs)

- **3-Day Prior Hospitalization.** Using the authority under Section 1812(f) of the Act, CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who experience dislocations, or are otherwise affected by COVID-19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for those

beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).

- **Reporting Minimum Data Set.** CMS is waiving 42 CFR 483.20 to provide relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.

- **Staffing Data Submission.** CMS is waiving 42 CFR 483.70(q) to provide relief to long-term care facilities on the requirements for submitting staffing data through the Payroll-Based Journal system.

- **Waive Pre-Admission Screening and Annual Resident Review (PASARR).** CMS is waiving 42 CFR 483.20(k), allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to State PASARR program for Level 2 Resident Review.

- **Physical Environment.** CMS is waiving requirements related at 42 CFR 483.90, specifically the following:
    - Provided that the state has approved the location as one that sufficiently addresses safety and comfort for patients and staff, CMS is waiving requirements under § 483.90 to allow for a non-SNF building to be temporarily certified and available for use by a SNF in the event there are needs for isolation processes for COVID-19 positive residents, which may not be feasible in the existing SNF structure to ensure care and services during treatment for COVID-19 are available while protecting other vulnerable adults.
    - CMS believes this will also provide another measure that will free up inpatient care beds at hospitals for the most acute patients while providing beds for those still in need of care. CMS will waive certain conditions of participation and certification requirements for opening a NF if the state determines there is a need to quickly stand up a temporary COVID-19 isolation and treatment location.
    - CMS is also waiving requirements under 42 CFR 483.90 to temporarily allow for rooms in a long-term care facility not normally used as a resident's room, to be used to accommodate beds and residents for resident care in emergencies and situations needed to help with surge capacity. Rooms that may be used for this purpose include activity rooms, meeting/conference rooms, dining rooms, or other rooms, as long as residents can be kept safe, comfortable, and other applicable requirements for participation are met. This can be done so long as it is not inconsistent with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department.

- **Resident Groups.** CMS is waiving the requirements at 42 CFR 483.10(f)(5), which ensure residents can participate in-person in resident groups. This waiver would only permit the facility to restrict in-person meetings during the national emergency given the recommendations of social distancing and limiting gatherings of more than ten people. Refraining from in-person gatherings will help prevent the spread of COVID-19.

- **Training and Certification of Nurse Aides.** CMS is waiving the requirements at 42 CFR 483.35(d) (with the exception of 42 CFR 483.35(d)(1)(i)), which require that a SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under § 483.35(d). CMS is waiving these requirements to assist in potential staffing shortages seen with the COVID-19 pandemic. To ensure the health and safety of nursing home residents, CMS is not waiving 42 CFR § 483.35(d)(1)(i), which requires facilities to not use any individual working as a nurse aide for more than four months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services. We further note that we are not waiving § 483.35(c), which requires facilities to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

- **Physician Visits in Skilled Nursing Facilities/Nursing Facilities.** CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in- person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.

- **Resident Roommates and Grouping.** CMS is waiving the requirements in 42 CFR 483.10(e) (5), (6), and (7) solely for the purposes of grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19, and separating them from residents who are asymptomatic or tested negative for COVID-19. This action waives a facility's requirements, under 42 CFR 483.10, to provide for a resident to share a room with his or her roommate of choice in certain circumstances, to provide notice and rationale for changing a resident's room, and to provide for a resident's refusal a transfer to another room in the facility. This aligns with CDC guidance to preferably place residents in locations designed to care for COVID-19 residents, to prevent the transmission of COVID-19 to other residents.

- **Resident Transfer and Discharge.** CMS is waiving requirements in 42 CFR 483.10(c)(5); 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), (c)(9), and (d); and § 483.21(a)(1)(i), (a)(2)(i), and (b)(2)(i) (with some exceptions) to allow a long term care (LTC) facility to transfer or discharge residents to another LTC facility solely for the following cohorting purposes:

    1. Transferring residents with symptoms of a respiratory infection or confirmed diagnosis of COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents;

    2. Transferring residents without symptoms of a respiratory infection or confirmed to not have COVID-19 to another facility that agrees to accept each specific resident, and is

dedicated to the care of such residents to prevent them from acquiring COVID-19; or

3. Transferring residents without symptoms of a respiratory infection to another facility that agrees to accept each specific resident to observe for any signs or symptoms of a respiratory infection over 14 days.

Exceptions:

- These requirements are **only** waived in cases where the transferring facility receives confirmation that the receiving facility agrees to accept the resident to be transferred or discharged. Confirmation may be in writing or verbal. If verbal, the transferring facility needs to document the date, time, and person that the receiving facility communicated agreement.

- In § 483.10, we are only waiving the requirement, under § 483.10(c)(5), that a facility provide advance notification of options relating to the transfer or discharge to another facility. Otherwise, all requirements related to § 483.10 are not waived. Similarly, in § 483.15, we are only waiving the requirement, under § 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), and (d), for the written notice of transfer or discharge to be provided before the transfer or discharge. This notice must be provided as soon as practicable.

- In § 483.21, we are only waiving the timeframes for certain care planning requirements for residents who are transferred or discharged for the purposes explained in 1–3 above. Receiving facilities should complete the required care plans as soon as practicable, and we expect receiving facilities to review and use the care plans for residents from the transferring facility, and adjust as necessary to protect the health and safety of the residents the apply to.

- These requirements are also waived when the transferring residents to another facility, such as a COVID-19 isolation and treatment location, with the provision of services "under arrangements," as long as it is not inconsistent with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department. In these cases, the transferring LTC facility need not issue a formal discharge, as it is still considered the provider and should bill Medicare normally for each day of care. The transferring LTC facility is then responsible for reimbursing the other provider that accepted its resident(s) during the emergency period.
    - If the LTC facility does not intend to provide services under arrangement, the COVID-19 isolation and treatment facility is the responsible entity for Medicare billing purposes. The LTC facility should follow the procedures described in 40.3.4 of the Medicare Claims Processing Manual (**https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf**) to submit a discharge bill to Medicare. The COVID-19 isolation and treatment facility should

then bill Medicare appropriately for the type of care it is providing for the beneficiary. If the COVID-19 isolation and treatment facility is not yet an enrolled provider, the facility should enroll through the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area to establish temporary Medicare billing privileges.

We remind LTC facilities that they are responsible for ensuring that any transfers (either within a facility, or to another facility) are conducted in a safe and orderly manner, and that each resident's health and safety is protected.

We also remind states that under 42 CFR 488.426(a)(1), in an emergency, the State has the authority to transfer Medicaid and Medicare residents to another facility.

- **Physician Services.** CMS is providing relief to long-term care facilities related to provision of physician services through the following actions:
    - **Physician Delegation of Tasks in SNFs.** 42 CFR 483.30(e)(4). CMS is waiving the requirement in § 483.30(e)(4) that prevents a physician from delegating a task when the regulations specify that the physician must perform it personally. This waiver gives physicians the ability to delegate any tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who meets the applicable definition in 42 CFR 491.2 or, in the case of a clinical nurse specialist, is licensed as such by the State and is acting within the scope of practice laws as defined by State law. We are temporarily modifying this regulation to specify that any task delegated under this waiver must continue to be under the supervision of the physician. This waiver does not include the provision of § 483.30(e)(4) that prohibits a physician from delegating a task when the delegation is prohibited under State law or by the facility's own policy.
    - **Physician Visits.** 42 CFR 483.30(c)(3). CMS is waiving the requirement at § 483.30(c)(3) that all required physician visits (not already exempted in § 483.30(c)(4) and (f)) must be made by the physician personally. We are modifying this provision to permit physicians to delegate any required physician visit to a nurse practitioner (NPs), physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the State and performing within the state's scope of practice laws.
    - **Note to Facilities.** These actions will assist in potential staffing shortages, maximize the use of medical personnel, and protect the health and safety of residents during the PHE. We note that we are not waiving the requirements for the frequency of required physician visits at § 483.30(c)(1). As set out above, we have only modified the requirement to allow for the requirement to be met by an NP, physician assistant, or clinical nurse specialist, and via telehealth or other remote communication options, as appropriate. In addition, we note that we are not waiving our requirements for physician supervision in § 483.30(a)(1), and the requirement at § 483.30(d)(3) for the facility to provide or arrange for the provision of physician services 24 hours a day, in

case of an emergency. It is important that the physician be available for consultation regarding a resident's care.

- **Quality Assurance and Performance Improvement (QAPI).** CMS is modifying certain requirements in 42 CFR §483.75, which require long-term care facilities to develop, implement, evaluate, and maintain an effective, comprehensive, data-driven QAPI program. Specifically, CMS is modifying §483.75(b)–(d) and (e)(3) to the extent necessary to narrow the scope of the QAPI program to focus on adverse events and infection control. This will help ensure facilities focus on aspects of care delivery most closely associated with COVID-19 during the PHE.
- **In-Service Training:** CMS is modifying the nurse aide training requirements at §483.95(g)(1) for SNFs and NFs, which requires the nursing assistant to receive at least 12 hours of in-service training annually. In accordance with section 1135(b)(5) of the Act, we are postponing the deadline for completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes.
- **Detailed Information Sharing for Discharge Planning for Long-Term Care (LTC) Facilities.** CMS is waiving the discharge planning requirement in §483.21(c)(1)(viii), which requires LTC facilities to assist residents and their representatives in selecting a post-acute care provider using data, such as standardized patient assessment data, quality measures and resource use. This temporary waiver is to provide facilities the ability to expedite discharge and movement of residents among care settings. CMS is maintaining all other discharge planning requirements, such as but not limited to, ensuring that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident; involving the interdisciplinary team, as defined at 42 CFR §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan address the resident's goals of care and treatment preferences.
- **Clinical Records.** Pursuant to section 1135(b)(5) of the Act, CMS is modifying the requirement at 42 CFR §483.10(g)(2)(ii) which requires long-term care (LTC) facilities to provide a resident a copy of their records within two working days (when requested by the resident). Specifically, CMS is modifying the timeframe requirements to allow LTC facilities ten working days to provide a resident's record rather than two working days.
- **Paid Feeding Assistants.** CMS is modifying the requirements at 42 CFR §§ 483.60(h)(1)(i) and 483.160(a) regarding required training of paid feeding assistants. Specifically, CMS is modifying the minimum timeframe requirements in these sections, which require this training to be a minimum of 8 hours. CMS is modifying to allow that the training can be a minimum of 1 hour in length. CMS is not waiving any other requirements under 42 CFR §483.60(h) related to paid feeding assistants or the required training content at 42 CFR §483.160(a)(1)-(8), which contains infection control training and other elements. Additionally, CMS is also not waiving or modifying the requirements at 42 CFR §483.60(h)(2)(i), which requires that a feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).

Home Health Agencies (HHAs)

- **Requests for Anticipated Payment (RAPs).** CMS is allowing Medicare Administrative Contractors (MACs) to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies.

- **Reporting.** CMS is providing relief to HHAs on the timeframes related to OASIS Transmission through the following actions below:
    - Extending the 5-day completion requirement for the comprehensive assessment to 30 days.
    - Waiving the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE.

- **Initial Assessments.** CMS is waiving the requirements at 42 CFR §484.55(a) to allow HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review. This will allow patients to be cared for in the best environment for them while supporting infection control and reducing impact on acute care and long- term care facilities. This will allow for maximizing coverage by already scarce physician, and advanced practice clinicians, and allow those clinicians to focus on caring for patients with the greatest acuity.

- **Waive Onsite Visits for HHA Aide Supervision.** CMS is waiving the requirements at 42 CFR §484.80(h), which require a nurse to conduct an onsite visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. This waiver is also temporarily suspending the 2-week aide supervision by a registered nurse for home health agencies requirement at §484.80(h)(1), but virtual supervision is encouraged during the period of the waiver.

- **Allow Occupational Therapists (OTs), Physical Therapists (PTs), and Speech Language Pathologists (SLPs) to Perform Initial and Comprehensive Assessment for all Patients.** CMS is waiving the requirements in 42 CFR § 484.55(a)(2) and § 484.55(b)(3) that rehabilitation skilled professionals may only perform the initial and comprehensive assessment when only therapy services are ordered. This temporary blanket modification allows any rehabilitation professional (OT, PT, or SLP) to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether or not the service establishes eligibility for the patient to be receiving home care. The existing regulations at § 484.55(a) and (b)(2) would continue to apply; rehabilitation skilled professionals would not be permitted to perform assessments in nursing-only cases. We would continue to expect HHAs to match the appropriate discipline that performs the assessment to the needs of the patient to the greatest extent possible. Therapists must act within their state scope of practice laws when performing initial and comprehensive

assessments, and access a registered nurse or other professional to complete sections of the assessment that are beyond their scope of practice. Expanding the category of therapists who may perform initial and comprehensive assessments provides HHAs with additional flexibility that may decrease patient wait times for the initiation of home health services.

- **12-hour Annual In-service Training Requirement for Home Health Aides.** CMS is modifying the requirement at 42 CFR §484.80(d) that home health agencies must assure that each home health aide receives 12 hours of in-service training in a 12-month period. In accordance with section 1135(b)(5) of the Act, we are postponing the deadline for completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes. This will allow aides and the registered nurses (RNs) who teach in-service training to spend more time delivering direct patient care and additional time for staff to complete this requirement.

- **Detailed Information Sharing for Discharge Planning for Home Health Agencies.** CMS is waiving the requirements of 42 CFR §484.58(a) to provide detailed information regarding discharge planning, to patients and their caregivers, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, (another) home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures.

    - This temporary waiver provides facilities the ability to expedite discharge and movement of residents among care settings. CMS is maintaining all other discharge planning requirements.

- **Clinical Records:** In accordance with section 1135(b)(5) of the Act, CMS is extending the deadline for completion of the requirement at 42 CFR §484.110(e), which requires HHAs to provide a patient a copy of their medical record at no cost during the next visit or within four business days (when requested by the patient). Specifically, CMS will allow HHAs ten business days to provide a patient's clinical record, instead of four.

Home Health Agencies (HHAs) and Hospice

- **Training and Assessment of Aides:** CMS is waiving the requirement at 42 CFR §418.76(h)(2) for Hospice and 42 CFR §484.80(h)(1)(iii) for HHAs, which require a registered nurse, or in the case of an HHA a registered nurse or other appropriate skilled professional (physical therapist/occupational therapist, speech language pathologist) to make an annual onsite supervisory visit (direct observation) for each aide that provides services on behalf of the agency. In accordance with section 1135(b)(5) of the Act, we are postponing completion of these visits. All postponed onsite assessments must be completed by these professionals no later than 60 days after the expiration of the PHE.

- **Quality Assurance and Performance Improvement (QAPI).** CMS is modifying the requirement

at 42 CFR §418.58 for Hospice and §484.65 for HHAs, which requires these providers to develop, implement, evaluate, and maintain an effective, ongoing, hospice/HHA-wide, data-driven QAPI program. Specifically, CMS is modifying the requirements at §418.58(a)–(d) and §484.65(a)–(d) to narrow the scope of the QAPI program to concentrate on infection control issues, while retaining the requirement that remaining activities should continue to focus on adverse events. This modification decreases burden associated with the development and maintenance of a broad-based QAPI program, allowing the providers to focus efforts on aspects of care delivery most closely associated with COVID-19, and tracking adverse events during the PHE. The requirement that HHAs and hospices maintain an effective, ongoing, agency-wide, data-driven quality assessment and performance improvement program will remain.

Hospice

- **Waive Requirement for Hospices to Use Volunteers**. CMS is waiving the requirement at 42 CFR §418.78(e) that hospices are required to use volunteers (including at least 5% of patient care hours). It is anticipated that hospice volunteer availability and use will be reduced related to COVID-19 surge and potential quarantine.

- **Comprehensive Assessments.** CMS is waiving certain requirements at 42 CFR §418.54 related to updating comprehensive assessments of patients. This waiver applies the timeframes for updates to the comprehensive assessment found at §418.54(d). Hospices must continue to complete the required assessments and updates; however, the timeframes for updating the assessment may be extended from 15 to 21 days.

- **Waive Non-Core Services.** CMS is waiving the requirement for hospices to provide certain non-core hospice services during the national emergency, including the requirements at 42 CFR §418.72 for physical therapy, occupational therapy, and speech-language pathology.

- **Waived Onsite Visits for Hospice Aide Supervision.** CMS is waiving the requirements at 42 CFR §418.76(h), which require a nurse to conduct an onsite supervisory visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time.

- **Hospice Aide Competency Testing Allow Use of Pseudo Patients.** 42 CFR 418.76(c)(1). CMS is temporarily modifying the requirement in § 418.76(c)(1) that a hospice aide must be evaluated by observing an aide's performance of certain tasks with a patient. This modification allows hospices to utilize pseudo patients such as a person trained to participate in a role-play situation or a computer-based mannequin device, instead of actual patients, in the competency testing of hospice aides for those tasks that must be observed being performed on a patient. This increases the speed of performing competency testing and allows new aides to

begin serving patients more quickly without affecting patient health and safety during the public health emergency (PHE).

- **12 hour Annual In-service Training Requirement for Hospice Aides.** 42 CFR 418.76(d). CMS is waiving the requirement that hospices must assure that each hospice aide receives 12 hours of in-service training in a 12 month period. This allows aides and the registered nurses (RNs) who teach in-service training to spend more time delivering direct patient care.

- **Annual Training.** CMS is modifying the requirement at 42 CFR §418.100(g)(3), which requires hospices to annually assess the skills and competence of all individuals furnishing care and provide in-service training and education programs where required. Pursuant to section 1135(b)(5) of the Act, we are postponing the deadline for completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes. This does not alter the minimum personnel requirements at 42 CFR §418.114. Selected hospice staff must complete training and have their competency evaluated in accordance with unwaived provisions of 42 CFR Part 418.

End-Stage Renal Dialysis (ESRD) Facilities

- **Training Program and Periodic Audits.** CMS is waiving the requirement at 42 CFR §494.40(a) related to the condition on Water & Dialysate Quality, specifically that on-time periodic audits for operators of the water/dialysate equipment are waived to allow for flexibilities.

- **Defer Equipment Maintenance & Fire Safety Inspections.** CMS is waiving the requirement at 42 CFR §494.60(b) for on-time preventive maintenance of dialysis machines and ancillary dialysis equipment. Additionally, CMS is also waiving the requirements under §494.60(d) which requires ESRD facilities to conduct on-time fire inspections. These waivers are intended to ensure that dialysis facilities are able to focus on the operations related to the Public Health Emergency.

- **Emergency Preparedness.** CMS is waiving the requirements at 42 CFR §494.62(d)(1)(iv) which requires ESRD facilities to demonstrate as part of their Emergency Preparedness Training and Testing Program, that staff can demonstrate that, at a minimum, its patient care staff maintains current CPR certification. CMS is waiving the requirement for maintenance of CPR certification during the COVID-19 emergency due to the limited availability of CPR classes.

- **Ability to Delay Some Patient Assessments.** CMS is not waiving subsections (a) or (c) of 42 CFR §494.80, but is waiving the following requirements at 42 CFR §494.80(b) related to the frequency of assessments for patients admitted to the dialysis facility. CMS is waiving the "on-time" requirements for the initial and follow up comprehensive assessments within the specified timeframes as noted below. This waiver applies to assessments conducted by members of the interdisciplinary team, including: a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. These waivers are intended to ensure that

dialysis facilities are able to focus on the operations related to the Public Health Emergency. Specifically, CMS is waiving:

- §494.80(b)(1): An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session.
- §494.80(b)(2): A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in §494.90.

- **Time Period for Initiation of Care Planning and Monthly Physician Visits.** CMS is modifying two requirements related to care planning, specifically:
  - 42 CFR §494.90(b)(2): CMS is modifying the requirement that requires the dialysis facility to implement the initial plan of care within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. This modification will also apply to the requirement for monthly or annual updates of the plan of care within 15 days of the completion of the additional patient assessments.
  - §494.90(b)(4): CMS is modifying the requirement that requires the ESRD dialysis facility to ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant providing ESRD care at least monthly, and periodically while the hemodialysis patient is receiving in-facility dialysis. CMS is waiving the requirement for a monthly in-person visit if the patient is considered stable and also recommends exercising telehealth flexibilities, e.g. phone calls, to ensure patient safety.

- **Dialysis Home Visits to Assess Adaptation and Home Dialysis Machine Designation.** CMS is waiving the requirement at 42 CFR §494.100(c)(1)(i) which requires the periodic monitoring of the patient's home adaptation, including visits to the patient's home by facility personnel. For more information on existing flexibilities for in-center dialysis patients to receive their dialysis treatments in the home, or long-term care facility, reference QSO-20-19-ESRD.

- **Home Dialysis Machine Designation – Clarification.** The ESRD Conditions for Coverage (CFCs) do not explicitly require that each home dialysis patient have their own designated home dialysis machine. The dialysis facility is required to follow FDA labeling and manufacturer's directions for use to ensure appropriate operation of the dialysis machine and ancillary equipment. Dialysis machines must be properly cleaned and disinfected to minimize the risk of infection based on the requirements at 42 CFR §494.30 Condition: Infection Control if used to treat multiple patients.

- **Special Purpose Renal Dialysis Facilities (SPRDF) Designation Expanded.** CMS authorizes the establishment of SPRDFs under 42 CFR §494.120 to address access to care issues due to COVID-19 and the need to mitigate transmission among this vulnerable population. This will not include the normal determination regarding lack of access to care at §494.120(b) as this standard has been met during the period of the national emergency. Approval as a Special Purpose Renal Dialysis Facility related to COVID-19 does not require Federal survey prior to providing services.

- **Dialysis Patient Care Technician (PCT) Certification.** CMS is modifying the requirement at 42 CFR §494.140(e)(4) for dialysis PCTs that requires certification under a state certification program or a national commercially available certification program within 18 months of being hired as a dialysis PCT for newly employed patient care technicians. CMS is aware of the challenges that PCTs are facing with the limited availability and closures of testing sites during the time of this crisis. CMS will allow PCTs to continue working even if they have not achieved certification within 18 months or have not met on time renewals.

- **Transferability of Physician Credentialing.** CMS is modifying the requirement at 42 CFR §494.180(c)(1) which requires that all medical staff appointments and credentialing are in accordance with state law, including attending physicians, physician assistants, nurse practitioners, and clinical nurse specialists. These waivers will allow physicians that are appropriately credentialed at a certified dialysis facility to function to the fullest extent of their licensure to provide care at designated isolation locations without separate credentialing at that facility, and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan**.**

- **Expanding Availability of Renal Dialysis Services to ESRD Patients.** CMS is waiving the following requirements related to Nursing Home residents:

    - **Furnishing Dialysis Services on the Main Premises:** ESRD requirements at 42 CFR §494.180(d) require dialysis facilities to provide services directly on its main premises or on other premises that are contiguous with the main premises. CMS is waiving this requirement to allow dialysis facilities to provide service to its patients who reside in the nursing homes, long-term care facilities, assisted living facilities and similar types of facilities, as licensed by the state (if applicable). CMS continues to require that services provided to these patients or residents are under the direction of the same governing body and professional staff as the resident's usual Medicare-certified dialysis facility.

Further, in order to ensure that care is safe, effective and is provided by trained and qualified personnel, CMS requires that the dialysis facility staff: 1) furnish all dialysis care and services; 2) provide all equipment and supplies necessary; 3) maintain equipment and supplies in off-premises location; 4) and complete all equipment maintenance, cleaning and disinfection using appropriate infection control procedures and manufacturer's instructions for use.

- **Clarification for Billing Procedures**. Typically, ESRD beneficiaries are transported from a SNF/NF to an ESRD facility to receive renal dialysis services. In an effort to keep patients in their SNF/NF and decrease their risk of being exposed to COVID-19, ESRD facilities may temporarily furnish renal dialysis services to ESRD beneficiaries in the SNF/NF instead of the offsite ESRD facility. The in-center dialysis center should bill Medicare using Condition Code 71 (Full care unit. Billing for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility). The in-center dialysis center should also apply condition code DR to claims if all the treatments billed on the claim meet this condition or modifier CR on the line level to identify individual treatments meeting this condition. The ESRD provider would need to have their trained personnel administer the treatment in the SNF/ NF. In addition, the provider must follow the CFCs. In particular, under the CFCs is the requirement that to use a dialysis machine, the FDA-approved labeling must be adhered to § 494.100 and it must be maintained and operated in accordance with the manufacturer's recommendations (§ 494.60) and follow infection control requirements at § 494.30.

Physical Environment for Multiple Providers/Suppliers

Inspection, Testing & Maintenance (ITM) under the Physical Environment Conditions of Participation: CMS is waiving certain physical environment requirements for Hospitals, CAHs, inpatient hospice, ICF/IIDs, and SNFs/NFs to reduce disruption of patient care and potential exposure/transmission of COVID-19. The physical environment regulations require that facilities and equipment be maintained to ensure an acceptable level of safety and quality.

CMS will permit facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment.

- **Specific Physical Environment Waiver Information:**
    - 42 CFR §482.41(d) for hospitals, §485.623(b) for CAH, §418.110(c)(2)(iv) for inpatient hospice, §483.470(j) for ICF/IID; and §483.90 for SNFs/NFs all require these facilities and their equipment to be maintained to ensure an acceptable level of safety and quality. CMS is temporarily modifying these requirements to the extent necessary to permit these facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment.
    - 42 CFR §482.41(b)(1)(i) and (c) for hospitals, §485.623(c)(1)(i) and (d) for CAHs, §482.41(d)(1)(i) and (e) for inpatient hospices, §483.470(j)(1)(i) and (5)(v) for ICF/IIDs,

and §483.90(a)(1)(i) and (b) for SNFs/NFs require these facilities to be in compliance with the Life Safety Code (LSC) and Health Care Facilities Code (HCFC). CMS is temporarily modifying these provisions to the extent necessary to permit these facilities to adjust scheduled ITM frequencies and activities required by the LSC and HCFC. The following LSC and HCFC ITM are considered critical are not included in this waiver:

- Sprinkler system monthly electric motor-driven and weekly diesel engine-driven fire pump testing.
- Portable fire extinguisher monthly inspection.
- Elevators with firefighters' emergency operations monthly testing.
- Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing.
- Means of egress daily inspection in areas that have undergone construction, repair, alterations, or additions to ensure its ability to be used instantly in case of emergency.

- 42 CFR §482.41(b)(9) for hospitals, §485.623(c)(7) for CAHs, §418.110(d)(6) for inpatient hospices, §483.470(e)(1)(i) for ICF/IIDs, and §483.90(a)(7) for SNFs/NFs require these facilities to have an outside window or outside door in every sleeping room. CMS will permit a waiver of these outside window and outside door requirements to permit these providers to utilize facility and non-facility space that is not normally used for patient care to be utilized for temporary patient care or quarantine.

Specific Life Safety Code (LSC) for Multiple Providers - Waiver Information:

CMS is waiving and modifying particular waivers under 42 CFR §482.41(b) for hospitals; §485.623(c) for CAHs; §418.110(d) for inpatient hospice; §483.470(j) for ICF/IIDs and §483.90(a) for SNF/NFs. Specifically, CMS is modifying these requirements as follows:

- **Alcohol-based Hand-Rub (ABHR) Dispensers:** We are waiving the prescriptive requirements for the placement of alcohol-based hand rub (ABHR) dispensers for use by staff and others due to the need for the increased use of ABHR in infection control. However, ABHRs contain ethyl alcohol, which is considered a flammable liquid, and there are restrictions on the storage and location of the containers. This includes restricting access by certain patient/resident population to prevent accidental ingestion. Due to the increased fire risk for bulk containers (over five gallons) those will still need to be stored in a protected hazardous materials area.

  Refer to: 2012 LSC, sections 18/19.3.2.6. In addition, facilities should continue to protect ABHR dispensers against inappropriate use as required by 42 CFR §482.41(b)(7) for hospitals; §485.623(c)(5) for CAHs; §418.110(d)(4) for inpatient hospice; §483.470(j)(5)(ii) for ICF/IIDs and §483.90(a)(4) for SNF/NFs.

- **Fire Drills:** Due to the inadvisability of quarterly fire drills that move and mass staff together, we will instead permit a documented orientation training program related to the current fire plan, which considers current facility conditions. The training will instruct employees,

including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area.

Refer to: 2012 LSC, sections 18/19.7.1.6.

- **Temporary Construction:** CMS is waiving requirements that would otherwise not permit temporary walls and barriers between patients.

  Refer to: 2012 LSC, sections 18/19.3.3.2.

Intermediate Care Facility for Individuals with Intellectual Disabilities

- **Staffing Flexibilities.** CMS is waiving the requirements at 42 CFR §483.430(c)(4), which requires the facility to provide sufficient Direct Support Staff (DSS) so that Direct Care Staff (DCS) are not required to perform support services that interfere with direct client care. DSS perform activities such as cleaning of the facility, cooking, and laundry services. DSC perform activities such as teaching clients appropriate hygiene, budgeting, or effective communication and socialization skills. During the time of this waiver, DCS may be needed to conduct some of the activities normally performed by the DSS. This will allow facilities to adjust staffing patterns, while maintaining the minimum staffing ratios required at §483.430(d)(3).

- **Suspension of Community Outings.** CMS is waiving the requirements at 42 CFR §483.420(a)(11) which requires clients have the opportunity to participate in social, religious, and community group activities. The federal and/or state emergency restrictions will dictate the level of restriction from the community based on whether it is for social, religious, or medical purposes. States may have also imposed more restrictive limitations. CMS is authorizing the facility to implement social distancing precautions with respect to on and off-campus movement. State and Federal restrictive measures should be made in the context of competent, person-centered planning for each client.

- **Suspend Mandatory Training Requirements.** CMS is waiving, in-part, the requirements at 42 CFR §483.430(e)(1) related to routine staff training programs unrelated to the public health emergency. CMS is not waiving 42 CFR §483.430(e)(2)-(4) which requires focusing on the clients' developmental, behavioral and health needs and being able to demonstrate skills related to interventions for inappropriate behavior and implementing individual plans. We are not waiving these requirements as we believe the staff ability to develop and implement the skills necessary to effectively address clients' developmental, behavioral and health needs are essential functions for an ICF/IID. CMS is also not waiving initial training for new staff hires or training for staff around prevention and care for the infection control of COVID-19. It is critical that new staff gain the necessary skills and understanding of how to effectively perform their role as they work with this complex client population and that staff understand how to prevent and care for clients with COVID-19.

- **Modification of Adult Training Programs and Active Treatment.** CMS recognizes that during the public health emergency, active treatment will need to be modified. The requirements at 42 CFR §483.440(a)(1) require that each client must receive a continuous active treatment program, which includes consistent implementation of a program of specialized and generic training, treatment, health services and related services.

  CMS is waiving those components of beneficiaries' active treatment programs and training that would violate current state and local requirements for social distancing, staying at home, and traveling for essential services only. For example, although day habilitation programs and supported employment are important opportunities for training and socialization of clients at intermediate care facilities for individuals with developmental disabilities, these programs pose too high of a risk to staff and clients for exposure to a person with suspected or confirmed COVID-19. In accordance with §483.440(c)(1), any modification to a client's Individual Program Plan (IPP) in response to treatment changes associated with the COVID-19 crisis requires the approval of the interdisciplinary team. For facilities that have interdisciplinary team members who are unavailable due to the COVID-19, CMS would allow for a retroactive review of the IPP under 483.440(f)(2) in order to allow IPPs to receive modifications as necessary based on the impact of the COVID-19 crisis.

Ambulatory Surgical Centers (ASCs)

- **Medical Staff.** 42 CFR 416.45(b). CMS is waiving the requirement at § 416.45(b) that medical staff privileges must be periodically reappraised, and the scope of procedures performed in the ASC must be periodically reviewed. This will allow for physicians whose privileges will expire to continue practicing at the ambulatory surgical center, without the need for reappraisal, and for ASCs to continue operations without performing these administrative tasks during the PHE. This waiver will improve the ability of ASCs to maintain their current workforce during the PHE.

Community Mental Health Clinics (CMHCs)

- **Quality assessment and performance improvement (QAPI).** 42 CFR 485.917(a)-(d) We are modifying the requirements for CMHC's quality assessment and performance improvement (QAPI). Specifically, we are retaining the overall requirement that CMHC's maintain an effective, ongoing, CMHC-wide, data-driven QAPI program, while providing flexibility for CMHCs to use their QAPI resources to focus on challenges and opportunities for improvement related to the PHE by waiving the specific detailed requirements for the QAPI program's organization and content at § 485.917(a)-(d). Waiving the requirements related to the details of the QAPI program's organization and content will make it easier for CMHCs to reconfigure their QAPI programs, as needed, to adapt to specific needs and circumstances that arise during the PHE. These flexibilities may be implemented so long as they are consistent with a state's emergency preparedness or pandemic plan.

- **Provision of Services.** 42 CFR 485.918(b)(1)(iii). We are waiving the specific requirement at § 485.918(b)(1)(iii) that prohibits CMHCs from providing partial hospitalization services and other CMHC services in an individual's home so that clients can safely shelter in place during the PHE while continuing to receive needed care and services from the CMHC. This waiver is a companion to recent regulatory changes (INSERT IFR CITATION WHEN RELEASED) that clarify how CMHCs should bill for services provided in an individual's home, and how such services should be documented in the medical record. While this waiver will now allow CMHCs to furnish services in client homes, including through the use of using telecommunication technology, CMHCs continue to be, among other things, required to comply with the non-waived provisions of 42 CFR Part 485, Subpart J, requiring that CMHCs: 1) assess client needs, including physician certification of the need for partial hospitalization services, if needed; 2) implement and update each client's individualized active treatment plan that sets forth the type, amount, duration, and frequency of the services; and 3) promote client rights, including a client's right to file a complaint.

- **40 Percent Rule.** 42 CFR 485.918(b)(1)(v) We are waiving the requirement at § 485.918(b)(1)(v) that a CMHC provides at least 40 percent of its items and services to individuals who are not eligible for Medicare benefits. Waiving the 40 percent requirement will facilitate appropriate timely discharge from inpatient psychiatric units and prevent admissions to these facilities because CMHCs will be able to provide PHP services to Medicare beneficiaries without restrictions on the proportion of Medicare beneficiaries that they are permitted to treat at a time. This will allow communities greater access to health services, including mental health services.

Ambulance Services: Medicare Ground Ambulance Data Collection System *(New since May 11 Release)*

- CMS is modifying the data collection period and data reporting period, as defined at 42 CFR § 414.626(a), for ground ambulance organizations (as defined at 42 CFR § 414.605) that were selected by CMS under 42 CFR § 414.626(c) to collect data beginning between January 1, 2020 and December 31, 2020 (year 1) for purposes of complying with the data reporting requirements described at 42 CFR § 414.626. Under this modification, these ground ambulance organizations can select a new continuous 12-month data collection period that begins between January 1, 2021 and December 31, 2021, collect data necessary to complete the Medicare Ground Ambulance Data Collection Instrument during their selected data collection period, and submit a completed Medicare Ground Ambulance Data Collection Instrument during the data reporting period that corresponds to their selected data collection period. CMS is modifying this data collection and reporting period to increase flexibilities for ground ambulance organizations that would otherwise be required to collect data in 2020-2021 so that they can focus on their operations and patient care.

  As a result of this modification, ground ambulance organizations selected for year 1 data collection and reporting will collect and report data during the same period of time that will

apply to ground ambulance organizations selected by CMS under 42 CFR § 414.626(c) to collect data beginning between January 1, 2021 and December 31, 2021 (year 2) for purposes of complying with the data reporting requirements described at 42 CFR § 414.626.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

- When DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable, CMS is allowing DME Medicare Administrative Contractors (MACs) to have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered unusable or unavailable as a result of the emergency.

Practitioner Locations

CMS is temporarily waiving requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state. CMS will waive the physician or non-physician practitioner licensing requirements when the following four conditions are met: 1) must be enrolled as such in the Medicare program; 2) must possess a valid license to practice in the state, which relates to his or her Medicare enrollment; 3) is furnishing services – whether in person or via telehealth – in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and, 4) is not affirmatively excluded from practice in the state or any other state that is part of the 1135 emergency area.

- In addition to the statutory limitations that apply to 1135-based licensure waivers, an 1135 waiver, when granted by CMS, does not have the effect of waiving state or local licensure requirements or any requirement specified by the state or a local government as a condition for waiving its licensure requirements. Those requirements would continue to apply unless waived by the state. Therefore, in order for the physician or non-physician practitioner to avail him- or herself of the 1135 waiver under the conditions described above, the state also would have to waive its licensure requirements, either individually or categorically, for the type of practice for which the physician or non-physician practitioner is licensed in his or her home state.

Provider Enrollment

- **Non-Waiver CMS Action:** CMS has a toll-free hotline for physicians and non-physician practitioners and Part A certified providers and suppliers establishing isolation facilities to enroll and receive temporary Medicare billing privileges.

- Waive the following screening requirements:
    - Application Fee - (to the extent applicable).
    - Criminal background checks associated with fingerprint-based criminal background checks (FCBC) (to the extent applicable) - 42 CFR §424.518.
    - Site visits (to the extent applicable) - 42 CFR §424.517.
- Postpone all revalidation actions.
- Allow licensed providers to render services outside of their state of enrollment.
- Expedite any pending or new applications from providers.
- Allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location.
- Allow opted-out physicians and non-physician practitioners to terminate their opt-out status early and enroll in Medicare to provide care to more patients.

Modification of 60-Day Limit for Substitute Billing Arrangements (Locum Tenens)

CMS is modifying the 60-day limit in section 1842(b)(6)(D)(iii) of the Social Security Act to allow a physician or physical therapist to use the same substitute for the entire time he or she is unavailable to provide services during the COVID-19 emergency plus an additional period of no more than 60 continuous days after the public health emergency expires. On the 61st day after the public health emergency ends (or earlier if desired), the regular physician or physical therapist must use a different substitute or return to work in his or her practice for at least one day in order to reset the 60-day clock. Without this flexibility, the regular physician or physical therapist generally could not use a single substitute for a continuous period of longer than 60 days, and would instead be required to secure a series of substitutes to cover sequential 60-day periods. The modified timetable applies to both types of substitute billing arrangements under Medicare fee-for-service (i.e., reciprocal billing arrangements and fee-for-time compensation arrangements (formerly known as locum tenens)).

Notes: Under the Medicare statute, only 1) physicians and 2) physical therapists who furnish outpatient physical therapy services in a health professional shortage area (HPSA), a medically underserved area (MUA), or a rural area can receive Medicare fee-for-service payment for services furnished by a substitute under a substitute billing arrangement. In addition, Medicare can pay for services under a substitute billing arrangement only when the regular physician or physical therapist is unavailable to provide the services. Finally, as provided by law, a regular physician or physical therapist who has been called or ordered to active duty as a member of a reserve component of the Armed Forces may continue to use the same substitute for an unlimited time even after the emergency ends.

Medicare Appeals in Fee for Service (FFS), Medicare Advantage (MA) and Part D

CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractors (QICs) in the FFS program pursuant to 42 CFR §405.942 and 42 CFR §405.962 (including for MA and Part D plans), as well as the MA and Part D Independent Review Entities (IREs) under 42 CFR §422.562, 42 CFR §423.562, 42 CFR §422.582 and 42 CFR §423.582, to allow extensions to file an appeal**.** CMS is allowing MACs and QICs in the FFS program under 42 CFR §405.950 and 42 CFR §405.966 and the MA and Part D IREs to waive requests for timeliness requirements for additional information to adjudicate appeals.

- CMS is allowing MACs and QICs in the FFS program under 42 CFR §405.910 and MA and Part D plans, as well as the MA and Part D IREs, to process an appeal even with incomplete Appointment of Representation forms as outlined under 42 CFR §422.561 and 42 CFR §423.560. However, any communications will only be sent to the beneficiary.

- CMS is allowing MACs and QICs in the FFS program under 42 CFR §405.950 and 42 CFR §405.966 (also including MA and Part D plans), as well as the MA and Part D IREs, to process requests for appeals that do not meet the required elements using information that is available as outlined within 42 CFR §422.561 and 42 CFR §423.560.

- CMS is allowing MACs and QICs in the FFS program under 42 CFR §405.950 and 42 CFR §405.966 (also including MA and Part D plans), as well as the MA and Part D IREs under 42 CFR §422.562 and 42 CFR §423.562 to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

Medicaid and CHIP (as of 3/13/2020)

States and territories can request approval that certain statutes and implementing regulations be waived by CMS, pursuant to section 1135 of the Act. To assist states in this process, CMS released an 1135 Waiver Checklist to make it easier for states to receive federal waivers and implement flexibilities in their Medicaid and CHIP programs. States' use of this 1135 checklist will expedite their ability to apply for and receive approval for 1135 waivers that are now available under the President's national emergency declaration.

States and territories may submit a Section 1135 waiver request directly to their Center for Medicaid & CHIP Services (CMCS) state lead or Jackie Glaze, Acting Director, Medicaid & CHIP Operations Group, Center for Medicaid & CHIP Services at CMS by e-mail (**Jackie.Glaze@cms.hhs.gov**) or letter.

The following are examples of flexibilities that states and territories may seek through a Section 1135 waiver request:

- Waive prior authorization requirements in fee-for-service programs.
- Permits providers located out of state/territory to provide care to another state's Medicaid enrollee impacted by the emergency.
- Temporarily suspend certain provider enrollment and revalidation requirements to increase access to care.
- Temporarily waive requirements that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have an equivalent licensing in another state; and,
- Temporarily suspend requirements for certain pre-admission and annual screenings for nursing home residents.

States and territories are encouraged to assess their needs and request these available flexibilities, which are more completely outlined in the Medicaid and CHIP Disaster Response Toolkit. For more information and to access the toolkit and the **1135 waiver checklist**, visit: **https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html**.

ATTACHMENT A

Blanket Waivers of Sanctions under the Physician Self- Referral Law (also known as the "Stark Law")

CMS has issued blanket waivers of sanctions under section 1877(g) of the Act. The blanket waivers may be used now without notifying CMS. Individual waivers of sanctions under section 1877(g) of the Act may be granted upon request. For more information, visit: **https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Spotlight.**

For resources and additional information on 1135 Waivers, please also visit:

- **https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page**
- **https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers**

For questions, please email: **1135waiver@cms.hhs.gov**

Blanket Waivers: Stafford Act, Public Health Emergency (PHE) and Section 1135 Waivers

Background

On March 13, 2020, the President issued an emergency declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5207 (the "Stafford Act") to declare a national health emergency. The Secretary of the Department of Health and Human Services (the Secretary) is authorized to waive certain Medicare, Medicaid and Children's Health Insurance Program (CHIP) program requirements and conditions of participation under Section 1135 of the Social Security Act once the President has declared an emergency through the Stafford Act[1] and the Secretary has declared a Public Health Emergency (PHE). The Secretary issued a PHE on January 31, 2020[2]. As a result of this authority, CMS can grant waivers that will ease certain requirements for affected providers as stated under Section 1135 of the Social Security Act[3].

CMS can issue two types of waivers: blanket waivers and provider/supplier requested waivers. Specifics about the two types of waivers are outlined in detail below. Examples of these 1135 waivers or modifications include:

- Conditions of participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements
- Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure)
- Emergency Medical Treatment and Labor Act (EMTALA)
- Sanctions under the physician self-referral law (also known as the "Stark Law")
- Performance deadlines and timetables may be adjusted (but not waived)
- Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers

Waivers under Section 1135 of the Social Security Act typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published. The Secretary can extend the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.

[1] https://www.whitehouse.gov/wp-content/uploads/2020/03/LetterFromThePresident.pdf

[2] https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx

[3] https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx

The 1135 waiver authority applies **only** to Federal requirements and **does not apply** to State requirements for licensure or conditions of participation.

In addition to the 1135 waiver authority, Section 1812(f) of the Social Security Act (the Act) authorizes the Secretary to provide for Skilled Nursing Facilities (SNF) coverage in the absence of a qualifying hospital stay, as long as this action does not increase overall program payments and does not alter the SNF benefit's "acute care nature" (that is, its orientation toward relatively short-term and intensive care).

Federally certified/approved providers must continue to operate under normal rules and regulations, unless they have sought and have been granted modifications under the waiver authority from specific requirements.

In addition, the Coronavirus Preparedness and Response Supplemental Appropriations Act, as signed into law by the President on March 6, 2020, includes a provision allowing the Secretary to waive certain Medicare telehealth payment requirements during the PHE the Secretary declared on January 31, 2020 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home. Under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas, and patients in their homes will be eligible for telehealth services, effective for services starting March 6, 2020[4].

[4] **https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf**

CMS Section 1135 Waiver Authority: Blanket Waivers, Provider/Supplier Individual Waivers, Medicaid and Special Waivers

Medicare Blanket Waivers

- **Approval:** CMS implements specific waivers or modifications under the 1135 authority on a "blanket" basis when a determination has been made that all similarly situated providers in the emergency area need such a waiver or modification. These waivers prevent gaps in access to care for beneficiaries impacted by the emergency. **Once approved these waivers apply automatically to all applicable providers and suppliers. Providers and suppliers do not need to apply for an individual waiver if a blanket waiver is issued by CMS.**

- **Claims Submission for Blanket Waivers:** When submitting claims covered by the blanket waivers, the "DR" (disaster-related) condition code should be used for institutional billing (i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450). The "CR" (catastrophe/disaster-related) modifier should be used for Part B billing, both institutional and non-institutional (i.e., claims submitted using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format). This requirement does not apply for purposes of compliance with waivers (blanket or individual) of sanctions under the physician self- referral law.

Medicare Provider/Supplier Individual Waivers

- **Approval:** Providers and suppliers can submit requests for individual 1135 waivers. These requests must include a justification for the waiver and expected duration of the modification requested. The State Survey Agency and CMS Survey Operations Group will review the provider's request and make appropriate decisions, usually on a case-by- case basis. Providers and suppliers should keep careful records of beneficiaries to whom they provide services, in order to ensure that proper payment may be made. Providers are expected to come into compliance with any waived requirements prior to the end of the emergency period.

- With the exception of physician self-referral law waivers, the process for requesting an 1135 waiver is managed through the Survey Operations Group, and CMS locations, previously known as the CMS Regional Offices. More information on the process is located at **https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers**. The website includes contact information for each CMS location. Facilities should ensure to review the process and identify the appropriate contact based on the location of the facility.

Examples of Individual Requests for 1135 Waivers
An individual hospital may request a waiver of COPs related to doubling of single occupancy patient rooms or a waiver of the requirement to discharge to a specified location or situation.

Waiver Request Process
You **do not** have to make a request for a blanket waiver that has already been issued, and you **do not** have to notify CMS if you are taking action in accordance with a waiver during the time period in which the waiver is valid. If you are requesting an 1135 waiver outside of those outlined in this document or are already available at the CMS **Current Emergencies** page, please send your request or questions about a request to **1135waiver@cms.hhs.gov**.

Medicaid Waivers

Approval
CMS works with the states and territories to respond to public health emergencies and disasters. States and territories have multiple strategies available to support Medicaid and CHIP Operations and enrollees in times of crisis. Some of these strategies are available without needing approval from CMS while some disaster-related and Public Health Emergency legal authorities include:

- Medicaid State Plan Amendments;
- CHIP Disaster Relief State Plan Amendments;
- Verification Plans;
- 1915(c) Waivers Appendix K;
- 1135 Waivers; and
- 1115 Demonstrations.

In Medicaid and CHIP, 1135 waivers can be used to implement a range of flexibilities. Some of these include: provider enrollment and participation; Medicaid prior authorization requirements; pre-admission screening and annual resident review (PASARR) Level I and Level II Assessments for 30 days; extend minimum data set authorizations for nursing facility and SNF residents; state fair hearing and appeal process timelines; and reporting and oversight. Under 1135 waivers, states also have flexibility on public notice, tribal consultation, and the effective dates of state plan amendment (SPA) submissions. For public notice, Section 1135 authority can be used to provide flexibility related to the need and timing for public notice associated with cost sharing, Alternative Benefit Plan (ABP) benefit and payment SPAs. Section 1135 authority can be used to provide flexibility related to the timing of tribal consultation including shortening consultation or conducting tribal consultation after submission of the SPA. For SPA submission dates, Section 1135 authority can be utilized to effectively permit states to submit a Medicaid SPA after the end of this quarter and still have an effective date retroactive to the date of the declaration by the Secretary of a Public Health Emergency.

In the event of a disaster or public health emergency, state Medicaid agencies should contact CMS for questions and waiver requests. More information on this process is located at: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html

Special Waivers

EMTALA:

Only two aspects of the EMTALA requirements can be waived under 1135 Waiver Authority: 1) Transfer of an individual who has not been stabilized, if the transfer arises out of an emergency or, 2) Redirection to another location (offsite alternate screening location) to receive a medical screening exam under a state emergency preparedness or pandemic plan. A waiver of EMTALA sanctions is effective only if actions under the waiver do not discriminate as to source of payment or ability to pay. Hospitals are generally able to manage the separation and flow of potentially infectious patients through alternate screening locations on the hospital campus.

Therefore, waivers to provide Medical Screening Examinations at an offsite alternate screening location not owned or operated by the hospital will be reviewed on a case-by-case basis. Please note, there is no waiver authority available for any other EMTALA requirement.

For the duration of the COVID-19 national emergency, CMS is waiving the enforcement of section 1867(a) of the Social Security Act (the Emergency Medical Treatment and Active Labor Act, or EMTALA). This will allow hospitals, psychiatric hospitals, and CAHs to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, in accordance with the state emergency preparedness or pandemic plan.

Individual Physician Self-Referral Law Waiver Requests:

CMS has issued blanket waivers of sanctions under the physician self-referral law. The blanket waivers may be used now without notifying CMS. For more information, visit: https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Spotlight.

Unlike other 1135 waiver requests, any requests for individual waivers of sanctions under the physician self- referral law related to COVID-19 will be handled by CMS Baltimore. Please send your request to 1877CallCenter@cms.hhs.gov and include the words "Request for 1877(g) Waiver" in the subject line of the email. All requests should include the following minimum information:

- Name and address of requesting entity;
- Name, phone number and email address of person designated to represent the entity;
- CMS Certification Number (CCN) or Taxpayer Identification Number (TIN);
- Nature of request.

Individual waivers may be granted only upon request and on a case-by-case basis and require specific details concerning the actual or proposed financial relationship between the referring physician(s) and the referred-to entity. Unless and until a waiver of sanctions under the physician self-referral law (i.e., a waiver of section 1877(g) of the Social Security Act) is granted to the requesting party(ies), such party(ies) must comply with section 1877 of the Social Security Act and the regulations at 42 CFR §411.350 et seq.

Helpful Website Resources

- **Approved 1135 Waivers:** https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf
- **Approved Telehealth Waivers:** https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- **1135 Waiver Request Information:** https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers
- **Medicare Fee-For-Service Additional Emergency and Disaster-Related Policies and Procedures That May Be Implemented Only With an §1135 Waiver:** https://www. cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf
- **Blanket Waivers – Claims Submission:** https://www.cms.gov/files/document/se20011.pdf
- **Frequently Asked Questions – 1135 Waivers:** https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf
- **Frequently Asked Questions – non-1135 Waivers:** https://www.cms.gov/About-CMS/ Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_ QsAs.pdf
- **Medicaid Disaster Response Toolkit:** https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html

CMS Oversight

CMS remains committed to ensuring continuity of oversight activities during a national public health emergency. We continue to work State Survey Agencies and accrediting organizations, charged with inspecting Medicare and Medicaid providers to ensure compliance with Federal requirements, to ensure these activities are prioritized to allow providers to focus on current health and safety threats and provide needed care to beneficiaries. We will continue to monitor program operations to support proper enrollment and accurate billing practices. CMS will coordinate our oversight activities with the OIG and GAO.

Pendulum NFPA 99 2012 Risk Assessment Tool

General Information

Date of Assessment:

Baseline Assessment: ☐ Focused Assessment: ☐

Facility Name:

Address:

Phone:

Administrator:

Maintenance Director:

Number of Beds: **Number of Stories:**

Approximate Square Footage: Clear

Risk Assessment Tool Instructions

PURPOSE OF THE RISK ASSESSMENT TOOL

The purpose of the Risk Assessment Tool is to determine which sections of the NFPA 99, Health Care Facilities Code, 2012 edition[1] (referred to as the "code" throughout these instructions) apply to installed systems and/or equipment in a skilled nursing facility (SNF). This tool shall be used when an area(s) is required to be assessed due to change-of-use, renovation, remodeling, or new construction. The facility should maintain the findings on-file in all cases for general compliance purposes.

WHEN TO CONDUCT THE RISK ASSESSMENT

It is recommended that a baseline risk assessment to evaluate the consequences of failure be conducted on all systems and equipment within the facility and subsequently reviewed on an annual basis.

There may be times when specific work occurs within the SNF when a focused risk assessment will need to be conducted in a specific area(s) of the facility when change-of-use, renovation, remodeling, and/or new construction occurs. In advance of this work, a risk assessment to evaluate the consequences of failure of specific systems and applicable equipment shall be conducted in this area(s) to determine which sections of the code shall apply and to categorize them appropriately.

RISK ASSESSMENT

According to explanatory information provided in section 4.2 of the code, the assessment should follow procedures as outlined below.

The results should be documented with this tool, and records should be retained to illustrate compliance.

INSTRUCTIONS FOR USING THE RISK ASSESSMENT TOOL

Prior to utilizing the Risk Assessment Tool, the following should be considered for implementation:

- Establish an assessment team within the facility that can review all aspects of facility operations in order to complete a comprehensive assessment process from multiple perspectives on physical plant infrastructure, patient care, and occupant safety.
- Familiarize all team members with NFPA 99, Health Care Facilities Code (2012 edition); specifically, section 4.1 on Building Systems Categories and 4.2 on Risk Assessment.
- Ensure team members understand the importance of system reliability and the consequences of failure.

The Risk Assessment Tool has been organized into the following two (2) sections for skilled nursing facilities (SNF):

- Systems
- Equipment

[1] The 2012 edition of the code has been reorganized and is now a risk-based code; whereas, previous editions were presented as occupancy-based standards.

SYSTEMS AND EQUIPMENT

The Risk Assessment Tool has been organized in a manner where the specific systems that are typical in a healthcare facility are itemized in an order that corresponds to specific chapters of the code on the **Systems** page. For example: oxygen, medical air, vacuum, and waste anesthetic gas disposal (WAGD) are grouped together on the tool to correspond to chapter 5 of the code. Electrical systems correspond to chapter 6 of the code and so on.

When change-of-use, renovation, remodeling, or new construction occurs within the SNF, specific patient care equipment, as identified in the following sections of the code, should be assessed, and the findings of the evaluation should be entered on the **Equipment** page of the Risk Assessment Tool:

- Chapter 10: Performance Criteria and Testing for Patient Care-related Electrical Appliances and Equipment
    - Permanently Connected–Fixed Equipment
    - Cord and Plug-Connected–Portable Equipment
- Chapter 11: Gas Equipment
    - Equipment required for the administration of non-flammable medical gases
    - Equipment required for the administration of vapors and aerosols

The level of care provided in the SNF will determine what equipment needs to be evaluated during the process.

BUILDING SYSTEM CATEGORIES

When conducting the assessment, the goal is to categorize the system being evaluated to one of the following:

Category 1: Facility systems in which failure of such systems is likely to cause major injury or death of patients or caregivers shall be designed to meet system Category 1 requirements of the code.

NOTE: Systems are expected to work or be available at all times to support patient needs. Failure of a Category 1 system has very serious consequences. Major injury or death can be caused by the failure of a life support system in a SNF.

Major injury can include any of the following:

1. Any amputation
2. Loss of sight in an eye (whether temporary or permanent)
3. Chemical or hot metal burns to the eye or any penetrating injury to the eye
4. Any injuries that result from electrical shock or electrical burns leading to unconsciousness and that require resuscitation or admittance to a hospital for 24 hours or more
5. Any other injury that leads to hypothermia, heat-induced illness, or unconsciousness and that requires resuscitation or admittance to a hospital for 24 hours or more
6. Loss of consciousness caused by asphyxia or lack of oxygen or exposure to biological agent or harmful substance
7. Absorption of any substance by inhalation, skin, or ingestion, causing loss of consciousness or acute illness requiring medical treatment

8. Acute illness requiring medical treatment where there is reason to believe the exposure was to biological agents, toxins, or infected material

Category 2: Facility systems in which failure of such equipment is likely to cause minor injury to patients or caregivers shall be designated to meet system Category 2 requirements defined in the code. The code defines a minor injury as, *"not serious or involving risk of life."*

NOTE: Systems are expected to provide a high level of reliability; however, limited to short durations of system failure can be tolerated without significant impact on patient care. These systems support patient needs but are not critical for life support.

Failure of a Category 2 system will cause minor injury. Examples of Category 2 systems include the following in a SNF:

- Task or procedure lighting in patient rooms
- Potable water in patient care areas

Category 3: Facility systems in which failure of such equipment is not likely to cause injury to patients of caregivers, but can cause discomfort, shall be designed to meet system Category 3 requirements as defined in the code.

NOTE: The level of reliability of a normal building system is expected. Such systems support patient needs, but failure of such equipment would not immediately affect patient care. Such equipment is not critical for life support. Examples of Category 3 systems include the following in a SNF:

- Heating systems in the southern United States
- Humidity control in non-operating areas
- Motorized bed adjustments
- Cooling tower makeup water in the northwest United States

Category 4: Facility systems in which failure of such equipment would have no impact on patient care shall be designed to meet Category 4 system requirements defined in the code.

NOTE: Such systems have no impact on patient care and would not be noticeable to patients in the event of failure. Examples of Category 4 systems include the following in a SNF:

- Gray water lawn systems
- Seasonal lighting systems
- Public address systems
- Pneumatic tube systems

The category definitions apply to equipment operations and are not intended to consider the intervention of caregivers or others.

COMPLETING THE RISK ASSESSMENT FORM

Once the assessment of the consequences of failure of systems and applicable equipment has been completed in accordance with the methodology recommended in the "Risk Assessment" section of these instructions, the Risk Assessment Tool shall be completed with the findings of the assessment. The form has been designed with the following sections:

- General Information
- Instructions
- Systems Risk Assessment
- Equipment Risk Assessment
- Additional Information/Comments

The user shall complete all required sections of the document.

The **General Information** section will identify if the documents pertain to a baseline assessment or a focused assessment. The appropriate box needs to be checked to illustrate the type of assessment that the tool is being used for.

The **Instructions** section provides the guidance and references needed to use the Risk Assessment Tool.

The **Systems** and **Equipment** sections of the tool provide the space needed to illustrate the findings of the risk assessment in accordance with Categories 1 through 4 as identified in the code.

If a system identified in the **Systems** section of the tool is not installed within the facility, the Not Applicable (NA) box should be checked.

Itemization of applicable patient care equipment identified in Chapters 10 and 11 of the code shall be manually inserted in this section of the tool, and the findings of the risk assessment in accordance with Categories 1 through 4 identified in the code should be inserted in the space provided.

The **Additional Information/Comments** page provides space for any explanatory information that needs to be added to the tool.

Systems Risk Assessment

1	Facility systems in which failure of such equipment or systems is likely to cause major injury or death of patients or caregivers shall be designed to meet system Category 1 requirements as defined in this code.
2	Facility systems in which failure of such equipment or systems is likely to cause minor injury to patients or caregivers shall be designed to meet system Category 2 requirements as defined in this code.
3	Facility systems in which failure of such equipment or systems is not likely to cause injury to patients or caregivers but can cause discomfort to patients shall be designed to meet system Category 3 requirements as defined in this code.
4	Facility systems in which failure of such equipment would have no impact on patient care shall be designed to meet system Category 4 requirements as defined in this code.

Reset Section

	Systems	Category					Notes
		1	2	3	4	NA	
Chapter 5	**Oxygen**	○	○	○	○	○	
	Medical Air	○	○	○	○	○	
	Vacuum	○	○	○	○	○	
	WAGD (Waste Anesthetic Gas Disposal)	○	○	○	○	○	
Chapter 6	**Electrical Systems**	○	○	○	○	○	
Chapter 7	**Data**	○	○	○	○	○	
	Phone	○	○	○	○	○	

	Systems	Category					Notes
		1	2	3	4	NA	
	Nurse Call	○	○	○	○	○	
	Cable TV	○	○	○	○	○	
Chapter 8	Potable Water	○	○	○	○	○	
	Non-Potable Water	○	○	○	○	○	
	Water Heating	○	○	○	○	○	
	Water Conditioning	○	○	○	○	○	
	Non-Medical Compressed Air	○	○	○	○	○	
	Black Water Waste	○	○	○	○	○	
	Gray Water Waste	○	○	○	○	○	
	Clear Water Waste	○	○	○	○	○	
Chapter 9	Heating	○	○	○	○	○	
	Ventilation	○	○	○	○	○	
	Air Conditioning	○	○	○	○	○	
		○	○	○	○		

	Systems	Category					Notes
		1	2	3	4	NA	
		○	○	○	○		
		○	○	○	○		
		○	○	○	○		
		○	○	○	○		
		○	○	○	○		
		○	○	○	○		
		○	○	○	○		
		○	○	○	○		
		○	○	○	○		
		○	○	○	○		
		○	○	○	○		
		○	○	○	○		
		○	○	○	○		
		○	○	○	○		

Equipment Risk Assessment

1	Facility systems in which failure of such equipment or systems is likely to cause major injury or death of patients or caregivers shall be designed to meet system Category 1 requirements as defined in this code.
2	Facility systems in which failure of such equipment or systems is likely to cause minor injury to patients or caregivers shall be designed to meet system Category 2 requirements as defined in this code.
3	Facility systems in which failure of such equipment or systems is not likely to cause injury to patients or caregivers but can cause discomfort to patients shall be designed to meet system Category 3 requirements as defined in this code.
4	Facility systems in which failure of such equipment would have no impact on patient care shall be designed to meet system Category 4 requirements as defined in this code.

Equipment:	Electrical Equipment: Chapter 10 Requirements Gas Equipment: Chapter 11 Requirements

Reset Section

Room or Area Evaluated	Item	Equipment ID#	Category				Notes
			1	2	3	4	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	

Room or Area	Item	Equipment ID#	Category				Notes
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	
			○	○	○	○	

Additional Information/Comments

Additional Information/Comments:

Clear

Life Safety Documentation Requirements

Revision:10 7/14/18

Based on the 2012 edition of the Life Safety Code, for all Healthcare facilities Date Assessment: _____

Facility Name: _____ Location: _____

Fire Alarm Test Report

	Devices/Function	Frequency	NFPA Standard	Date of Most Recent	Compliant? Yes	No	N/A	Comment
Initiating Devices	Waterflow switches	Semi-annually	**72**-2010; 14.4.5					
	Smoke detectors	Annually	**72**-2010; 14.4.5					
	Heat detectors	Annually	**72**-2010; 14.4.5					
	Duct detectors	Annually	**72**-2010; 14.4.5					
	Manual pull stations	Annually	**72**-2010; 14.4.5					
Supervisory Signal Devices	Low air pressure switches	Quarterly	**72**-2010; 14.4.5					
	Low water level switches	Quarterly	**72**-2010; 14.4.5					
	Tamper switches	Semi-annually	**72**-2010; 14.4.5					
Notification Devices	Strobes	Annually	**72**-2010; 14.4.5					
	Horns	Annually	**72**-2010; 14.4.5					
	Bells	Annually	**72**-2010; 14.4.5					
	Chimes	Annually	**72**-2010; 14.4.5					
Interface relays and modules	Magnetic hold-open	Annually	**72**-2010; 14.4.5					
	Air handler shut-down	Annually	**72**-2010; 14.4.5					
	Kitchen hood suppression sys	Annually	**72**-2010; 14.4.5					
	Elevator recall	Annually	**72**-2010; 14.4.5					
	Magnetic locks / Electric strikes	Annually	**72**-2010; 14.4.5					
	Fire pump	Annually	**72**-2010; 14.4.5					
	Smoke dampers	Annually	**72**-2010; 14.4.5					
	CO2/Clean agent suppression	Annually	**72**-2010; 14.4.5					
	Sprinkler dry-pipe/pre-action	Annually	**72**-2010; 14.4.5					
	Overhead rolling fire doors	Annually	**72**-2010; 14.4.5					
Control panel batteries	Charger test	Annually	**72**-2010; 14.4.5					
	Discharge test	Annually	**72**-2010; 14.4.5					
	Load voltage test	Semi-annually	**72**-2010; 14.4.5					
Smoke detector sensitivity test		2-Years*	**72**-2010; 14.4.5					
Off-premises monitoring transmission equipment		Annually	**72**-2010; 14.4.5					

Fire Suppression System Test Report

Portable fire extinguishers	Inspection	Monthly	**10**-2010; 7.2.1.2					
	Maintenance	Annually	**10**-2010; 7.3.1.1.1					
Alternative suppression systems	Kitchen hood system – inspection	Monthly	**17A**-2009; 7.2.1					
	Kitchen hood system – test	Semi-annually	**17A**-2009; 7.3.3					
	Halon system – inspection & test	Semi-annually	**12A**-2009; 6.1.1					
	CO2 system – inspection	Monthly	**12**-2011 4.8.1					
	CO2 system – tank weigh	Semi-annually	**12**-2011; 4.8.3.5.1					
	CO2 system – test	Annually	**12**-2011; 4.8.3.2					
	Clean agent system – inspection	Semi-annually	**2001**-2012; 7.1.3					
	Clean agent system – test	Annually	**2001**-2012; 7.1.1					

Fire Suppression (cont'd)

	Devices/Function	Frequency	NFPA Standard	Date of Most Recent	Compliant? Yes	No	N/A	Comment
Water-based suppression systems	Fire pump churn test	Monthly	**25**-2011; 8.3.1					
	Control valve inspection	Monthly	**25**-2011; 13.3.2.1.1					
	Pressure Gauge Inspection	Monthly	**25**-2011; 13.2.7.1					
	Fire department connections	Quarterly	**25**-2011; 13.7.1					
	Fire hose valve – Inspection	Quarterly	**25**-2011; 13.5.6.1					
	Pre-action/Dry pipe valve priming water test	Quarterly	**25**-2011; 13.4.3.2.1					
	Sprinkler inspection	Annually	**25**-2011; 5.2.1					
	Piping & hanger inspection	Annually	**25**-2011; 5.2.2					
	Pre-action/Dry pipe valve trip test	Annually	**25**-2011; 13.4.3.2.2					
	Main drain test	Quarterly*	**25**-2011; 13.2.5.1					
		Annually	**25**-2011; 13.2.5					
	Control valve exercise	Annually	**25**-2011; 13.3.3.1					
	Backflow preventer	Annually	**25**-2011; 13.6.2					
	Anti-freeze test	Annually	**25**-2011; 5.3.4					
	Private service fire hydrants	Annually	**25**-2011; 7.3.2					
	2½ inch fire hose valve – test	Annually	**25**-2011; 13.5.6.2.1					
	Fire pump flow test	Annually	**25**-2011; 8.3.3					
	Occupant use fire hose – inspect	Annually	**1962**-2008; 4.3.4					
	1½ inch fire hose valve - test	3-Years	**25**-2011; 13.5.6.2.2					
	Occupant use fire hose – pressure test	5-Years, then every 3-Years	**1962**-2008; 4.3.2					
	Check valve inspection	5-Years	**25**-2011; 13.4.2.1					
	Pressure gauge calibration	5-Years	**25**-2011; 5.3.2					
	Standpipe waterflow test	5-Years	**25**-2011; 6.3.1					
	Private fire service mains	5-Years	**25**-2011; 7.3.1					
	Internal inspection of piping	5-Years	**25**-2011; 14.2.1					
	Dry Head sprinkler replacement	10-Years	**25**-2011; 5.3.1.1.1.6					
	QR sprinkler head replacement	20-Years	**25**-2011; 5.3.1.1.1.3					
	SR sprinkler head replacement	50-Years	**25**-2011; 5.3.1.1.1					
	Spare Sprinkler List	One-Time	**13**-2010; 6.2.9.7					

Additional Testing & Inspection Requirements

Emergency power generators	Inspection	Weekly	**110**-2010; 8.4.1					
	Battery electrolyte levels / Voltage	Monthly	**110**-2010; 8.3.7.1					
	Monthly load test	20 days to 40 days	**110**-2010; 8.4.2 and **99**-2012; 6.4.4.1.1.4					
	Annual load test (if required)	Annually*	**110**-2010; 8.4.2.3					
	Annual Fuel Test	Annually	**110**-2010; 8.3.8					
	Replace lead-acid start batteries	24-30 Months	**110**-2010, A.5.6.4.5.1					
	3-Year 4-Hour load test	3-Years	**110**-2010; 8.4.9					
Automatic Transfer Switches	Inspection of ATS	Weekly	**110**-2010; 8.4.1					
	Monthly test with generator	20 days to 40 days	**110**-2010; 8.4.6 and **99**-2012; 6.4.4.1.1.4					
Medical gas and Vacuum sys	Maintenance & testing	As per policy	**99**-2012; 5.1.14.4.5					
	Cross-contamination test	After breach	**99**-2012; 5.1.12.1.1					
	Purity and pressure test	After breach	**99**-2012; 5.1.12.1.1					
	Non-stationary booms w/flexible connectors leak tested	18-months	**99**-2012; 5.1.14.2.3.2					

	Devices/Function	Frequency	NFPA Standard	Date of Most Recent	Compliant? Yes	No	N/A	Comment
Alternative Life Safety Measures	Policy	Review policy	**101**-2012; 4.6.10.1					
	Implementation	As needed per policy	**101**-2012; 4.6.10.1					
	Fire Watch	Continuous	**101**-2012; 9.6.1.6 & **25**-2011; 15.5.2					
Fire/Smoke damper test	Inside hospital facility	1-Year then 6-years	**80**-2010; 19.4 and **105**-2010; 6.5.2					
	Outside hospital facility	1-Year then 4-years	**80**-2010; 19.4 and **105**-2010; 6.5.2					
Overhead rolling fire doors	Drop test	Annually	**80**-2010; 5.2.1					
Side-hinged fire doors	Annual test/inspection	Annually	**101**-2012; 8.3.3.1					
'Exit' signs	Illumination inspection	Monthly	**101**-2012; 7.10.9.1					
Elevator recall	Test of all elevators equipped with Fire Fighter Service	Monthly	**101**-2012; 9.4.6.2					
Kitchen hood cleaning	Remove grease	Semi-annually	**96**- 2011; 11.4					
Assessment of building systems for Risk Category	Risk assessment to determine Category designation of systems	Annually	**99**-2012; 4.2					
Ground Fault Circuit Interrupter	Monthly test per manufacturer	Monthly	**CMS** §482.41(c)(2)					
Emergency Shower	Flow test – ANSI Z358.1-2014	Weekly	4.6.3					
	Inspection – ANSI Z358.1-2014	Annually	4.6.5					
Emergency Eyewash	Flow test – ANSI Z358.1-2014	Weekly	5.5.2					
	Inspection – ANSI Z358.1-2014	Annually	5.5.5					
Battery Powered Emergency Light	Monthly test	Monthly	**101**-7.9.3.1.1 (1)					
	Annual test	Annually	**101**-7.9.3.1.1 (3)					
Fire Drills – Healthcare	1 per shift per quarter	Quarterly	**101**-19.7.1.6					
Fire Drills – Ambulatory	1 per shift per quarter	Quarterly	**101**-21.7.1.6					
Fire Drills - Business	1 per shift per year	Periodically	**101**-7.2					

*= If Required

Testing & Inspection Time Defined

Weekly, or "every 7 days"	Anytime during a calendar week
Monthly or "every 30 days"	Anytime during a calendar month
Quarterly or "every 3 months"	3 months from the previous test/inspection, conducted during the 3rd month
Semi-annually, or "every 6 months"	6 months from the previous test/inspection, conducted during the 6th month
Annually or "every 12 months"	12 months from the previous test/inspection, conducted during the 12th month
3-Years	36 months from the previous test/inspection, conducted during the 36th month
5-Years	60 months from the previous test/inspection, conducted during the 60th month
6-Years	72 months from the previous test/inspection, conducted during the 72nd month

Documentation Should Include the Following:

1. Name of individual performing the activity.
2. Affiliation of the individual performing the activity.
3. The signature of the individual performing the activity.
4. Activity name.
5. Date (month/day/year) that activity was performed.
6. The frequency that is required of the activity.
7. NFPA standard that requires the activity to be performed.
8. The results of the activity, such as "Pass" or "Fail".

GUEST COLUMNS

Life safety alert: Storage is prohibited in the means of egress

STAN SZPYTEK

SEPTEMBER 13, 2021

SHARE

Stan Szpytek

As a Life Safety Consultant working directly with LTC providers around the country as well as with many state healthcare associations, I need to start this piece by being blunt and will get straight to the point.

You cannot use the means of egress (hallways, exit paths and stairwells) in your facility to store the over-abundance of supplies you may have received for infection control measures including service corridors.

Having toured several facilities recently while conducting Mock Life Safety Surveys, I have personally observed multiple instances of non-compliant storage within the means of egress that will automatically trigger a deficiency (K-211). Storage is required to be in a protected space that has a hazardous area designation in accordance with NFPA 101, The Life Safety Code (2012 edition- Chapter 7 unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1). Storage rooms require higher levels of fire protection which includes fire-rated walls, ceilings and self-closing doors that should not be propped open.

Simply using the rationale that your facility does not have any space in your protected storage rooms for these new infection control supplies (boxes of masks, gowns, sanitizers, etc.) is not an acceptable reason to place storage of any type in your hallways or stairwells; even if it is confined to one side or beneath an open landing. Besides representing a deficiency, the presence of storage within the means of egress constitutes a safety hazard, risk exposure and may compromise your team's ability to effectively evacuate the building during an emergency.

Storage problems are not new to the built environment but the need and presence of infection control equipment and supplies have clearly magnified the issue. One strategy to consider is having your procurement team work closely with the logistics groups at your vendors to develop supply chain schedules to positively address this important matter. Alternate delivery schedules for IC supplies as well as other general supplies can be considered to help optimize the pipeline so a facility can manage storage practices in a safe and compliant manner.

Another solution may be to simply reorganize your storage rooms to accommodate equipment and supplies more efficiently. It is not uncommon to observe inefficient use of storage space within a facility. Of course, storage practices must always be mindful of required clearance zones around fire sprinkler heads (18 inches) and electrical equipment including circuit breaker boxes (36 inches). Where allowed by local codes and ordinances, obtaining portable storage containers that can be placed on the property can also provide temporary storage solutions.

Finally, a facility may want to reach out to their long-term care associations, purchasing groups or trade associations to see if they can provide perspective or direct support on this specific logistical matter. In consideration of other infectious disease outbreaks or supply chain issues that may be on the horizon, in-house storage and supply chain management should be part of your facility's emergency preparedness program.

Stan Szpytek is the president of the national consulting firm, Fire and Life Safety, Inc. based in Mesa, Arizona, and is the Life Safety/Disaster Planning Consultant for the Arizona Health Care Association, California Association of Health Facilities (CAHF), Utah Health Care Association and American Assisted Living Nurses Association (AALNA). Szpytek is a former deputy fire chief and fire marshal with more than 40 years of experience in life safety compliance and emergency preparedness. For more information, visit www.FLSafety.org or e-mail Szpytek at Firemarshal10@aol.com.

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RECOMMENDATIONS FOR HEATING, VENTILATION, AND AIR CONDITIONING IN HEALTHCARE FACILITIES

- Heating, Ventilation, and Air Conditioning (HVAC) systems are an important component of service in health care facilities. Providing adequate thermal conditions and ventilation systems that prevent the dispersion of pathogens, is fundamental to protect the health of patients, caregivers and staff and to the overall operation of sensitive equipment.
- HVAC systems provide thermal conditions that can be vital for patients
- Respiratory infections can be transmitted via respiratory droplets of different sizes from infected persons.
- In the context of COVID-19, airborne transmission may be possible in procedures or support treatments that generate aerosols i.e., endotracheal intubation, bronchoscopy, open suctioning, administration of nebulized treatment, manual ventilation before intubation, turning the patient to the prone position, disconnecting the patient from the ventilator, non-invasive positive-pressure ventilation, tracheostomy, and cardiopulmonary resuscitation. Special consideration should be given to such procedures to prevent airborne transmission.[1]
- For detailed HVAC design considerations for healthcare facilities please consult WHO[2] and CDC[3] guidelines and the recommendations from ASHRAE Epidemic Task Force[4].

GENERAL RECOMMENDATIONS FOR HVAC AND NATURAL VENTILATION SYSTEMS TO PREVENT VIRUS TRANSMISSION WHILE MAINTAINING ADEQUATE THERMAL AND VENTILATION CONDITIONS

Item	Key Actions
General recommendations (Applicable to common areas, offices and general spaces)	Planning Activities • Establish a plan to perform maintenance on all systems, that considers the specific needs and environmental conditions within the facility. • Assess the current status of the ventilation system (HVAC or Natural) within the facility to prevent transmission of respiratory infections. HVAC system design • Implement a “clean to less clean” directional design for airflows. • Require a minimum of 2 air changes per hour (ACH). • Establish a minimum separation distance of 10m (30ft) between exhaust outlets and outdoor air intakes. • Avoid Variable Air Volume (VAV) systems, which present a risk to maintaining “clean to less clean” airflow. Operational aspects • Make sure your HVAC provider has the certifications and licenses required to provide services in your jurisdiction. • Maintain relative humidity between 40-60%.

[1] https://www.who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations
[2] https://www.who.int/water_sanitation_health/publications/natural_ventilation/en/
[3] https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/air.html#c3
[4] https://www.ashrae.org/technical-resources/resources

	• Keep the temperature between 70°F–75°F (21°C–24°C). • Do not regularly turn HVAC systems or air filtration equipment off. Doing so affects airflows and can cause contamination with agents such as molds and fungi. • Develop a workplan with the maintenance team and HVAC provider to ensure timely maintenance and service of HVAC systems. • Ensure HVAC systems are connected to emergency power supplies. Air Filtration • Prefer Minimum Efficiency Reporting Value (MERV) 13 or higher for systems serving general environments.

Special considerations for clinical management and medical procedures with HVAC systems.	Operational and design considerations
	• Utilize airborne infection isolation rooms with negative pressure to perform aerosol generating procedures.
	• Facilities should monitor and record daily the proper negative-pressure function of these rooms.
	• Consider source control options (Local Exhaust Source Control at Patient Head, ventilated headboards, intubation guards, etc.).
	• Maintain doors closed.
	• Eliminate or minimize air recirculation.
	• Maintain negative pressure in all rooms to prevent contaminated air from entering hallways and corridors.
	• Recommendations for 2-person patient rooms:
	  ○ Isolation curtains
	  ○ Do not recirculate air
	
	Air Filtration
	• Work with your HVAC provider to implement filtration systems that match the layout and clinical goals of your facilities.
	• High Efficiency Particulate Air (HEPA) filtration is recommended for use in special-care areas. HEPA filters are usually fixed into the HVAC system serving those areas.
	• Air from Airborne Infection Isolation Rooms should be exhausted directly to the outside or be filtered through a HEPA filter directly.
	• Utilize portable HEPA filtration units in special-care areas that are not served by the HVAC system.
	• Notify Healthcare workers that HEPA units cannot be turned off once in place as this may result in an unsafe condition with the room becoming positively pressurized to the corridor.
	• Prefer Minimum Efficiency Reporting Value (MERV) higher than 13 for systems serving patient treatment areas of health care facilities.

Special considerations for clinical	• Define risk areas within the facility. Risk areas might include rooms where aerosol generating procedures are performed, and rooms where COVID-19 confirmed patients are located.

management and medical procedures in settings using natural ventilation, with no HVAC systems	• Separate areas with aerosol generating procedures from other areas where patients are seen, keeping patients separated according to symptomology, in order to reduce transmission. • Maintain doors closed in risk areas. • Assess ambient air quality conditions (air pollution, allergens such as pollen count and fungi etc.) prior to deciding whether to keep windows open in Intensive Care Units. • If outdoor air is clean, keep external windows open when performing aerosol generating procedures. • Separate suspected and confirmed patients. • Establish security perimeters to avoid airflow from areas with confirmed patients to other areas (consider both vertical and horizontal airflows). • Provide medical personnel in direct contact with COVID-19 confirmed patients with adequate and sufficient Personal Protective Equipment (PPE). • Use N95 respirators in areas without ventilation where aerosols are generated.
Maintenance	• Use PPE for maintenance activities. • Start with areas of least potential contamination and move to Intensive care units of COVID-19 positive cases last. • After maintenance activities, wash hands with soap and water or use an alcohol-based hand sanitizer. Change clothes between facilities. • Filters should be disinfected with a sodium hypochlorite solution at 10% or another appropriate disinfectant approved for use against SARS-CoV-2, allowing it to act for at least 5 minutes before removal. Filters can then be bagged and disposed of in regular waste[5].

Other important considerations	• Implement mold control measures.
	• Avoid additional emission sources:
	  ○ Cool-mist humidifiers should be avoided, since they can disseminate aerosols containing allergens and microorganisms.
	  ○ Do not use air fresheners, perfumed candles or essential oil diffusers.
	  ○ Do not use of solid fuels for cooking activities or burn incense.

Climate Change and Environmental Determinants of Health Unit
Communicable Diseases and Environmental Determinants of Health Department

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[5] https://www.ashrae.org/technical-resources/filtration-disinfection#replacement

McKnight's
LONG-TERM CARE NEWS

Blogs

March 24, 2020

Focus on life safety during the management of COVID-19

Stan Szpytek

Stan Szpytek

Note: This story was updated on May 12 to reflect new regulatory changes.

As skilled nursing facilities around the nation rise to the challenges of managing this current infectious disease outbreak, providers must remain focused on maintaining a safe environment of care within their buildings. Complying with Life Safety Code requirements is the first step in helping to promote safety for all building occupants.

In a revised communication on the 1135 waivers issued May 8, 2020, the Centers for Medicare & Medicaid Services is modifying (and clarifying) the following requirements:

- Alcohol-based Hand-Rub (ABHR) Dispensers: We are waiving the prescriptive requirements for the placement of alcohol based hand rub (ABHR) dispensers for use by staff and others due to the need for the increased use of ABHR in infection control. However, ABHRs contain ethyl alcohol, which is considered a flammable liquid, and there are restrictions on the storage and location of the containers. This includes restricting access by certain patient/resident population to prevent accidental ingestion. Due to the increased fire risk for bulk containers (over five gallons) those will still need to be stored in a protected hazardous materials area. Refer to: 2012 LSC, sections

18/19.3.2.6. In addition, facilities should continue to protect ABHR dispensers against inappropriate use as required by 42 CFR §482.41(b)(7) for hospitals; §485.623(c)(5) for CAHs; §418.110(d)(4) for inpatient hospice; §483.470(j)(5)(ii) for ICF/IIDs and §483.90(a)(4) for SNF/NFs.

- Fire Drills: Due to the inadvisability of quarterly fire drills that move and mass staff together, we will instead permit a documented orientation training program related to the current fire plan, which considers current facility conditions. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. Refer to: 2012 LSC, sections 18/19.7.1.6.

- Temporary Construction: CMS is waiving requirements that would otherwise not permit temporary walls and barriers between patients. Refer to: 2012 LSC, sections 18/19.3.3.2.

To review the actual revised CMS communication, click on the following link and examine pages 25 – 27: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

Other new 1135 life safety requirement waivers

To further assist skilled nursing facilities and other healthcare providers with infection control measures, CMS has issued additional 1135 blanket waivers that have direct impact on the requirements for maintaining the physical environment to reduce disruption of patient care and potential exposure/transmission of COVID-19. CMS is temporarily modifying these requirements to the extent necessary to permit facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment. Additionally, the same modifications will be allowed for ITM frequency and activities required by the Life Safety Code (LSC-NFPA #101, 2012 ed.) and the Health Care Facilities Code (HCFC- NFPA #99, 2012 ed.). The following LSC and HCFC ITM activities are considered critical and **not** included in this waiver:

- Sprinkler system monthly electric motor-driven and weekly diesel engine-driven fire pump testing.
- Portable fire extinguisher monthly inspection.
- Elevators with firefighters' emergency operations monthly testing.
- Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing.
- Means of egress daily inspection in areas that have undergone construction, repair, alterations or additions to ensure its ability to be used instantly in case of emergency.

The waivers will terminate once the emergency declaration is lifted and have an effective date of March 1, 2020. Specific information pertaining to these elements of the 1135 Waiver can be found on page 23 on this link: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

When varying from prescribed IMT frequency and activities or when any alterations to the building have occurred during the management of COVID-19, facilities should also consider implementing Alternate Life Safety Measure (ALSM) to help further promote a safe and compliant environment of care.

Here are some additional points for SNFs to consider:

- Prior to COVID-19, fire drills were required to be completed on all shifts as per regulations — one drill, per shift, per quarter.
- Some providers used fire safety consultants to conduct their fire drills. These consultants may not be allowed into a SNF so alternate ways of conducting these required drills with internal staff will need to be identified and implemented.
- Inspection, testing and maintenance (IMT) of fire protection and life safety systems may need to be deferred as service contractors (fire alarm, fire sprinkler, emergency generator, kitchen fire suppression, etc.) may not be allowed inside of a SNF.
- Storage practices must be maintained in a compliant manner inside of rated storage rooms with doors closed; not propped open for convenience purposes.
- Storage items should not be placed within means of egress (exits, hallways, common assembly areas, etc.) as this will compromise evacuation capabilities.
- Alcohol-based hand rub (ABHR) dispenser must be installed in a compliant manner and away from all potential ignition sources like electrical outlets and electrical switches. Here are some additional points of consideration:
- Maximum individual dispenser capacity is 0.32 gal. (0.53 gal. in suites) of fluid and 18 oz. of Level 1 aerosols
- Dispensers shall have a minimum of 4-foot horizontal spacing
- Not more than an aggregate of 10 gallons of fluid or 135 oz. aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room
- Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30
- Dispensers are not installed within 1 inch of an ignition source

Here is a link to all of the K-Tags associated with life safety within a federally regulated skilled nursing facility.

A building that complies with requirements of The Life Safety Code and the Health Care Facilities Code is a safe building from a fire and life safety perspective. Please understand that I am

not simply promoting compliance for “compliance sake.” Directly stated, Life Safety Code compliance equates to a safe environment of care.

As a fire safety professional with many years of experience, I know that if it looks unsafe, it likely is unsafe and noncompliant. Don’t turn your hallways into obstacle courses full of boxes of sanitation supplies. Don’t create a fire hazard by installing an ABHR dispenser directly above a light switch. If your team maintains a strong focus on compliance, you will be able to keep your facility’s occupants safe from the threat of fire and other life safety risks.

Stan Szpytek is the president of consulting firm Fire and Life Safety Inc., in Mesa, Arizona, and is the Life Safety/Disaster Planning Consultant for the Arizona Health Care Association and California Association of Health Facilities (CAHF). Szpytek is a former deputy fire chief and fire marshal with more than 40 years of experience in life safety compliance and emergency preparedness. For more information, visit www.FLSafety.org or email Szpytek at Firemarshal10@aol.com.

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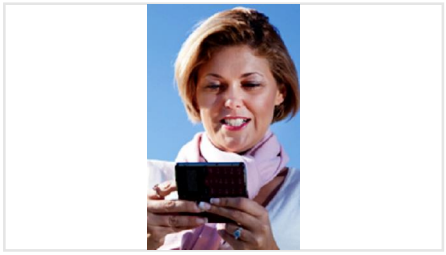

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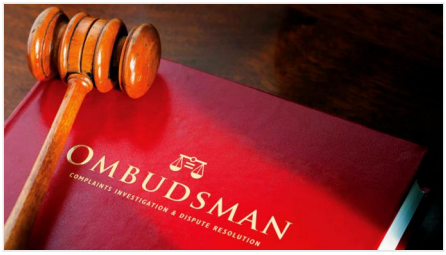

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2000 CODE

Form Approved
OMB No. 0938-0242

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1	K2

PART I — Life & Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
	A. BUILDING _____ B. WING _____ C. FLOOR _____ K3		A. ☐ Fully Sprinklered (All required areas are sprinklered) B. ☐ Partially Sprinklered (Not all required areas are sprinklered) C. ☐ None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
☐ MEDICARE ☐ MEDICAID	K4	K6	5. ☐ 2000 EXISTING 6. ☐ 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ☐ HOSPITAL 2. ☐ SKILLED/NURSING FACILITY 4. ☐ ICF/MR UNDER HEALTH CARE 5. ☐ HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW	3. ☐ IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED BY JCAHO/AOA?
1. ☐ ENTIRE FACILITY 2. ☐ DISTINCT PART OF (SPECIFY)_____	a. ☐ YES b. ☐ NO

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY _____	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE ____	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE _____	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID _____	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID _____

7. A. ☐ THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. ☐ COMPLIANCE WITH ALL PROVISIONS 2. ☐ ACCEPTANCE OF A PLAN OF CORRECTION 3. ☐ RECOMMENDED WAIVERS 4. ☐ FSES 5. ☐ PERFORMANCE BASED DESIGN

B. ☐ THE FACILITY DOES NOT MEET THE STANDARD

K9

SURVEYOR *(Signature)*	TITLE	OFFICE	DATE
SURVEYOR ID K10			
FIRE AUTHORITY OFFICIAL *(Signature)*	TITLE	OFFICE	DATE

ID PREFIX					MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES							
	BUILDING CONSTRUCTION							
K11	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2, 19.1.1.4.1, 19.1.1.4.2							
K12	2000 EXISTING Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1							
	1		I (443), I (332), II (222)	Any Height				
	2		II (111)	One story only (non-sprinklered).				
	3		II (111)	Not over three stories with complete automatic sprinkler system.				
	4		III (211)	Not over two stories with complete automatic sprinkler system.				
	5		V (111)					
	6		IV (2HH)					
	7		II (000)					
	8		III (200)	Not over one story with complete automatic sprinkler system.				
	9		V (000)					
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*							

ID PREFIX					MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1							
	1		I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2		II (111)	Not over three stories with complete automatic sprinkler system				
	3		III (211)	Not over one story with complete automatic sprinkler system.				
	4		V (111)					
	5		IV (2HH)					
	6		II (000)					
	7		III (200)	Not Permitted				
	8		V (000)					
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*							
K103	Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3 (Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)							

ID PREFIX		MET	NOT MET	N/A	REMARKS
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 *Indicate flame spread rating/s* _____				
	2000 NEW Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower portion of corridor walls can be Class C. 18.3.3.1, 18.3.3.2 *Indicate flame spread rating/s*_____				
K15	2000 EXISTING Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 *Indicate flame spread rating/s*_____				
	2000 NEW Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. *Indicate flame spread rating/s*_____				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K16	Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 18.3.3.3, 19.3.3.3 (Indicate N/A for existing interior floor finish.) In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.				
	CORRIDOR WALLS AND DOORS				
K17	2000 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 *If the walls have a fire resistance rating, give rating_____* *if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.*				
	2000 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	2000 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 New Doors protecting corridor openings shall be constructed to resist the passage of smoke. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5, 18.3.6.3.1, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4				
	VERTICAL OPENINGS				
K20	2000 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6, 19.3.1.1				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. ☐				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and sprinklered buildings up to three stories in height.) 18.3.1.1. An atrium may be used in accordance with 8.2.2.3.5.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure shall be permitted to be held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: ☐ (a) The required manual fire alarm system and ☐ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and ☐ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 19.2.2.2.6, 7.2.1.8.2				
	Describe method used in REMARKS				
K33	2000 EXISTING Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. ☐				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW Exit components (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 8.2.5.4, 18.3.1.1				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	SMOKE COMPARTMENTATION AND CONTROL				
K23	2000 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2				
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2				
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1				
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K25	2000 EXISTING Smoke barriers shall be constructed to provide at least a one-half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments shall be provided on each floor. Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4				
	2000 NEW Smoke barriers shall be constructed to provide at least a one-hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments shall be provided on each floor. Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3				
K26	Space shall be provided on each side of smoke barriers to adequately accommodate those occupants served. 18.3.7.4, 19.3.7.4				
K27	2000 EXISTING Door openings in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7				
	2000 NEW Door openings in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7				
	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows: Provider Type / Swinging Doors / Horizontal Sliding Doors Hospitals and Nursing Facilities / 41.5 inches (105 cm) / 83 inches (211 cm) Psychiatric Hospitals and Limited Care Facilities / 32 inches (81 cm) / 64 inches (163 cm) Vision panels of fire-rated glazing or wired panels in approved frames are provided for each door. 18.3.7.5, 18.3.7.7				
K104	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.				
	Describe any mechanical smoke control system in REMARKS.				
	HAZARDOUS AREA				
K29	2000 EXISTING One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Area / Automatic Sprinkler / Separation / N/A a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.*				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1				

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms			
c. Laundries (greater than 100 sq feet)			
d. Repair, Maintenance and Paint Shops			
e. Laboratories (if classified a Severe Hazard - see K31)			
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet)			
g. Trash Collection Rooms			
i. Soiled Linen Rooms			
m.Combustible Storage Rooms/Spaces (over 100 sq feet)			

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

K30	Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square ºfeet. 18.3.2.5, 19.3.2.5				

Area	Automatic Sprinkler	Separation	N/A
L. Gift Shop storing hazardous quantities of combustibles			

K211	2000 EXISTING Where Alcohol Based Hand Rub (ABHR) dispensers are installed: ❏ The corridor is at least 6 feet wide ❏ The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) ❏ The dispensers shall have a minimum spacing of 4 ft from each other ❏ Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. ❏ Dispensers are not installed over or adjacent to an ignition source. ❏ If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	2000 NEW Where Alcohol Based Hand Rub (ABHR) dispensers are installed: ❏ The corridor is at least 6 feet wide ❏ The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) ❏ The dispensers shall have a minimum spacing of 4 ft from each other ❏ Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. ❏ Dispensers are not installed over or adjacent to an ignition source. ❏ If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623				
	EXIT AND EXIT ACCESS				
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2				
	EXITS AND EGRESS				
K34	Stairways and smokeproof towers used as exits are in accordance with 7.2. 18.2.2.4, 19.2.2.3, 19.2.2.4				
K35	Capacity of exits in number of persons per unit of exit width is in accordance with 7.3. 18.2.3.1, 19.2.3.1				
K36	Travel distance (exit access) to exits are in accordance with 7.6. 18.2.6, 19.2.6				
K37	2000 EXISTING Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exists are accessible in not less than two different directions from all points in aisles, passageways, and corridors. 19.2.5.10				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Every exit and exit access shall be arranged so that no corridor, aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10				
K38	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1				
K39	2000 EXISTING Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3				
	2000 NEW Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5				
	2000 NEW Exit access doors and exit doors used by health care occupants are of the swinging type, with openings of at least 41.5 inches wide. Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In ICFs/MR, doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1, 18.2.5.9, 19.2.5.9 *If doors lead directly to grade from each room, check this box.* ☐				
K42	Any room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key.				
	Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5 *If door locking arrangement without delay egress is used indicate in REMARKS* 18.2.2.2.2, 19.2.2.2.2				
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5				
	ILLUMINATION AND EMERGENCY POWER				
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. 18.2.8, 19.2.8, 7.8				
K46	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1, 19.2.9.1.				
K47	2000 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one story buildings with less than 30 occupants where the line of exit travel is obvious.)				
	2000 NEW Exit and directional signs are displayed with continuous illumination also served by the emergency lighting, system in accordance with 7.10. 18.2.10.1				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K105	2000 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2, 18.5.1.1, 18.5.1.2 (Indicate N/A if life support equipment is for emergency purposes only).				
K107	2000 NEW (INDICATE N/A FOR EXISTING) Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1, 18.3.4.1.3				
K108	2000 NEW (INDICATE N/A FOR EXISTING) Alarms, emergency communication systems, and illumination of generator set locations are in accordance with NFPA 70. 9.1.2				
	EMERGENCY PLAN AND FIRE DRILLS				
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1				
K50	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	2000 EXISTING A fire alarm system with approved component, devices or equipment installed according to NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system shall be by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas, may be omitted provided that manual pull stations are within 200 ft of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests shall be available. A reliable second source of power must be provided. Fire alarm systems shall be in accordance with NFPA72, and records of maintenance kept readily available. There shall be annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6				
	2000 NEW A fire alarm system with approved component, devices or equipment installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system shall be by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests shall be available. A reliable second source of power must be provided. Fire alarm systems shall be maintained in accordance with NFPA72, and records of maintenance kept readily available. There shall be remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6				
K52	A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4				
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70				
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES) An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1 Smoke Detection System ❑ Corridors ❑ Rooms ❑ Bath				
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3				
	Give a brief description, in REMARKS of any smoke detection system which may be installed.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K55	2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8				
	2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8				
	AUTOMATIC SPRINKLER SYSTEMS				
K56	2000 EXISTING Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. 19.3.5, NPFA 13				
	2000 NEW There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. 18.3.5.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.				
	A. Date sprinkler system last checked and necessary maintenance provided. _____				
	B. Show who provided the service. _____				
	C. Note the source of water supply for the automatic sprinkler system._____				
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)				
K60	Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems. 18.3.4.2, 19.3.4.2, 9.6.2.1				
K61	Required automatic sprinkler systems shall have valves supervised so that at least a local alarm will sound when the valves are closed. 9.7.2.1, NFPA 72				
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5				
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13				
K64	Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	SMOKING REGULATIONS				
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4 ☐ (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. ☐ (2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. ☐ (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. ☐ (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.				
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2				
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.				
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96				
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82 ☐ (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5. ☐ (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. ☐ (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. ☐ (4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.				
K160	2000 EXISTING All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* 19.5.3, 9.4.3.2 ANSI A17.1 states 25 ft or more above or below the designated level and defines "designated level" as the main floor or other floor level that best serves the needs of emergency personnel for fire fighting purposes or rescue purposes identified by the building code or fire authority. Depending on floor slab thickness and heights this would generally apply to a three-story building, and almost certainly to a four-story building. Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors. 19.5.3, 9.4.3.2				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K161	2000 EXISTING All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* 19.5.3, 9.4.2.2 Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.				
	2000 NEW All elevators, escalators, and conveyors comply with ASME/ ANSI A17.1, *Safety Code for Elevators and Escalators* (Includes car emergency signaling, firefighters service phase I key and smoke detector automatic recall, firefighters service phase II emergency in-car operation, machine room smoke detectors, elevator lobby smoke detectors). 18.5.3, 9.4				
	FURNISHINGS AND DECORATIONS				
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10				
K73	No furnishings or decorations of highly flammable character shall be used. 18.7.5.2, 18.7.5.3, 18.7.5.4, 19.7.5.2, 19.7.5.3, 19.7.5.4				
K74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with provisions of 10.3.1 and NFPA 13 Standard for the Installation of Sprinkler Systems. Except shower curtains shall be in accordance with NFPA 701. ☐ Newly introduced upholstered furniture shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.1. 18.3.5.3 and NFPA 13 ☐ Newly introduced mattresses shall meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 Newly introduced upholstered furniture and mattresses means purchased since March, 2003.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft^2 (20.4 L/m^2). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft^2 (5.9-m^2) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5				
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) Laboratories in Health Care occupancies and medical and dental offices shall be in accordance with NFPA 99, Standard for Health Care Facilities 10.5.1.				
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with NFPA 99, 10.2.1.3.1, 18.3.2.2., 19.3.2.1				
K131	Emergency procedures shall be established for controlling chemical spills in accordance with NFPA 99. 10.2.1.3.2				
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with NFPA 99. 10.2.1.4.2				
K133	Fume hoods shall be in accordance with NFPA 99. 5.4.3, 5.6.2				
K134	Emergency Shower: Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with NFPA 99, 10.6.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code NFPA 99, 4.3, 10.7.2.1.				
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99, 4.3.1.1.2, 18.3.2.4, 19.3.2.4				
K77	Piped in medical gas systems comply with NFPA 99, Chapter 4.				
K78	Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% NFPA 99 4.3.1.2.3(n) and 5.4.1.1, 18.3.2.3, 19.3.2.3				
K140	(a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4.3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4.3.1.2.2(b) 3 a, b, c and d and with 4.3.1.2.2(c) 2 and 5 shall be permitted. (4.4.1 exception No. 4).				
K141	Non-smoking and no smoking signs in areas where oxygen is used or stored shall be in accordance with 18.3.2.4, 19.3.2.4, NFPA 99, 8.6.4.2				
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K143	Transferring of oxygen shall be: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8.6.2.5.2				
	ELECTRICAL				
K106	The hospital and all nursing homes and hospices with life support equipment has a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99, 3.4.2.2, 3.4.2.1.4				
K144	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99, 3.4.4.1, NFPA 110, 8.4.2				
K145	The Type I EES is divided into the critical branch, life safety branch and the emergency system and shall be in accordance with NFPA 99, 3.4.2.2.2				
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of $1^1/_2$ hour after loss of the normal source NFPA 99, 3.6.				
K147	Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. 9.1.2				
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1		* K4

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

[ ]
A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 [ ] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: [ ] K56: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]
1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]
4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]
7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E – SCORE HERE

K5: [ ] e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. [ ] (COMP. WITH ALL PROVISIONS)

A2. [ ] (ACCEPTABLE POC)

A3. [ ] (WAIVERS)

A4. [ ] (FSES)

A5. [ ] (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. [ ]

K0180

A. [ ] FULLY SPRINKLERED (All required areas are sprinklered)

B. [ ] PARTIALLY SPRINKLERED (Not all required areas are sprinklered)

C. [ ] NONE (No sprinkler system)

* MANDATORY

The Building Tour… By the Numbers

The following chart lists many of the life safety requirements that one may use during the building tour of the healthcare occupancy. The following information is based on codes and standards referenced by the 2012 Life Safety Code.

Number	Unit of Measure	Requirement	Standard
1/4	inch	The maximum abrupt change in elevation permitted on walking surfaces	NFPA 101 (2012) 7.1.6.2
3/4	inch	The maximum distance between the bottom of a fire-rated door and the bottom of a smoke compartment barrier door, and the floor	NFPA 101 (2012) 8.5.4.1
1	inch	The minimum distance an upright sprinkler head must be from a ceiling or deck	NFPA 13 (2010) 8.6.4.1.1.1
1	each	The number of alcohol based hand rub dispensers allowed per room that does not contribute to the total aggregate quantity of product in dispensers	NFPA 101 (2012) 19.3.2.6
1	inch	The minimum distance an alcohol based hand rub dispenser may be mounted to an ignition source	NFPA 101 (2012) 19.3.2.6
1	inch	The maximum distance between of a non-fire-rated corridor door and the floor	NFPA 101 (2012) 19.3.6.3.4
1	foot-candle	The minimum illumination required for the means of egress in existing construction, as measured at the floor	NFPA 101 (2012) 7.8.1.3
2	each	The number of exit access doors required in a sleeping suite larger than 1,000 square feet, and in a non-sleeping suite larger than 2,500 square feet	NFPA 101 (2012) 19.2.5.7.2.2 19.2.5.7.3.2
4	inch	The minimum distance that an upright or pendant sprinkler must be from a side wall	NFPA 13 (2010) 8.6.3.3
5	feet	The maximum distance a smoke detector may be from a door held open with magnetic hold-opens, unless entire corridor is protected with smoke detectors	NFPA 72 (2010) 17.7.5.6.6.1
5	lbs.	The amount of force required that is applied to the latch edge of a power-operated non-fire-rated corridor door, in lieu of positive latching	NFPA 101 (2012) 19.3.6.3.7
6	feet	The minimum width of a corridor before an alcohol based hand rub dispenser may be mounted	NFPA 101 (2012) 19.3.2.6
6	square feet	The maximum size of a hospital patient room closet before sprinklers are required	NFPA 101 (2012) 19.3.5.10
6	inch	The maximum projection for items mounted on walls of corridors that are at least 6 feet wide, in healthcare occupancies	NFPA 101 (2012) 19.2.3.4
6	feet	The minimum distance permitted between sprinklers without the use of baffles	NFPA 13 (2010) 8.6.3.4.1
6 - 8	feet - inch	The minimum headroom required on stairs	NFPA 101 (2012) 7.1.5.3
7	inch	The maximum projection of a door leaf into the corridor when the door is fully opened	NFPA 101 (2012) 7.2.1.4.3.1
7 - 0	feet - inch	The minimum head-room required in the means of egress for existing construction	NFPA 101 (2012) 7.1.5.1
7 - 6	feet - inch	The minimum head-room required in the means of egress for new construction	NFPA 101 (2012) 7.1.5.1
8	feet	The required width of corridors in new construction healthcare occupancies	NFPA 101 (2012) 18.2.3.4
9	persons	The maximum occupant load served by automatic sliding doors before the doors are required to be side-hinged and capable of swinging open	NFPA 101 (2012) 19.2.2.2.10.2
10	foot-candle	The minimum illumination required for the means of egress in new construction, as measured at the floor	NFPA 101 (2012) 7.8.1.3
12	inch	The maximum distance that a smoke detector may be mounted below a ceiling or deck (some exceptions apply)	NFPA 72 (2010) 17.7.3.2.1
12	inch	The maximum distance that a pendant or upright sprinkler head may be mounted below a ceiling or deck (some exceptions apply)	NFPA 13 (2010) 8.6.4.1.1.1
18	inch	The minimum distance that items may be stored or located below a sprinkler head	NFPA 13 (2010) 8.5.6.1
20	square inches	The maximum area of an opening for pass-throughs in corridor walls located in smoke compartments that are not fully protected with automatic sprinklers	NFPA 101 (2012) 19.3.6.5.1
20	percent	The maximum area of wall, ceiling and door permitted for combustible decorations in a space located in a smoke compartment not protected with automatic sprinklers	NFPA 101 (2012) 19.7.5.6
24	inch	Height of wall above door(s) held open on magnetic door-holds, before smoke detectors are required on both sides of the door(s)	NFPA 72 (2010) 17.7.5.6.5.1

Number	Unit of Measure	Requirement	Standard
28	inch	The minimum width of an exit access that is not a corridor in existing construction	NFPA 101 (2012) 7.3.4.1.2
30	square feet	The aggregate area per patient required for each smoke compartment	NFPA 101 (2012) 19.3.7.5.1
30	percent	The maximum area of wall, ceiling and door permitted for combustible decorations in a space located in a smoke compartment protected with automatic sprinklers	NFPA 101 (2012) 19.7.5.6
30	feet	The maximum length of existing dead-end corridors in healthcare occupancies	NFPA 101 (2012) 19.2.5.2
30	lbs.	The maximum force permitted to set a door leaf in motion	NFPA 101 (2012) 7.2.1.4.5.1
32	gallon	The maximum capacity of trash collection receptacles that are stored outside of a hazardous room	NFPA 101 (2012) 19.7.5.7.1
32	inch	The minimum clear width for door openings in the mean of egress for existing healthcare occupancies	NFPA 101 (2012) 19.2.3.6
36	inch	The minimum distance smoke and heat detectors must be located from a supply or return air diffuser	NFPA 72 (2010) A.17.7.4.1
36	inch	The minimum width of an exit access that is not a corridor in new construction	NFPA 101 (2012) 7.3.4.1
41½	inch	The minimum clear width of door openings in the means of egress for new construction healthcare occupancies	NFPA 101 (2012) 18.2.3.6
44	inch	The required width of corridors not intended for the use of inpatients in new and existing healthcare occupancies	NFPA 101 (2012) 19.2.3.4
48	inch	The required width for corridors serving the means of egress for patient sleeping rooms in existing healthcare occupancies	NFPA 101 (2012) 19.2.3.4
50	feet	The maximum travel distance from any point in a healthcare sleeping room to an exit access corridor	NFPA 101 (2012) 19.2.6.2.3
50	percent	The maximum area of wall, ceiling and door permitted for combustible decorations in a patient sleeping room not exceeding four persons, located in smoke compartment protected with automatic sprinklers	NFPA 101 (2012) 19.7.5.6
50	percent	One of two factors used to determine major vs. minor rehabilitation. If renovation is 50% or more of a single non-sprinklered smoke compartment, then the entire smoke compartment must be sprinklered	NFPA 101 (2012) 19.1.1.4.3.1
80	square inches	The maximum area of an opening for pass-throughs in corridor walls located in smoke compartments that are fully protected with automatic sprinklers	NFPA 101 (2012) 19.3.6.5.2
96	gallon	The maximum capacity of a recycling container that is left unattended outside of a hazardous room	NFPA 101 (2012) 19.7.5.7.2
100	feet	The maximum travel distance from any point in a suite to reach an exit access corridor	NFPA 101 (2012) 19.2.5.7.2.4
150	feet	The maximum travel distance from any point in a room or suite to reach an exit, in a building not fully protected with automatic sprinklers	NFPA 101 (2012) 19.2.5.7.2.4
200	feet	The maximum travel distance from any point in a room or suite to reach an exit, in a building that is fully protected with automatic sprinklers	NFPA 101 (2012) 19.2.5.7.2.4
200	feet	The maximum travel distance from any point to reach a smoke compartment barrier door	NFPA 101 (2012) 19.3.7.1
200	Feet	The maximum travel distance to reach a fire alarm manual pull station.	NFPA 72 (2010) 17.14.8
212	degrees	The maximum temperature (F) of the heater elements on portable heaters used in healthcare occupancies	NFPA 101 (2012) 19.7.8
4500	square feet	The second of two factors used to determine major vs. minor rehabilitation. If renovation is 4,500 square feet or more in a non-sprinklered smoke compartment, then the entire smoke compartment must be sprinklered	NFPA 101 (2012) 19.1.1.4.3.1
5000	square feet	The maximum area of sleeping suites that are located in a smoke compartment that is not protected with automatic sprinklers	NFPA 101 (2012) 19.2.5.7.2.3
7500	square feet	The maximum area of sleeping suites in smoke compartments that are protected with standard-response sprinklers and smoke detectors; or protected with quick-response sprinklers	NFPA 101 (2012) 19.2.5.7.2.3
10,000	square feet	The maximum area of sleeping suites that have direct supervision of patients, total smoke detection, and protected with quick-response sprinklers	NFPA 101 (2012) 19.2.5.7.2.3
10,000	square feet	The maximum area of non-sleeping suites.	NFPA 101 (2012) 19.2.5.7.3.3
22,500	square feet	The maximum area of a smoke compartment	NFPA 101 (2012) 19.3.7.1

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 17-38-LSC

DATE: **July 28, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Fire and Smoke Door Annual Testing Requirements in Health Care Occupancies

Memorandum Summary

- In health care occupancies, fire door assemblies are required to be annually inspected and tested in accordance with the 2010 National Fire Protection Association (NFPA) 80.
- In health care occupancies, non-rated doors assemblies including corridor doors to patient care rooms and smoke barrier doors are not subject to the annual inspection and testing requirements of either NFPA 80 or NFPA 105.
- Non-rated doors should be routinely inspected as part of the facility maintenance program.
- Full compliance with the annual fire door assembly inspection and testing in accordance with 2010 NFPA 80 is required by January 1, 2018.
- Life Safety Code (LSC) deficiencies associated with the annual inspection and testing of fire doors should be cited under K211 – *Means of Egress - General.*

Background

The Centers for Medicare & Medicaid Services (CMS) adopted the 2012 edition of the NFPA LSC, which includes requirements for the maintenance, inspection, and testing of fire doors and smoke doors in certain certified health care facilities.

The 2012 LSC added new provisions under Section 7.2.1.15 – *Inspection of Door Openings* for the annual inspection and testing of certain fire doors and smoke doors assemblies in accordance with the 2010 editions of NFPA 80 – *Standard for Fire Doors and Other Opening Protectives,* and NFPA 105 – *Standard for Smoke Door Assemblies and Other Opening Protectives.*

The new LSC provisions under sections 7.2.1.15.1 and 7.2.1.15.2 require certain fire door and smoke door assemblies to be inspected and tested annually in accordance with the NFPA 80 and NFPA 105. However, section 7.2.1.15.1 states that these requirements only apply where required by Chapters 11 through 43. Therefore, as the LSC health care occupancy chapters (i.e., Chapters 18, 19, 20, 21) do not directly reference section 7.2.1.15, these new annual inspection and testing requirement do not apply to health care occupancies.

It should be noted that the LSC chapters for assembly occupancies, education occupancies, day care occupancies, and residential board and care occupancies do directly reference 7.2.1.15. Therefore, if a health care occupancy contains a separated multiple occupancy, the 7.2.1.15 requirement for annual fire and smoke door inspection and testing would be applicable to these other occupancies.

Annual Inspection & Testing Requirements in Health Care Occupancies

Although the requirements under LSC section 7.2.1.15 are not applicable to health care occupancies, annual inspection and testing of fire doors assemblies in accordance with NFPA 80 are still required in health care occupancies by LSC section 8.3.3.1, which is applicable to all occupancy chapters.

In addition, with the exception of new doors in horizontal exits, the annual inspection and testing of smoke door assemblies in accordance with NFPA 105 is not required per LSC section 8.5.4.2 as doors in health care occupancies are not required to be smoke-leakage-rated.

Conclusion

In health care occupancies, annual inspection and testing in accordance with the 2010 NFPA 80 is required for all fire door assemblies. Non-rated doors, including corridor doors to patient care rooms and smoke barrier doors, are not subject to the annual inspection and testing requirements of either NFPA 80 or NFPA 105. But, non-rated doors should be routinely inspected as part of the facility maintenance program as all required life safety features and systems must be maintained in proper working order. LSC deficiencies associated with the annual inspection and testing of fire doors should be cited under K211 – *Means of Egress - General*.

Compliance Time Extension

CMS regulatory adoption of the 2012 LSC regulation was July 5, 2016, therefore the required annual door inspections and testing would be expected by July 6, 2017. However, considering the level of reported misunderstanding of this requirement, CMS has extended the compliance date for this requirement by six months. Full compliance with the annual fire door assembly inspection and testing in accordance with 2010 NFPA 80 is required by January 1, 2018.

Contact: If you have questions concerning this memorandum, please send them to SCG_LifeSafetyCode@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

cc: Survey and Certification Regional Office Management

Skilled Nursing Facility
2012 Life Safety and Health Care Facilities Code
K Tag Reference

2000 Tag #	2012 Tag #	2012 Code Language
	K100	General Requirements – Other List in the REMARKS section, any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.
	K111	Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: Requirements of Chapter 18 and 19 • Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1 1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)
	K112	Sprinkler Requirements for Major Rehabilitation: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 square feet of the area of the smoke compartment. 18.1.1.4.3.3, 19.1.1.4.3.3
	K131	Multiple Occupancies – Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: • They are not intended to serve four or more inpatients. • They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. • The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623

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2000 Tag #	2012 Tag #	2012 Code Language
	K132	Multiple Occupancies – Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. 18.1.3.4.1, 19.1.3.4.1
K11	K133	Multiple Occupancies – Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: • The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 • The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3
K12	K161	Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 1 Type I (442), I (332), II (222) Any number of stories (non-sprinklered and sprinklered) Type II (111) One story (non-sprinklered) ≤ 3 stories (sprinklered) Type II (000) No stories (non-sprinklered) ≤ 2 stories (sprinklered) Type III (211) No stories (non-sprinklered) ≤ 2 stories (sprinklered) Type III (200) No stories (non-sprinklered) ≤ 1 story (sprinklered) Type IV (2HH) No stories (non-sprinklered) ≤ 2 stories (sprinklered) Type V (111) No stories (non-sprinklered) ≤ 2 stories (sprinklered) Type V (000) No stories (non-sprinklered) ≤ 1 story (sprinklered) Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

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K Tag Reference

2000 Tag #	2012 Tag #	2012 Code Language
K12	K161	Building Construction Type and Height 2012 NEW Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7. 18.1.6.4, 18.1.6.5 Type I (442), I (332), II (222) No stories (non-sprinklered), Any number of stories (sprinklered) Type II (111) No stories (non-sprinklered) ≤ 3 stories (sprinklered) Type II (000) No stories (non-sprinklered) ≤ 1 story (sprinklered) Type III (211) No stories (non-sprinklered) ≤ 1 story (sprinklered) Type III (200), V (000) No stories permitted Type IV (2HH) No stories (non-sprinklered) ≤ 1 story (sprinklered) Type V (111) No stories (non-sprinklered) ≤ 1 story (sprinklered) Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.
	K162	Roofing Systems Involving Combustibles 2012 EXISTING Buildings of Type I (442), (332) or Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class C requirements 2. roof is separated from occupied building portions with 2-hour fire resistive noncombustible floor assembly using not less than 2-1/2 inches concrete or gypsum fill 3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system 19.1.6.2*, ASTM E108, ANSI/UL 790
	K162	Roofing Systems Involving Combustibles 2012 NEW Buildings of Type I (442), (332) or Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class A requirements 2. roof is separated from occupied building portions with 2-hour fire resistive noncombustible floor assembly using not less than 2-1/2 inches concrete or gypsum fill 3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building 18.1.6.2, ASTM E108, ANSI/UL 790
K103	K163	Interior Non-Bearing Wall Construction Interior non-bearing walls in Type I or II construction are constructed of noncombustible or limited-combustible

Skilled Nursing Facility
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K Tag Reference

2000 Tag #	2012 Tag #	2012 Code Language
		materials. Interior non-bearing walls required to have a minimum 2-hour fire resistance rating are fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5
	K200	Means of Egress Requirements – Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2
K72	K211	Means of Egress – General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full instant use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1
K43	K221	Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4
	K222	Egress Doors - Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by

Skilled Nursing Facility
2012 Life Safety and Health Care Facilities Code
K Tag Reference

2000 Tag #	2012 Tag #	2012 Code Language
		an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4
K21	K223	Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and • Loss of power 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8
	K224	Horizontal Sliding Doors Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: • Area served by the door has no hazards • Door is operable from either side without special knowledge or effort • Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width • Assembly is appropriately fire rated, and where rated is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80 • Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 18.2.2.2.10, 19.2.2.2.10
K34	K225	Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2
K44	K226	Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5
	K227	Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10
K35	K231	Means of Egress Capacity The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1
K39	K232	Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of non-ambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5

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2012 Life Safety and Health Care Facilities Code
K Tag Reference

2000 Tag #	2012 Tag #	2012 Code Language
K39	K232	Aisle, Corridor or Ramp Width 2012 NEW The width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet, except as modified by the 18.2.3.4 or 18.2.3.5 exceptions. 18.2.3.4, 18.2.3.5
K40	K233	Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7
K40	K233	Clear Width of Exit and Exit Access Doors 2012 NEW Exit access doors and exit doors are of the swinging type and are at least 41-1/2 inches in clear width. In psychiatric hospitals or limited care facilities, doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries shall be no less than 32 inches in clear width. If using a pair of doors, the doors shall be provided with a rabbet, bevel, or astragal at the meeting edge, at least one of the doors shall provide 32 inches in clear width, and the inactive leaf of the pair shall be secured with automatic flush bolts. 18.2.3.6, 18.2.3.7
	K241	Number of Exits – Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4
K37	K251	Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2
K37	K251	Dead-End Corridors and Common Path of Travel 2012 NEW Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet. 18.2.5.2, 18.2.5.3
K32	K252	Number of Exits – Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4
K42	K253	Number of Exits – Patient Sleeping and Non-Sleeping Rooms Patient sleeping rooms of more than 1,000 square feet or non-sleeping rooms of more than 2,500 square feet have at least two exit access doors remotely located from each other. 18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2
K41	K254	Corridor Access All habitable rooms not within suites have a door leading directly outside to grade or have a door leading to an exit access corridor. Patient sleeping rooms with less than eight patient beds may have one room intervening to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system. 18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4

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	K255	Suite Separation, Hazardous Content, and Subdivision All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4
	K256	Sleeping Suites Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites shall be provided with constant staff supervision. Staff shall have direct visual supervision of patient sleeping rooms, from a constantly attended location or the room shall be provided with an automatic smoke detection system. Suites more than 1,000 square feet shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed the following size limitations: • 5,000 square feet if the suite is not fully smoke detected or fully sprinklered • 7,500 square feet if the suite is either fully smoke detected or fully sprinklered • 10,000 square feet if the suite is both fully smoke detected and fully sprinklered and the sleeping rooms have direct supervision from a constantly attended location Travel distance between any point in a suite to exit access shall not exceed 100 ft. and distance to an exit shall not exceed 150 ft. (200 ft. if building is fully sprinklered). 18.2.5.7.2, 19.2.5.7.2
	K257	Non-Sleeping Suites Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites more than 2,500 square feet shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed 10,000 square feet. Travel distance between any point in a suite to exit access shall not exceed 100 ft. and distance to an exit shall not exceed 150 ft. (200 ft. if building is fully sprinklered). 18.2.5.7.3, 19.2.5.7.3
K36	K261	Travel Distance to Exits Travel distance (excluding suites) to exits are measured in accordance with 7.6. • From any point in the room or suite to exit ≤ 150 feet (≤ 200 ft. if the building is fully sprinklered) • Point in a room to room door ≤ 50 ft. 18.2.6, 19.2.6
K38	K271	Discharge from Exits - Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38
K45	K281	Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8
K46	K291	Emergency Lighting Emergency lighting of at least 1½-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1

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K105	K292	Life Support Means of Egress 2012 NEW (INDICATE FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (Indicate if life support equipment is for emergency purposes only.) 18.2.9.2, 18.2.10.5
K47, K22	K293	Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)
K47, K22	K293	Exit Signage 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1
	K300	Protection – Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.
K20, K33	K311	Vertical Openings – Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1, through 19.3.1.6 *If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.*
K20, K33	K311	Vertical Openings – Enclosures 2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1 hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7. 18.3.1 through 18.3.1.5
K29	K321	Hazardous Areas – Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area, Automatic Sprinkler, Separation, a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)

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K29	K321	Hazardous Areas – Enclosure 2012 NEW Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area, Automatic Sprinkler, Separation, a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 50 square feet)
K69	K324	Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, *Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations* , unless: • residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 • cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, • cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2
K211	K325	Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: • Corridor is at least 6 feet wide • Maximum individual dispenser capacity is 0.32 gal. (0.53 gal. in suites) of fluid and 18 oz. of Level 1 aerosols • Dispensers shall have a minimum of 4-foot horizontal spacing • Not more than an aggregate of 10 gallons of fluid or 135 oz. aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 • Dispensers are not installed within 1 inch of an ignition source • Dispensers over carpeted floors are in sprinklered smoke compartments • ABHR does not exceed 95% alcohol • Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) • ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485

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K14, K15	K331	Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s)._____
K14, K15	K331	Interior Wall and Ceiling Finish 2012 NEW Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. Individual rooms not exceeding four persons may have a Class A or B finish. Lower half of corridor walls, not exceeding 4 feet in height, may have a Class A or B flame spread rating. 10.2, 18.3.3.1, 18.3.3.2 Indicate flame spread rating(s)._____
	K332	Interior Floor Finish 2012 NEW (Indicate for 2012 EXISTING) Interior finishes shall comply with 10.2. Floor finishes in exit enclosures and exit access corridors and spaces not separated by walls that resist the passage of smoke shall be Class I or II. 18.3.3.3.1, 18.3.3.3.2, 18.3.3.3.3, 10.2, 10.2.7.1, 10.2.7.2
K51	K341	Fire Alarm System – Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm Code* to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8
K60	K342	Fire Alarm System – Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200 feet travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5
	K343	Fire Alarm – Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1)
	K343	Fire Alarm – Notification 2012 NEW Positive alarm sequence in accordance with 9.6.3.4 are permitted. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation and annunciation zoning for fire alarm and sprinklers shall be provided by audible and visual indicators and zones shall not be larger

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		than 22,500 square feet per zone. 18.3.4.3 through 18.3.4.3.3, 9.6.4
K107	K344	Fire Alarm – Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72
K52	K345	Fire Alarm System – Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25
K155	K346	Fire Alarm – Out of Service Where required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6
K53, K54	K347	Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2
K53, K54	K347	Smoke Detection 2012 NEW Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping room has: • smoke detection, or • automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3
K56	K351	Sprinkler System – Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)
K56	K351	2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10

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K61	K352	Sprinkler System – Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72
K62, K63	K353	Sprinkler System – Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25
K154	K354	Sprinkler System – Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)
K64	K355	Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10
K30	K361	Corridors – Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1
K17	K362	Corridors – Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least ½-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. *If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.* 19.3.6.2, 19.3.6.2.7
K17	K362	Corridors – Construction of Walls 2012 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2
K18	K363	Corridor – Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance

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		between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 *Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.* 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1 Where required by Chapters 11 through 43, door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8. 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, *Standard for Fire Doors and Other Opening Protectives*. 7.2.1.15.3 The inspection and testing interval for fire-rated and nonrated door assemblies shall be permitted to exceed 12 months under a written performance-based program in accordance with 5.2.2 of NFPA 80, *Standard for Fire Doors and Other Opening Protectives*. 7.2.1.15.4 A written record of the inspections and testing shall be signed and kept for inspection by the authority having jurisdiction. 7.2.1.15.5 Functional testing of door assemblies shall be performed by individuals who can demonstrate knowledge and understanding of the operating components of the type of door being subjected to testing. 7.2.1.15.6 Door assemblies shall be visually inspected from both sides of the opening to assess the overall condition of the assembly. 7.2.1.15.7 As a minimum, the following items shall be verified: (1) Floor space on both sides of the openings is clear of obstructions, and door leaves open fully and close freely. (2) Forces required to set door leaves in motion and move to the fully open position do not exceed the requirements in 7.2.1.4.5. (3) Latching and locking devices comply with 7.2.1.5. (4) Releasing hardware devices are installed in accordance with 7.2.1.5.9.1. (5) Door leaves of paired openings are installed in accordance with 7.2.1.5.10. (6) Door closers are adjusted properly to control the closing speed of door leaves in accordance with accessibility requirements. (7) Projection of door leaves into the path of egress does not exceed the encroachment permitted by 7.2.1.4.3. (8) Powered door openings operate in accordance with 7.2.1.9. (9) Signage required by 7.2.1.4.1(3), 7.2.1.5.4, 7.2.1.6, and 7.2.1.9 is intact and legible. (10) Door openings with special locking arrangements function in accordance with 7.2.1.6. (11) Security devices that impede egress are not installed on openings, as required by 7.2.1.5.11.

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		7.2.1.15.8 Door openings not in proper operating condition shall be repaired or replaced without delay.
K19	K364	Corridor – Openings, Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 in² and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in². Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3
K23, K24	K371	Subdivision of Building Spaces – Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors.
K23, K24	K371	Subdivision of Building Spaces – Smoke Compartments 2012 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2. 18.3.7.1, 18.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors.
K25, K104	K372	Subdivision of Building Spaces – Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a ½-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) *Describe any mechanical smoke control system in REMARKS.*
K25, K104	K372	2012 NEW Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 *Describe any mechanical smoke control system in REMARKS.*
K26	K373	Subdivision of Building Spaces – Accumulation Space Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining

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		compartments 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2
K27, K28	K374	Subdivision of Building Spaces – Smoke Barrier Doors 2012 NEW Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8
K25	K379	Smoke Barrier Door Glazing 2012 EXISTING Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5
K25	K379	2012 NEW Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9
K55	K381	Sleeping Room Outside Windows and Doors Every patient sleeping room has an outside window or outside door. In new occupancies, sill height does not exceed 36 in. above the floor. Windows in atrium walls are considered outside windows.
	K400	Special Provisions – Other List in the REMARKS section any LSC Section 18.4 and 19.4 Special Provisions requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.
	K500	Building Services – Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.
K108, K147	K511	Utilities – Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2
K67	K521	HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2
K68	K522	HVAC – Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety features to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected • takes air for combustion from outside

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		• combustion system separate from occupied area atmosphere 18.5.2.2, 19.5.2.2
	K523	HVAC – Suspended Unit Heaters Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms • Located high enough to be out of reach of people in the area • Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1)
	K524	HVAC – Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54
	K525	HVAC – Solid Fuel-Burning Fireplaces Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided: • Areas are separated by 1-hour fire resistance construction • Fireplace complies with 9.2.2 • Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass • Room has supervised CO detection per 9.8 18.5.2.3(3) and 19.5.2.3(3)
K160	K531	Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3
K161	K532	Escalators, Dumbwaiters, and Moving Walks 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2
K161	K532	Escalators, Dumbwaiters, and Moving Walks 2012 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. 18.5.3, 9.4.2.2
K71	K541	Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a

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		fire protection rating of 1 hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82
K71	K541	Rubbish Chutes, Incinerators, and Laundry Chutes 2012 NEW Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. • The fire resistance rating of chute charging room shall not be required to exceed 1 hour. • Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. • Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82
	K700	Operating Features – Other List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567.
K48	K711	Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 **19.7.2.2 Fire Safety Plan.** A written health care occupancy fire safety plan shall provide for all of the following: (1)Use of alarms (2)Transmission of alarms to fire department (3)Emergency phone call to fire department (NEW) (4)Response to alarms (5)Isolation of fire (6)Evacuation of immediate area (7)Evacuation of smoke compartment (8)Preparation of floors and building for evacuation

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		(9)Extinguishment of fire
K50	K712	Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 **19.7.2.1* Protection of Patients.** **19.7.2.1.1** For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. **19.7.2.1.2** The basic response required of staff shall include the following: (1) Removal of all occupants directly involved with the fire emergency (2) Transmission of an appropriate fire alarm signal to warn other building occupants and summon staff (3) Confinement of the effects of the fire by closing doors to isolate the fire area (4) Relocation of patients as detailed in the health care occupancy's fire safety plan
K66	K741	Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4

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K74	K751	Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20% of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1
	K752	Upholstered Furniture and Mattresses Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4
K73	K753	Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701 • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. • The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 **19.7.5.6** Combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2)The decorations meet the requirements of NFPA 701, *Standard Methods of Fire Tests for Flame Propagation of Textiles and Films*. (3)The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, *Standard Method of Fire Test for Individual Fuel Packages*, using the 20 kW ignition source. (4)The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following:

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		(a)Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms, having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.
K75	K754	Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is ≤ 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7
	K771	Engineer Smoke Control Systems 2012 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7
	K771	Engineer Smoke Control Systems 2012 NEW When installed, engineered smoke control systems are tested in accordance with NFPA 92, Standard for Smoke Control Systems. Test documentation is maintained on the premises. 18.7.7
K70	K781	Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies. Except, unless used in non-sleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius).

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		18.7.8, 19.7.8
	K791	Construction, Repair, and Improvement Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1
	K900	Health Care Facilities Code - Other List in the REMARKS section, any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567.
K145	K901	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)
K77	K902	Gas and Vacuum Piped Systems – Other List in the REMARKS section, any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 5 (NFPA 99)
	K903	Gas and Vacuum Piped Systems – Categories Medical gas, medical air, surgical vacuum, WAGD, and air supply systems in which failure is likely to cause major injury or death are designated Category 1. Systems in which failure is likely to cause minor injury to patients are designated Category 2. Systems in which failure is not likely to cause injury, but can cause discomfort is designated Category 3. Deep sedation and general anesthesia are not administered when using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)
K140	K904	Gas and Vacuum Piped Systems – Warning Systems All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)
	K905	Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening. 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)
K77	K906	Gas and Vacuum Piped Systems – Central Supply System Operations Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are

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		secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)
	K907	Gas and Vacuum Piped Systems – Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)
	K908	Gas and Vacuum Piped Systems – Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)
K141	K909	Gas and Vacuum Piped Systems – Information and Warning Signs Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 ft., are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)
	K910	Gas and Vacuum Piped Systems – Modifications Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)
	K911	Electrical Systems – Other List in the REMARKS section, any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)
	K912	Electrical Systems – Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room,

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		ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99)
	K913	Electrical Systems – Wet Procedure Locations Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2
K144	K914	Electrical Systems – Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For, LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)
K106, K146	K915	Electrical Systems – Essential Electric System Categories Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3
	K916	Electrical Systems – Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)
	K917	Electrical Systems – Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)

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	K918	Electrical Systems – Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10-seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)
	K919	Electrical Equipment – Other List in the REMARKS section, any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99)
	K920	Electrical Equipment – Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5

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	K921	Electrical Equipment – Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacture include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing trained. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8
	K922	Gas Equipment – Other List in the REMARKS section, any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 11 (NFPA 99)
K76	K923	Gas Equipment – Cylinder and Container Storage ≥ 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. > 300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. ≤ 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2 A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)
	K925	Gas Equipment – Respiratory Therapy Sources of Ignition Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99)

Skilled Nursing Facility
2012 Life Safety and Health Care Facilities Code
K Tag Reference

2000 Tag #	2012 Tag #	2012 Code Language
	K926	Gas Equipment – Qualifications and Training of Personnel - Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)
K143	K927	Gas Equipment – Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)
	K928	Gas Equipment – Labeling Equipment and Cylinders Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flow meters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)
	K929	Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99) 11.6.2 (NFPA 99)
	K930	Gas Equipment – Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)
K130	K932	Features of Fire Protection – Other List in the REMARKS section, any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.