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## **DEPARTMENT OF HEALTH AND HUMAN SERVICES**

### **Centers for Medicare & Medicaid Services**

**42 CFR Parts 403, 416, 418, 460, 482, 483, and 485**

**[CMS-3277-F]**

**RIN 0938- AR72**

### **Medicare and Medicaid Programs; Fire Safety Requirements for Certain Health Care Facilities**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Final rule.

**SUMMARY:** This final rule will amend the fire safety standards for Medicare and Medicaid participating hospitals, critical access hospitals (CAHs), long-term care facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IID), ambulatory surgery centers (ASCs), hospices which provide inpatient services, religious non-medical health care institutions (RNHCIs), and programs of all-inclusive care for the elderly (PACE) facilities. Further, this final rule will adopt the 2012 edition of the Life Safety Code (LSC) and eliminate references in our regulations to all earlier editions of the Life Safety Code. It will also adopt the 2012 edition of the Health Care Facilities Code, with some exceptions.

**DATES:** This regulation is effective July 5, 2016.

The incorporation by reference of certain publications listed in the rule is approved by the Director of the **Federal Register** as of July 5, 2016.

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CMS-3277-F

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**SUPPLEMENTARY INFORMATION:**

**Acronyms**

ABHR- Alcohol Based Hand Rubs

ADA- Americans with Disabilities Act

AHJ- Authority Having Jurisdiction

ASC- Ambulatory Surgical Center

ASHRAE- American Society of Heating, Refrigeration, and Air Conditioning Engineers

CAH- Critical Access Hospital

CDC- Centers for Disease Control and Prevention

CFR- Code of Federal Regulations

CMS- Centers for Medicare & Medicaid

DOJ- Department of Justice

EES- Essential Electrical System

FR- Federal Register

FSES- Fire Safety Evaluation System

GAO- Government Accountability Office

HHS- Department of Health and Human Services

HVAC- Heating, Ventilation, and Air Conditioning

ICF-IID- Intermediate Care Facilities for Individuals with Intellectual Disabilities

LSC- Life Safety Code

LTC- Long- term Care

NFPA- National Fire Protection Association

OPPS- Outpatient Prospective Payment System

PACE- Programs of All-inclusive Care for the Elderly

CMS-3277-F

RFA- Regulatory Flexibility Act

RIA-Regulatory Impact Analysis

RNHCI- Religious Non-Medical Health Care Institution

TIA- Tentative Interim Amendment

UMRA- Unfunded Mandates Reform Act

WAGD- Waste Anesthetic Gas Disposal System

### **Definitions**

Approved, Automatic Sprinkler System: A fire protection system, deemed acceptable by the Authority Having Jurisdiction, consisting of an integrated network of piping designed in accordance with fire protection engineering standards and including a water supply, a water control valve, a water flow alarm, a drain, and automatic sprinklers which are fire suppression or control devices that operate automatically when their heat-actuated element is heated to its thermal rating or above, allowing water to discharge over a specified area.

Deck: An exterior floor supported on at least two opposing sides by an adjacent structure and/or posts, piers, or other independent supports.

Porch: An outside walking area having a floor that is elevated more than 8 in. (203 mm) above grade.

Space: A portion of the health care facility designated by the governing body that serves a specific purpose.

[Note: The word “space” takes its meaning from the context in which it is used as it is a definable area, such as a room, toilet room, storage room, assembly room, corridor, or lobby.]

CMS-3277-F

Non-Supervised Automatic Sprinkler System: An automatic sprinkler system lacking electrical supervisory attachments and; therefore, unable to provide a distinctive supervisory signal to indicate a condition that would impair the satisfactory operation of the sprinkler system.

Supervised Automatic Sprinkler System: An automatic sprinkler system equipped with electrical supervisory attachments, installed and monitored for integrity in accordance with NFPA 72, *National Fire Alarm and Signaling Code*, that provides a distinctive supervisory signal to indicate a condition that would impair the satisfactory operation of the sprinkler system.

[Note: For a sprinkler system to be considered supervised as required by NFPA 101, the supervision must be electrical as contrasted with supervision via chaining and locking of valves in the open position as permitted for supervision by NFPA 13. Supervision in accordance with NFPA 101 involves more than valve monitoring as any condition that would impair satisfactory operation of the sprinkler system must provide a supervisory signal.]

## **I. Background**

### A. Overview

The Life Safety Code (LSC) is a compilation of fire safety requirements for new and existing buildings, and is updated and published every 3 years by the National Fire Protection Association (NFPA), a private, nonprofit organization dedicated to reducing loss of life due to fire. The LSC regulations adopted by Centers for Medicare & Medicaid Services (CMS) apply to hospitals, long-term care facilities (LTC), critical access hospitals (CAHs), ambulatory surgical centers (ASC), intermediate care facilities

CMS-3277-F

for individuals with intellectual disabilities (ICF-IIDs), hospice inpatient care facilities, programs for all inclusive care for the elderly (PACE), and religious non-medical health care institutions (RNHCIs). The Medicare and Medicaid regulations have historically incorporated these requirements by reference, along with Secretarial waiver authority. The statutory basis for incorporating NFPA's LSC into the regulations we apply to Medicare and, as applicable, Medicaid providers and suppliers is the Secretary of the Department of Health and Human Services (the Secretary's) authority to stipulate health and safety regulations for each type of Medicare and (if applicable) Medicaid-participating facility, as well as the Secretary's general rulemaking authority, set out at sections 1102 and 1871 of the Social Security Act (the Act).

In our regulations, issued pursuant to the Act, we have stated that we believe CMS has the authority to grant waivers of some provisions of the LSC when necessary; for instance, to hospitals under section 1861(e)(9) of the Act, and to LTC facilities at sections 1819(d)(2)(B) and 1919(d)(2)(B) of the Act. Under our current regulations, the Secretary may waive specific provisions of the LSC for any type of facility, if application of our rules would result in unreasonable hardship for the facility, and if the health and safety of its patients would not be compromised by such waiver.

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

CMS-3277-F

a facility. Waiver approval in these instances would be subject to a review of documentation maintained by the facility, verification of the applicability of the waiver, and confirmation that the terms and requirements of the waiver have been implemented by the facility. In most cases such verification occurs when an onsite survey of the facility is conducted. We plan to continue this approach, but would like to clarify that in those cases where we have issued a prior public communication providing for a categorical waiver, an advance recommendation from a state survey agency or accrediting organization (as applicable), is not required in order for a waiver to be granted. We have issued categorical waivers of LSC requirements when newer editions of the LSC provided equally effective means of ensuring life safety compared to requirements of earlier LSC editions. When CMS has evaluated the alternative (such as examining new fire safety research and technology), and concluded that the specific alternative would improve or maintain the safety of the residents or patients of the facility, CMS may defer to newer editions of the LSC. CMS requires that providers comply with any applicable non-waived provisions of the version of the LSC referenced in the categorical waiver.

In addition, the Secretary may accept a state's fire and safety code instead of the LSC if CMS determines that the protections of the state's fire and safety code are equivalent to, or more stringent than, the protections offered by the LSC. Further, the NFPA's Fire Safety Evaluation System (FSES), an equivalency system, provides alternatives to meeting various provisions of the LSC, thereby achieving the same level of fire protection as the LSC. These flexibilities mitigate the potential unnecessary burdens of applying the requirements of the LSC to all affected health care facilities.

CMS-3277-F

On January 10, 2003, we published a final rule in the **Federal Register** (68 FR 1374) adopting the 2000 edition of the LSC. In that final rule, we required that all affected providers and suppliers meet the provisions of the 2000 edition of the LSC, except for certain specific sections. One of the exceptions to the 2000 edition of the LSC is the code's use of roller latches on corridor doors in buildings that are fully protected by a sprinkler system. We believe that roller latches on corridor doors are a safety hazard under all circumstances, and prohibit their use on corridor doors in all Medicare and applicable Medicaid facilities. We also removed references to all previous editions of the LSC.

In 2002, the Centers for Disease Control and Prevention (CDC) published on its web site (<http://www.cdc.gov/handhygiene/Guidelines.html>) an initial set of hand hygiene guidelines for health care settings. The guidelines recommended the use of alcohol-based hand rub (ABHR) dispensers. On September 22, 2006, we published a final rule (71 FR 55326) to allow certain health care facilities to place ABHR dispensers in exit corridors under specified conditions. To accommodate the placement of ABHR dispensers in health care facilities, the NFPA retroactively amended the 2000 edition of the code. When CMS adopts an edition of the LSC, it adopts that edition as it existed on the day of publication of the proposed rule. Since the changes to the 2000 edition of the LSC occurred after publication of the January 2003 final rule that adopted the 2000 edition of the LSC, CMS was required to use the notice and comment rulemaking process to adopt the amendment that the NFPA made to the code.

The September 2006 final rule also required that LTC facilities, at a minimum, install battery-powered single station smoke alarms in resident rooms and common areas

CMS-3277-F

if their buildings were not fully sprinklered, or if the building did not have system-based smoke detectors. A Government Accountability Office (GAO) report entitled “Nursing Home Fire Safety: Recent Fires Highlight Weaknesses in Federal Standards and Oversight” GAO-04-660, July 16, 2004 (<http://www.gao.gov/products/GAO-04-660>) examined two LTC facility fires (Hartford and Nashville) in 2003, that resulted in 31 total resident deaths. The report examined Federal fire safety standards and enforcement procedures, as well as results from the fire investigations of these two incidents. It specifically cited requiring smoke detectors in these facilities as one way to strengthen the requirements. We agreed with the GAO findings and added this smoke alarm requirement in response to the GAO report.

On August 13, 2008, we published a final rule (73 FR 47075) to require all LTC facilities to install automatic sprinkler systems throughout their buildings in accordance with the technical provisions of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems, and to test, inspect, and maintain sprinkler systems in accordance with the technical requirements of the 1998 edition of NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. The August 2008 final rule required all LTC facilities to be equipped with sprinkler systems by August 13, 2013. This rule was also in response to the July 2004 GAO report on nursing home fire safety. In addition to its findings related to smoke alarms, the GAO recommended that fire safety standards for unsprinklered LTC facilities be strengthened and stated that sprinklers were the single most effective fire protection feature for LTC facilities.

On May 12, 2014 CMS also published a final rule, “Part II Regulatory Provisions



CMS-3277-F

to Promote Program Efficiency, Transparency, and Burden Reduction” (79 FR 27106) that allows CMS to grant very limited extensions of the due date for a facility that is building a replacement facility or undergoing major modifications to unsprinklered living areas.

On October 24, 2011, we published a proposed rule (76 FR 65891), to reform hospital and critical access hospital conditions of participation. Many of the public comments received during the comment period strongly encouraged CMS to adopt the 2012 edition of the LSC. The commenters stated that the 2012 edition of the LSC would clarify several issues and would be beneficial to facilities.

On April 16, 2014, we published a proposed rule (79 FR 21552), “Fire Safety Requirements for Certain Health Care Facilities” that would amend the fire safety standards. We proposed the adoption of the 2012 edition of the NFPA LSC and the elimination of references to earlier editions of the LSC.

CMS must emphasize that the LSC is not an accessibility code, and compliance with the LSC does not ensure compliance with the requirements of the Americans with Disabilities Act (ADA). State and local government programs and services, including health care facilities, are required to comply with Title II of the ADA. Private entities that operate public accommodations such as nursing homes, hospitals, and social service center establishments are required to comply with Title III of the ADA. The same accessibility standards apply regardless of whether health care facilities are covered under Title II or Title III of the ADA. <sup>1</sup> For more information about the ADA’s

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<sup>1</sup> Facilities newly constructed or altered after March 15, 2012 must comply with the 2010 Standards for Accessible Design (2010 Standards). Facilities newly constructed or altered between September 15, 2010 and March 15, 2012 had the option of complying with either the 1991 Standards for Accessible Design (1991 Standards) or the 2010 Standards. Facilities newly constructed between

CMS-3277-F

requirements, see the Department of Justice's Web site at <http://www.ada.gov> or call 1-800-514-0301 (voice) or 1-800-514-0383 (TTY).

#### B. 2012 Edition of the Life Safety Code

The 2012 edition of the LSC includes new provisions that we believe are vital to the health and safety of all patients and staff. Our intention is to ensure that patients and staff continue to experience the highest degree of fire safety possible. The term "Patient(s)" will be globally used throughout this document, and refers to patient, clients, residents and all other terms used to describe the type of individuals cared for in each provider type.

The use of earlier editions of the code can become problematic due to advances in safety and technology, and changes made to each edition of the code. Newer buildings are typically built to comply with the newer versions of the LSC because state and local jurisdictions, as well as non-CMS-approved accreditation programs, often adopt and enforce newer versions of the code as they become available. Therefore, a health care facility that is constructed or renovated in 2015 would likely be required by its state and local authorities to comply with a more recent edition of the LSC, while also being required to comply with the 2000 edition of the LSC in order to meet the Medicare and applicable Medicaid regulatory requirements. Requiring compliance with two different editions of the LSC at the same time can create unnecessary conflicts, duplications, and inconsistencies that increase construction and compliance costs without any fire safety or patient care benefits. For example, the 2000 edition of the LSC limits ABHRs to gel form, whereas the 2012 edition of the LSC expands to allow aerosol and gel ABHRs.

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January 26, 1993 and September 15, 2010, or altered between January 26, 1992 and September 15, 2010 were required to comply with the 1991 Standards under Title III and either the 1991 Standards or the Uniform Federal Accessibility Standards under Title II.

CMS-3277-F

Limiting the choice of ABHRs creates barriers to improved hand hygiene, which has been shown to reduce the number of health care associated infections. We believe that adopting the 2012 LSC would simplify and modernize the construction and renovation process for affected health care providers and suppliers, reduce compliance-related burdens, and allow for more resources to be used for patient care.

The 2012 edition of the LSC contains a new chapter, —“Building Rehabilitation.” This new chapter allows for the application of the requirements for new construction versus the requirements for existing construction to vary based on the type and extent of rehabilitation work being done to a given building. This chapter sets out different types of building rehabilitation work (that is, repair, renovation, modification, reconstruction, change of use, change of occupancy and addition) to which different standards apply.

Buildings that have not received, all pre-construction governmental approvals before the rule’s effective date, or those buildings that begin construction after the effective date of this regulation, will be required to meet the New Occupancy chapters of the 2012 edition of the LSC. Buildings constructed before the effective date of this regulation will be required to meet the Existing Occupancy chapters of the 2012 edition of the LSC. Any changes made to buildings will be required to comply with Chapter 43- Building Rehabilitation, which depending on the changes being made, could require compliance with the new or existing occupancy chapters. In any instances where mandatory LSC references do not include existing chapters, such as Chapter 43- Building Rehabilitation, existing occupancies must ensure buildings and equipment are in compliance with provisions previously adopted by CMS at the time they were constructed or installed.

CMS-3277-F

C. Incorporation by Reference

In this final rule we are incorporating by reference the NFPA 101<sup>®</sup> 2012 edition of the LSC, issued August 11, 2011, and all Tentative Interim Amendments issued prior to April 16, 2014; and the NFPA 99<sup>®</sup> 2012 edition of the Health Care Facilities Code, issued August 11, 2011, and all Tentative Interim Amendments issued prior to April 16, 2014.

(1) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;

(i) TIA 12-1 to NFPA 101, issued August 11, 2011.

(ii) TIA 12-2 to NFPA 101, issued October 30, 2012.

(iii) TIA 12-3 to NFPA 101, issued October 22, 2013.

(iv) TIA 12-4 to NFPA 101, issued October 22, 2013.

(2) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011.

(i) TIA 12-2 to NFPA 99, issued August 11, 2011.

(ii) TIA 12-3 to NFPA 99, issued August 9, 2012.

(iii) TIA 12-4 to NFPA 99, issued March 7, 2013.

(iv) TIA 12-5 to NFPA 99, issued August 1, 2013.

(v) TIA 12-6 to NFPA 99, issued March 3, 2014.

The materials that are incorporated by reference are reasonably available to interested parties and can be inspected at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, [www.nfpa.org](http://www.nfpa.org), 1.617.770.3000. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the **Federal Register** to announce the changes.

CMS-3277-F

The NFPA 101<sup>®</sup> 2012 edition of the LSC (including the TIAs) provides minimum requirements, with due regard to function, for the design, operation and maintenance of buildings and structures for safety to life from fire. Its provisions also aid life safety in similar emergencies.

The NFPA 99<sup>®</sup> 2012 edition of the Health Care Facilities Code (including the TIAs) provides minimum requirements for health care facilities for the installation, inspection, testing, maintenance, performance, and safe practices for facilities, material, equipment, and appliances, including other hazards associated with the primary hazards.

#### Health Care Occupancies

The following are key provisions that appear in the 2012 edition of the LSC for Chapter 18, “New Health Care Occupancies,” and Chapter 19, “Existing Health Care Occupancies.” We have provided the LSC citation and a description of the 2012 requirement at the beginning of each section discussed.

The 2012 edition of the LSC classifies a “Health Care Occupancy” as a facility having 4 or more patients on an inpatient basis. We proposed that the LSC exception for health care occupancy facilities with fewer than four occupants/patients would be inapplicable to the Medicare and Medicaid facilities; all health care occupancies that provide care to one or more patients would be required to comply with the relevant requirements of the 2012 edition of the LSC.

#### Sections 18.2.3.4 (2) and 19.2.3.4(2) - Corridor projections.

This provision requires noncontinuous projections to be no more than 6 inches from the corridor wall. In addition to following the requirements of the LSC, health care facilities must comply with the requirements of the ADA, including the requirements for

CMS-3277-F

protruding objects. The 2010 Standards for Accessible Design (2010 Standards) generally limit the protrusion of wall-mounted objects into corridors to no more than 4 inches from the wall when the object's leading edge is located more than 27 inches, but not more than 80 inches, above the floor. See Sections 204.1 and 307 of the 2010 Standards, available at <http://www.ada.gov/regs2010/2010ADASTandards/Guidance2010ADAstandards.htm><sup>2</sup> ("2010 Standards"). This requirement protects persons who are blind or have low vision from being injured by bumping into a protruding object that they cannot detect with a cane.

Although the LSC allows 6-inch projections, under the ADA, objects mounted above 27 inches and no more than 80 inches high can only protrude a maximum of 4 inches into the corridor beyond a detectable surface mounted less than 27 inches above the floor (except for certain handrails which may protrude up to 4 ½"). See section 307 of the 2010 standards for requirements for handrails and post-mounted objects. CMS intends to provide technical assistance regarding strategies for how to avoid noncompliance with the ADA's protruding objects requirement, as well as how to modify non-compliant protruding objects.

#### Sections 18.7.5.7.2 and 19.7.5.7.2-Recycling

This new provision requires that containers used solely for recycling clean waste be limited to a maximum capacity of 96 gallons. If the recycling containers are located in a protected hazardous area, container size will not be limited.

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<sup>2</sup> Regardless of which set of ADA Standards for Accessible Design applied at the time a facility was built or altered, the requirements for wall-mounted protruding objects are essentially the same. See Section 4.4 of the 1991 Standards, available at <http://www.ada.gov/1991standards/1991standards-archive.html>.

CMS-3277-F

Sections 18.3.6.3.9.1 and 19.3.6.3.5 -Roller Latches

A roller latch is a type of door latching mechanism to keep a door closed. The 2012 edition of the LSC requires corridor doors to be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction. The LSC permits roller latches capable of keeping the door fully closed if a force of 5 pounds is applied at the latch edge or roller latches in fully sprinklered buildings. However, we proposed not to adopt these standards from the 2012 LSC. Through fire investigations, roller latches have proven to be an unreliable door latching mechanism requiring extensive maintenance to operate properly. Many roller latches in fire situations failed to provide adequate protection to residents in their rooms during an emergency. Roller latches will be prohibited in existing and new Health Care Occupancies for corridor doors and doors to rooms containing flammable or combustible materials. These doors will be required to have positive latching devices instead.

Sections 18.4.2 and 19.4.2 –Sprinklers in High-Rise buildings

This provision requires buildings over 75' (generally greater than 7 or 8 stories) in height to have automatic sprinkler systems installed throughout the building. The 2012 LSC allows 12 years from when the authority having jurisdiction (which in this case is CMS) officially adopts the 2012 edition of the LSC for existing facilities to comply with the sprinkler system installation requirement. Therefore, those facilities that are not already required to do so will have 12 years following publication of this final rule, which adopts the 2012 LSC, to install sprinklers in high-rise buildings.

CMS-3277-F

Sections 18.2.2.2.5.2 and 19.2.2.2.5.2 -Door Locking

Where the needs of patients require specialized protective measures for their safety, door-locking arrangements are permitted by this section. For example, locked psychiatric facilities are designed such that the entire facility is secure and obstructs patients and others from improperly entering and exiting. This provision allows interior doors to be locked, subject to the following requirements: (1) all staff must have keys; (2) smoke detection systems must be in place; (3) the facility must be fully sprinklered; (4) the locks are electrical locks that will release upon loss of power to the device; and (5) the locks release by independent activation of the smoke detection system and the water flow in the automatic sprinkler system.

Sections 18.3.2.6 and 19.3.2.6 –Alcohol based hand rubs (ABHRs)

This provision explicitly allows aerosol dispensers, in addition to gel hand rub dispensers. The aerosol dispensers are subject to limitations on size, quantity, and location, just as gel dispensers are limited. Automatic dispensers are also now permitted in health care facilities, provided that the following requirements are met: (1) they do not release contents unless they are activated; (2) the activation occurs only when an object is within 4 inches of the sensing device; (3) any object placed in the activation zone and left in place must not cause more than one activation; (4) the dispenser must not dispense more than the amount required for hand hygiene consistent with the label instructions; (5) the dispenser is designed, constructed and operated in a way to minimize accidental or malicious dispensing; and (6) all dispensers are tested in accordance with the manufacturer's care and use instructions each time a new refill is installed. The



CMS-3277-F

provision further defines prior language regarding “above or adjacent to an ignition source” as being “within 1 inch” of the ignition source.

Sections 18.3.5 and 19.3.5- Extinguishment Requirements

This provision is related to sprinkler system requirements and requires the evacuation of a building or the instituting of an approved fire watch when a sprinkler system is out of service for more than 10 hours in a 24-hour period until the system has been returned to service. We proposed not to adopt this requirement. In its place, we proposed that a health care occupancy must evacuate a building or institute an approved fire watch when a sprinkler system is out of service for more than 4 hours. Based on comments received from the industry, we are withdrawing our proposal and adopting the requirement as specified by NFPA for an evacuation of a building or the instituting of an approved fire watch when a sprinkler system is out of service for more than 10 hours in a 24-hour period until the system has been returned to service.

Section 18.3.2.3 and 19.3.2.3- Anesthetizing Locations

This provision requires that anesthetizing locations be protected in accordance with the 2012 edition of NFPA 99, Health Care Facilities Code. Separate from the requirements of the NFPA 99, we proposed that dedicated supply and exhaust systems for windowless anesthetizing locations must be arranged to automatically vent smoke and products of combustion to prevent the circulation of smoke originating from within and outside the operating rooms.

Sections 18.2.3.4 and 19.2.3.4—Corridors

This provision allows for wheeled equipment that is in use, medical emergency equipment not in use, and patient lift and transportation equipment be permitted to be

CMS-3277-F

kept in the corridors for more timely patient care. This provision also allows facilities to place fixed furniture in the corridors, although the placement of furniture or equipment must not obstruct accessible routes required by the ADA. See section 403.5 of the 2010 Standards.

#### Sections 18.3.2.5.3 and 19.3.2.5.3 –Cooking facilities

Cooking facilities are allowed in a smoke compartment where food is prepared for 30 individuals or fewer (by bed count). The cooking facility is permitted to be open to the corridor, provided that the following conditions are met:

- The area being served is limited to 30 beds or less.
- The area is separated from other portions of the facility by a smoke barrier.
- The range hood and stovetop meet certain standards—

++ A switch must be located in the area that is used to deactivate the cook top or range whenever the kitchen is not under staff supervision.

++ The switch also has a timer, not exceeding 120-minute capacity that automatically shuts off after time runs out.

- Two smoke detectors must be located no closer than 20 feet and not further than 25 feet from the cooktop or range.

#### Sections 18.7.5.1 and 19.7.5.1 –Furnishings & Decorations

This provision allows combustible decor in any health care occupancy as long as the décor is flame-retardant or treated with approved fire-retardant coating that is listed

CMS-3277-F

and labeled, and meet fire test standards. Additionally, decor may not exceed—(1) 20 percent of the wall, ceiling and doors, in any room that is not protected by an approved automatic sprinkler system; (2) 30 percent of the wall, ceiling and doors, in any room (no maximum capacity) that is not protected by an approved, supervised automatic sprinkler system; and (3) 50 percent of the wall, ceiling and doors, in any room with a capacity of 4 people (the actual number of occupants in the room may be less than its capacity) that is not protected by an approved, supervised automatic sprinkler system.

#### Sections 18.5.2.3 and 19.5.2.3 –Fireplaces

This provision allows direct-vent gas fireplaces in smoke compartments without the 1 hour fire wall rating. Fireplaces must not be located inside of any patient sleeping room. Solid fuel-burning fireplaces are permitted and can be used only in areas other than patient sleeping rooms, and must be separated from sleeping rooms by construction of no less than a 1 hour fire resistance wall rating.

#### Outside Window or Door Requirements

Separate from the requirements of the LSC, we proposed that every health care occupancy patient sleeping room must have an outside window or outside door with an allowable sill height not to exceed 36 inches above the floor with certain exceptions, as follows:

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

CMS-3277-F

inches above the floor.

### Ambulatory Health Care Occupancies

The following are key provisions in the 2012 edition of the LSC from Chapter 20, “New Ambulatory Health Care Occupancies” and Chapter 21, “Existing Ambulatory Health Care Occupancies.” We have provided the LSC citation and a description of the requirement at the beginning of each section discussed.

The 2012 edition of the LSC defines an “Ambulatory Health Care Occupancy” as a facility capable of treating 4 or more patients simultaneously on an outpatient basis. CMS regulations at 42 CFR 416.44 require that all ASCs meet the provisions applicable to Ambulatory Health Care Occupancy, regardless of the number of patients served. We believe that hospital outpatient surgical departments are comparable to ASCs and thus should also be required to meet the provisions applicable to Ambulatory Health Care Occupancy Chapters, regardless of the number of patients served.

### Sections 20.3.2.1 and 21.3.2.1 –Doors

This provision requires all doors to hazardous areas be self-closing or close automatically.

### Sections 20.3.2.6 and 21.3.2.6 –ABHRs

This provision explicitly allows aerosol dispensers, in addition to gel hand rub dispensers. The aerosol dispensers are subject to limitations on size, quantity, and location, just as gel dispensers are limited. Automatic dispensers are also now permitted in ambulatory care facilities, provided, among other things, that--(1) they do not release contents unless they are activated; (2) the activation occurs only when an object is within 4 inches of the sensing device; (3) any object placed in the activation zone and left in

CMS-3277-F

place must not cause more than one activation; (4) the dispenser must not dispense more than the amount required for hand hygiene consistent with the label instructions; (5) the dispenser is designed, constructed and operated in a way to minimize accidental or malicious dispensing; (6) all dispensers are tested in accordance with the manufacturer's care and use instructions each time a new refill is installed. The provision further defines prior language regarding "above or adjacent to an ignition source" as being "within 1 inch" of the ignition source.

#### Sections 20.3.5 and 21.3.5- Extinguishment Requirements

This provision is related to sprinkler system requirements and requires the evacuation of a building or the instituting of an approved fire watch when a sprinkler system is out of service for more than 10 hours in a 24-hour period until the system has been returned to service. We proposed to replace this requirement with a separate requirement for evacuation or a fire watch when a sprinkler system is out of service for more than 4 hours. Based on comments received from the industry, we are withdrawing our proposal and adopting the requirement as specified by NFPA for an evacuation of a building or the instituting of an approved fire watch when a sprinkler system is out of service for more than 10 hours in a 24-hour period until the system has been returned to service.

#### Section 20.3.2.3 and 21.3.2.3- Anesthetizing Locations

This provision requires that anesthetizing locations be protected in accordance with the 2012 edition of NFPA 99, Health Care Facilities Code. The 2012 edition of NFPA 99 does not require a smoke control ventilation system in anesthetizing locations. We proposed a requirement, separate from the LSC and NFPA 99, to require air supply

CMS-3277-F

and exhaust systems for windowless anesthetizing locations that is arranged to automatically vent smoke and products of combustion to prevent the circulation of smoke originating from within and outside the operating room.

#### Residential Board and Care Occupancies

Both the 2000 and 2012 editions of the LSC classify “board and care” as a facility “used for lodging or boarding of 4 or more patients not related to the owners or operators by blood or marriage, for the purpose of providing personal care services.” We proposed that the LSC requirements would apply to a facility regardless of the number of patients served. We note that the only CMS-regulated facilities that would be subject to these provisions would be intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs), which are regulated under 42 CFR part 483, subpart I.

The following are key provisions that appear in the 2012 edition of the LSC for Chapter 32, “New Residential Board and Care Occupancies” and Chapter 33, “Existing Residential Board and Care Occupancies.” We are providing the LSC citation and a description of the requirement at the beginning of each section discussed.

#### Section 32.2.3.5.3.2- Sprinklers

This revised provision has been expanded to require that sprinkler systems be installed in all habitable areas, closets, roofed porches, balconies and decks of new occupancies.

#### Sections 32.2.3.5.7 and 33.2.3.5.7- Attics

This new provision requires attics of new and existing facilities to be sprinklered. For both new and existing board and care facilities, if the attic is used for living purposes, storage, or housing of fuel fired equipment, it must be protected with an automatic

CMS-3277-F

approved sprinkler system. If the attic is used for other purposes or is not used, then it must meet one of the following requirements: (1) have a heat detection system that activates the building fire alarm system; (2) have automatic sprinklers; (3) be of noncombustible or limited-combustible construction; or (4) be constructed of fire-retardant-treated-wood.

#### Section 32.3.3.4.7- Smoke Alarms

This provision will only affect newly constructed facilities. Approved smoke alarms are required to be installed inside every sleeping room, outside every sleeping area, in the immediate vicinity of the bedrooms, and on all levels within a resident unit.

#### Section 33.3.3.2.3- Hazardous Areas

This provision is for existing facilities with impractical evacuation capabilities. All hazardous areas must be separated from other parts of the building by smoke partitions.

#### Waiver Authority

We proposed to retain our existing authority to waive provisions of the LSC under certain circumstances, further reducing the exposure to additional cost and burden for facilities with unique situations. A waiver may be granted for a specific LSC requirement if we determine that-- (1) the waiver would not adversely affect patient/staff health and safety; and (2) it would impose an unreasonable hardship on the facility to meet a specific LSC requirement. In cases where a provider or supplier has been cited for a LSC deficiency, the provider or supplier may request a waiver recommendation from its State Survey Agency or Accrediting Organization (AO) with a CMS-approved Medicare and applicable Medicaid accreditation program. The State Survey Agency or

CMS-3277-F

AO reviews the request and makes a recommendation to the appropriate CMS Regional Office. The CMS Regional Office will review the waiver request and the recommendation and make a final decision. CMS will not grant a waiver if patient health and safety is compromised.

The LSC recognizes alternative systems, methods, or devices approved as equivalent by the authority having jurisdiction (AHJ) as being in compliance with the LSC. CMS, as the AHJ for certification, will determine equivalency through the waiver approval process.

#### State Fire Codes

In addition to the proposed waiver option, a state may request that its state fire safety requirements, imposed by state law, be used in lieu of the 2012 edition of the LSC. The state must submit the request to the appropriate CMS Regional Office, and the Regional Office will forward the request to CMS central office for final determination<sup>3</sup>.

#### Fire Safety Evaluation System (FSES)

We retain our authority to apply the Fire Safety Evaluation System (FSES) option within the LSC as an alternative approach to meeting the requirements of the LSC. This includes the determination of how the FSES will be applied to each occupancy and which edition of the FSES is most appropriate to use.

#### D. 2012 Edition of the Health Care Facilities Code

The 2012 edition of the NFPA 99, “Health Care Facilities Code,” addresses requirements for both health care occupancies and ambulatory care occupancies, and serves as a resource for those who are responsible for protecting health care facilities

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<sup>3</sup> CMS reminds such states that compliance with state fire safety requirements, like compliance with the LSC, does not ensure compliance with the ADA requirements.



CMS-3277-F

from fire and associated hazards. The purpose of this Code is to provide minimum requirements for the installation, inspection, testing, maintenance, performance, and safe practices for health care facility materials, equipment and appliances. This Code is a compilation of documents that have been developed over a 40-year period by NFPA, and is intended to be used by those persons involved in the design, construction, inspection, and operation of health care facilities, and in the design, manufacture, and testing of appliances and equipment used in patient care areas of health care facilities. It provides information on subjects, for example, medical gas and vacuum systems, electrical systems, electrical equipment, and gas equipment. The NFPA 99 applies specific requirements in accordance with the results of a risk-based assessment methodology. A risk-based approach allows for the application of requirements based upon the types of treatment and services being provided to patients or residents rather than the type of facility in which they are being performed. In order to ensure the minimum level of protection afforded by NFPA 99 is applicable to all patient and resident care areas within a health care facility, CMS proposed the adoption of the 2012 edition of NFPA 99, with the exception of chapters 7-Information Technology and Communications Systems for Health Care Facilities; 8-Plumbing; 12-Emergency Management; and 13-Security Management. In the following section, we describe the key provisions within the NFPA 99.

The first three chapters of the NFPA 99 address the administration of the NFPA 99, the referenced publications and definitions.

#### Chapter 4- Fundamentals

Chapter 4 provides guidance on how to apply NFPA 99 requirements to health

CMS-3277-F

care facilities based upon “categories” determined when using a risk-based methodology.

There are four categories utilized in the risk assessment methodology, depending on the types of treatment and services being provided to patients or residents. Section 4.1.1 of NFPA 99 describes Category 1 as, “Facility systems in which failure of such equipment or system is likely to cause major injury or death of patients or caregivers....” Section A.4.1.1 provides examples of what a major injury could include, such as amputation or a burn to the eye. Section 4.1.2 describes Category 2 as, “Facility systems in which failure of such equipment is likely to cause minor injury to patients or caregivers....” Section A.4.1.2 describes a minor injury as one that is not serious or involving risk of life. Section 4.1.3 describes Category 3 as, “Facility systems in which failure of such equipment is not likely to cause injury to patients or caregivers, but can cause patient discomfort....” Section 4.1.4 describes Category 4 as, “Facility systems in which failure of such equipment would have no impact on patient care....”

Section 4.2 requires that each facility that is a health care or ambulatory occupancy define its risk assessment methodology, implement the methodology, and document the results. CMS does not require the submission of risk assessment methods to CMS. However, CMS, will confirm that facilities are using risk assessment methodologies when conducting onsite surveys. We did not propose to require the use of any particular risk assessment procedure. However, if future situations indicate the need to define a particular risk assessment procedure, we would pursue that through a separate notice and comment rulemaking.

#### Chapter 5- Gas and Vacuum Systems

The hazards addressed in Chapter 5 include the ability of oxygen and nitrous

CMS-3277-F

oxide to exacerbate fires, safety concerns from the storage and use of pressurized gas, and the reliance upon medical gas and vacuum systems for patient care. Chapter 5 does not mandate the installation of any systems; rather, if they are installed or are required to be installed, the systems will be required to comply with NFPA 99. Chapter 5 covers the performance, maintenance, installation, and testing of the following:

- Nonflammable medical gas systems with operating pressure below a gauge pressure of 300 psi;
- Vacuum systems in health care facilities;
- Waste anesthetic gas disposal systems (WAGD); and
- Manufactured assemblies that are intended for connection to the medical gas, vacuum, or WAGD systems.

#### Chapter 6- Electrical Systems

The hazards addressed in Chapter 6 are related to the electrical power distribution systems in health care facilities, and address issues such as electrical shock, power continuity, fire, electrocution, and explosions that might be caused by faults in the electrical system.

Chapter 6 covers the performance, maintenance, and testing of the electrical systems in health care facilities.

#### Chapter 9- Heating, Ventilation, and Air Conditioning (HVAC)

Chapter 9 requires HVAC systems serving spaces- a portion of the health care facility designated by the governing body that serves a specific purpose or providing health care functions to be in accordance with the American Society of Heating,

CMS-3277-F

Refrigeration and Air-Conditioning Engineers (ASHRAE) Standard 170- Ventilation of Health Care Facilities (2008 edition) (<http://www.ashrae.org>).

Chapter 9 does not apply to existing HVAC systems, but applies to the construction of new health care facilities, and the altered, renovated, or modernized portions of existing systems or individual components. Chapter 9 ensures minimum levels of heating, ventilation, and air conditioning performance in patient and resident care areas. Some of the issues discussed in Chapter 9 are:

- HVAC system energy conservation.
- Commissioning.
- Piping.
- Ductwork.
- Acoustics.
- Requirements for the ventilation of medical gas storage and trans-filling areas.
- Waste anesthetic gases.
- Plumes from medical procedures.
- Emergency power system rooms.
- Ventilation during construction.

#### Chapter 10- Electrical Equipment

Chapter 10 covers the performance, maintenance, and testing of electrical equipment in health care facilities. Much of this chapter applies to requirements for portable electrical equipment in health care facilities, but there are also requirements for fixed-equipment and information on administrative issues.

CMS-3277-F

### Chapter 11- Gas Equipment

The hazards addressed in Chapter 11 relate to general fire, explosions, and mechanical issues associated with gas equipment, including compressed gas cylinders.

### Chapter 14- Hyperbaric Facilities

Chapter 14 addresses the hazards associated with hyperbaric facilities in health care facilities, including electrical, explosive, implosive, and fire hazards. Chapter 14 sets forth minimum safeguards for the protection of patients and personnel administering hyperbaric therapy and procedures. Chapter 14 contains requirements for hyperbaric chamber manufacturers, hyperbaric facility designers, and personnel operating hyperbaric facilities. It also contains requirements related to construction of the hyperbaric chamber itself and the equipment used for supporting the hyperbaric chamber, as well as administration and maintenance. Many requirements in this chapter are applicable only to new construction and new facilities.

### Chapter 15- Features of Fire Protection

Chapter 15 covers the performance, maintenance, and testing of fire protection equipment in health care facilities. Issues addressed in this chapter range from the use of flammable liquids in an operating room to special sprinkler protection. These fire protection requirements are independent of the risk-based approach, as they are applicable to all patient care areas in both new and existing facilities.

Chapter 15 has several sections taken directly from the NFPA 101, including requirements for the following:

- Construction and compartmentalization of health care facilities.
- Laboratories.

CMS-3277-F

- Utilities.
- Heating, ventilation and air conditioning systems.
- Elevators.
- Escalators.
- Conveyors.
- Rubbish Chutes.
- Incinerators.
- Laundry Chutes.
- Fire detection, alarm and communication systems.
- Automatic sprinklers and other extinguishing equipment.
- Compact storage including mobile storage and maintenance.
- Testing of water based fire protection systems.

These sections have requirements for inspection, testing and maintenance which apply to all facilities, as well as specific requirements for existing systems and equipment that also apply to all facilities.

## **II. Provisions of the Proposed Regulations**

This section details the specific regulatory changes for each affected provider and supplier. Due to the similar content and structure of the regulations for the various providers and suppliers, most of the information presented repeats for each provider.

1. Religious Nonmedical Health Care Institutions: Condition of Participation: Life Safety From Fire (§403.744).

In §403.744, we proposed to maintain most of the current provisions for Religious

CMS-3277-F

Nonmedical Health Care Institutions (RNHCI) published in the **Federal Register** on January 10, 2003 (68 FR 1374), except if they conflicted with the 2012 LSC and the requirements were within the provisions detailed in Section I of this preamble regardless of the number of patients the facility served.

In addition, we proposed to--

- Retain the requirements at §403.744(a)(1)(ii) related to the prohibition of roller latches in health care facilities. We also proposed to update the LSC chapter reference from “19.3.6.3.2 exception number 2” to “19.3.6.3.5 numbers 1 and 2 and 19.3.6.3.6 number 2”.

- Modify the requirements specific to ABHRs, since most of the requirements in our regulation are now included in the 2012 edition of the LSC.

Therefore, we proposed to remove the requirements at §403.744(a)(4)(i), (ii), (iv) and (v).

- Retain the requirements at §403.744(a)(4)(iii) related to protection against inappropriate access, and redesignate it at §403.744(a)(4).

- Add a new requirement at §403.744(a)(5) that required facilities with sprinkler systems that were out of service for more than 4 hours in a 24-hour period to evacuate the building or portion of the building affected by the system outage, or establish a fire watch until the system is back in service, notwithstanding the lower standard of the LSC.

- Add a new requirement at §403.744(a)(6) to require window sills must not exceed 36 inches above the floor.

- Retain the requirement at §403.744(b) related to the Secretary’s waiver authority and state imposed codes. We did not propose to make any changes to this

CMS-3277-F

section.

- Remove the requirements at §403.744(c) related to the phase-in period for compliance with emergency lighting. In the 2003 final rule, we allowed facilities until March 13, 2006, to upgrade their emergency lighting equipment. This phase-in period has now expired and is no longer a necessary regulatory provision.

- Add a new Condition of Participation at §403.745 requiring RNHCIs to comply with the 2012 edition of the NFPA 99.

- Chapters 7, 8, 12, and 13 of the NFPA 99 would not apply to RNHCIs.

- Allow for waivers of these provisions under the same conditions and procedures that we currently use for waivers of applicable provisions of the LSC.

## 2. Ambulatory Surgery Centers: Condition for Coverage: Environment (§416.44)

In §416.44, we proposed that all ASCs meet the provisions applicable to Ambulatory Health Care Centers in the 2012 edition of the LSC, except as detailed in section I of this preamble, regardless of the number of patients the facility serves. We also proposed to retain the provision at §416.44(b)(2) and (b)(3) related to the Secretary's waiver authority and state imposed codes. We did not propose to make any changes to these provisions.

In addition, we proposed to--

- Remove the requirements at §416.44(b)(4) related to the phase-in period for compliance with emergency lighting. This phase-in period has now expired and this phase-in provision is no longer a necessary regulatory provision.

- Modify the requirements specific to ABHRs since most of the requirements are now included in the 2012 edition of the LSC. Specifically, we proposed



CMS-3277-F

to remove the requirements at §416.44(b)(5)(i), (ii), (iv), (A) through (G), and (v).

- Retain the requirements at §416.44(b)(5)(iii) related to protection against inappropriate access and redesignate it at §416.44(b)(4).
- Add a new requirement at §416.44(b)(5) to require a facility with a sprinkler system that is out of service for more than 4 hours in a 24-hour period to evacuate the building or portion of the building affected by the system outage, or establish a fire watch until the system is back in service, notwithstanding the lower standard of the 2012 LSC.
- Add a new requirement at §416.44(b)(6) to require facilities with windowless anesthetizing locations to have an air supply and exhaust system that automatically vents smoke and products of combustion, prevents recirculation of smoke originating within the operating room, and prevents the circulation of smoke entering the system intake.
- Add a new paragraph at §416.44(c) requiring ASCs to comply with the 2012 edition of the NFPA 99.
  - Chapters 7, 8, 12, and 13 of the NFPA 99 would not apply to ASCs.
  - Allow for waivers of these provisions under the same conditions and procedures that we currently use for waivers of applicable provisions of the LSC.

### 3. Hospice Care: Condition of Participation: Hospices That Provides Inpatient Care Directly (§418.110)

In §418.110, we proposed that all inpatient hospice facilities meet the provisions applicable to health care occupancies in the 2012 edition of the LSC, with the exceptions discussed in section I of this preamble, regardless of the number of patients they serve.

CMS-3277-F

We note that this is not a change in requirements, but merely a clarification that, for LSC purposes, an inpatient hospice facility is considered a health care occupancy. The LSC does not apply to hospice care that is provided in a patient's home.

In addition, we proposed to --

- Retain the requirements at §418.110(d)(1)(ii) related to the prohibition of roller latches in health care facilities. We proposed to update the LSC chapter reference from “19.3.6.3.2 exception number 2” to “19.3.6.3.5 numbers 1 and 2 and 19.3.6.3.6 number 2.”
- Retain the provision at §418.110(d)(2) and (3) related to the Secretary's waiver authority and state imposed codes. We did not propose any changes to these provisions.
- Modify the requirements specific to ABHRs because most of the requirements are now included in the 2012 edition of the LSC. We proposed to remove the requirements at §418.110(d)(4)(i), (ii) and (iv). We proposed to retain the requirements at §418.110(d)(4)(iii) related to protection against inappropriate access and redesignate this requirement at §418.110(d)(4).
- Add a new requirement at §418.110(d)(5) to require a facility with a sprinkler system that is out of service for more than 4 hours in a 24-hour period to evacuate the building or portion of the building affected by the system outage, or establish a fire watch until the system is back in service, notwithstanding the lower standard of the 2012 LSC.
- Add a new requirement at §418.110(d)(6) to require that window sills must not exceed 36 inches.

CMS-3277-F

- Add a new paragraph at §418.110(e) requiring hospices to comply with the 2012 edition of the NFPA 99.
- Chapters 7, 8, 12, and 13 of the NFPA 99 not would apply to hospices.
- Allow for waivers of these provisions under the same conditions and procedures that we currently use for waivers of applicable provisions of the LSC.

4. Programs of All-Inclusive Care for the Elderly (PACE): Condition of Participation: Physical Environment (§460.72)

In §460.72, we proposed to retain most of the provisions of the existing final regulation for Programs of All-Inclusive Care for the Elderly (PACE) published in the **Federal Register** on January 10, 2003 (68 FR 1374), regardless of the number of patients the PACE facility serves. PACE providers will continue to be required to meet LSC specifications for the type of facilities in which the programs are located (that is, hospitals and office buildings).

In addition, we proposed to--

- Retain the requirements at §460.72(b)(1)(ii) related to the prohibition of roller latches in health care facilities. We proposed to update the LSC chapter reference from “19.3.6.3.2 exception number 2” to “19.3.6.3.5 numbers 1 and 2 and 19.3.6.3.6 number 2.”
- Retain the provision at §460.72(b)(2)(i) and (ii) related to the Secretary’s waiver authority and state imposed codes. We did not propose to make any changes to these provisions.
- Remove the requirement at §460.72(b)(3) related to the phase-in period for compliance with emergency lighting. This phase-in period has now expired and is

CMS-3277-F

no longer a necessary regulatory provision.

- Remove the requirements at §460.72(b)(4) related to the phase-in period for the prohibition of roller latches in health care facilities. This phase-in period has now ended and is no longer a necessary regulatory provision.

- Modify the requirements specific to ABHRs because most of the requirements are now located in the 2012 edition of the LSC. We proposed to remove the requirements at §460.72(b)(5)(i), (ii), (iv) and (v). We proposed to retain the requirements at §460.72(b)(5)(iii) related to protection against inappropriate access, and redesignate it to §460.72(b)(3). We proposed to add a new requirement at §460.72(b)(4) to require a facility with a sprinkler system that is out of service for more than 4 hours in a 24-hour period to evacuate the building or portion of the building affected by the system outage, or establish a fire watch until the system is back in service, notwithstanding the lower standard of the 2012 LSC.

- Add a new paragraph at §460.72(d) to require PACE centers to comply with the 2012 edition of the NFPA 99.

- Chapters 7, 8, 12, and 13 of the NFPA 99 would not apply to PACEs.

- Allow for waivers of these provisions under the same conditions and procedures that we currently use for waivers of applicable provisions of the LSC.

##### 5. Hospitals: Condition of Participation: Physical Environment (§482.41)

In §482.41, we proposed that the hospitals meet the health care occupancy provisions of the 2012 edition of the LSC, regardless of the number of patients the hospital serves. There can be multiple occupancy classifications within a single hospital. Therefore, multiple chapters of the code may be applied to a single hospital in accordance

CMS-3277-F

with the Multiple Occupancies provisions in 18.1.3 and 19.1.3. We also proposed that hospital outpatient surgical departments are comparable to ASCs and thus should be required to meet the provisions applicable to Ambulatory Health Care Occupancy chapters, regardless of the number of patients served.

In addition, we proposed to--

- Retain most of the provisions from the existing final regulation for hospitals published in the **Federal Register** on January 10, 2003 (68 FR 1374).
- Retain the requirements at §482.41(b)(1)(ii) related to the prohibition of roller latches in health care facilities. We proposed to update the LSC chapter reference from “19.3.6.3.2 exception number 2” to “19.3.6.3.5 numbers 1 and 2 and 19.3.6.3.6 number 2.”
- Retain the provision at §482.41(b)(2) and (3) related to the Secretary’s waiver authority and state imposed codes. We did not propose to make any changes to these provisions.
- Remove the requirements at §482.41(b)(4) related to the phase-in period for compliance with emergency lighting. This phase-in period has now ended, and is no longer a necessary regulatory provision.
- Remove the requirements at §482.41(b)(5) related to the phase-in period of the prohibition on roller latches in health care facilities. This phase-in period has now expired and is no longer a necessary regulatory provision.
- Retain the requirements at §482.41(b)(6) through (b)(8), and redesignate them at §482.41(b)(4) through (b)(6), without changes.
- Modify the requirements specific to ABHRs since most of the

CMS-3277-F

requirements are now located in the 2012 edition of the LSC. We proposed to remove the requirements at §482.41(b)(9)(i), (ii), (iv) and (v). We proposed to retain the requirement at §482.41(b)(9)(iii) related to protection against inappropriate access and redesignate it at §482.41(b)(7).

- Add a new requirement at §482.41(b)(8) to require a facility with a sprinkler system that is out of service for more than 4 hours in a 24-hour period to evacuate the building or portion of the building affected by the system outage, or establish a fire watch until the system is back in service, notwithstanding the lower standard of the 2012 LSC.
- Add a new requirement at §482.41(b)(9) that to require facilities with windowless anesthetizing locations to have an air supply and exhaust system that automatically vents smoke and products of combustion, prevents recirculation of smoke originating within the surgical suite, and prevents the circulation of smoke entering the system intake.
- Add a new requirement at §482.41(b)(10) to require a minimum 36 inch window sill, with certain exceptions for newborn nurseries, rooms intended for occupancy for less than 24 hours, and special nursing care areas.
- Add a new paragraph at §482.41(c) requiring hospitals to comply with the 2012 edition of the NFPA 99.
  - Chapters 7, 8, 12, and 13 of the NFPA 99 would not apply to hospitals.
  - Allow for waivers of these provisions under the same conditions and procedures that we currently use for waivers of applicable provisions of the LSC.

CMS-3277-F

6. Long-Term Care Facilities: Condition of Participation: Physical Environment  
(§483.70)

In §483.70, we proposed to retain most of the provisions of the existing final regulation for LTC facilities published in the **Federal Register** on January 10, 2003 (68 FR 1374) regardless of the number of residents the facility serves.

In addition, we proposed to--

- Retain the requirements at §483.70(a)(1)(ii) related to the prohibition of roller latches in health care facilities. We proposed to update the LSC chapter reference from “19.3.6.3.2 exception number 2” to “19.3.6.3.5 numbers 1 and 2 and 19.3.6.3.6 number 2.”
- Retain the provision at §483.70(a)(2) and (3) related to the Secretary’s waiver authority and state imposed codes. We did not propose to make any changes to these provisions.
- Remove the requirements at §483.70(a)(4) related to the phase-in period for compliance with emergency lighting. This phase-in period has now expired and is no longer a necessary regulatory provision.
- Remove the requirements at §483.70(a)(5) related to the phase-in period for the prohibition of roller latches in health care facilities. This phase-in period has now ended and is no longer a necessary regulatory provision.
- Modify the requirements specific to ABHRs since most of the requirements are now included in the 2012 edition of the LSC. Specifically, we proposed to remove the requirements at §483.70(a)(6)(i), (ii), (iv) and (v). We proposed to retain

CMS-3277-F

the requirement at §483.70(a)(6)(iii) related to protection against inappropriate access, and redesignate it at §483.70(a)(4).

- Retain the requirements at §483.70(a)(7)(i), (ii), (iii), (A) and (B) related to installation, inspection, testing and maintenance of battery operated single station smoke alarms, without changes. We proposed to redesignate these requirements at §483.70(a)(5) (i), (ii), (iii) (A) and (B).

- Retain the requirements at §483.70(a)(8)(i) and (ii) related to the installation of supervised automatic sprinklers and the testing, inspection and maintenance of the sprinkler system. We proposed to redesignate these requirements as §483.70(a)(6)(i) and (ii), without changes.

- Add a new requirement at §483.70(a)(7) to require a minimum 36 inch window sill.

- Add a new paragraph at §483.70(b) to require LTC facilities to comply with the 2012 edition of the NFPA 99.

- Chapters 7, 8, 12, and 13 of the NFPA 99 would not apply to LTC facilities.

- Allow for waivers of these provisions under the same conditions and procedures that we currently use for waivers of applicable provisions of the LSC.

#### 7. Intermediate Care Facilities for Individuals with Intellectual Disabilities: Condition of Participation: Physical Environment (§483.470)

In §483.470, we proposed to retain most of the provisions of the existing regulation for ICFs/IID. In accordance with the regulatory requirements at §483.470 (j)(2), ICFs/IID will continue to be permitted to meet either the Residential Board and



CMS-3277-F

Care Occupancies chapter or the Health Care Occupancy chapter of the LSC, as appropriate, in accordance with the determination of the State survey agency, regardless of the number of patients the facility serves.

In addition, we proposed to--

- Not adopt the provisions at Chapters 32.3.2.11.2 and 33.3.2.11.2, related to “lockups.” Lock-ups, as described in the LSC, are not appropriate under any circumstances for board and care facilities.
- Retain the requirements at §483.470(j)(1)(ii) related to the prohibition of roller latches in health care facilities. We proposed to update the LSC chapter reference from “19.3.6.3.2 exception number 2” to “19.3.6.3.5 numbers 1 and 2 and 19.3.6.3.6 number 2.”
- Retain the requirements at §483.470(j)(2), (3), and (4).
- Remove the requirements at §483.470(j)(5) related to the phase-in period for compliance with emergency lighting. This phase-in period has expired and is no longer a necessary regulatory provision.
- Remove §483.470(j)(6) related to the phase-in period for the prohibition of roller latches in health care facilities. This phase-in period has now ended and is no longer a necessary regulatory provision.
- Retain the provision at §483.470(j)(7)(A) and (B) related to the Secretary’s waiver authority and state imposed codes. We proposed to redesignate these provisions at §483.470(j)(5)(A) and (B) without change.
- Modify the requirements specific to ABHRs since most of the requirements are now included in the 2012 edition of the LSC. Specifically, we proposed

CMS-3277-F

to remove the requirements at §483.470(j)(7)(ii)(A), (B), (D) and (E). We proposed to retain the requirements at §483.470(j)(7)(ii)(C) related to protection against inappropriate access, and redesignate it at §483.470(j)(5)(ii).

- Add a new requirement at §483.470(j)(5)(iii) to require a facility with a sprinkler system that is out of service for more than 4 hours in a 24-hour period to evacuate the building or portion of the building affected by the system outage, or establish a fire watch until the system is back in service, notwithstanding the lower standard of the 2012 LSC.
- Add a new paragraph at §483.470(j)(5)(iv) to require ICF-IIDs to comply with the 2012 edition of the NFPA 99.
- Chapters 7, 8, 12, and 13 of the NFPA 99 would not apply to ICF-IIDs.
- Allow for waivers of these provisions under the same conditions and procedures that we currently use for waivers of applicable provisions of the LSC.

#### 8. Critical Access Hospitals: Condition of Participation: Physical Plant and Environment (§485.623)

In §485.623, we proposed to retain most of the provisions of the existing final regulation for Critical Access Hospitals (CAHs) published in the **Federal Register** on January 10, 2003 (68 FR 1374), regardless of the number of patients the facility serves.

In addition, we proposed to--

- Retain the requirements at §485.623(d)(1)(ii) related to the prohibition of roller latches in health care facilities. We proposed to update the LSC chapter reference from “19.3.6.3.2 exception number 2” to “19.3.6.3.5 numbers 1 and 2 and 19.3.6.3.6 number 2.”

CMS-3277-F

- Retain the requirements at §485.623(d)(2) through (d)(4), without any changes.
- Remove the requirement at §485.623(d)(5) related to the phase-in period for compliance with emergency lighting. This phase-in period has now expired and is no longer a necessary regulatory provision.
- Remove the requirement at §485.623(d)(6) related to the phase-in period of the prohibition on roller latches in health care facilities. This phase-in period has also expired and is no longer a necessary regulatory provision.
- Modify the requirements specific to ABHRs since most of the requirements are now incorporated in the 2012 edition of the LSC. Specifically, we proposed to remove the requirements at §485.623(d)(7)(i), (ii), (iv) and (v). We proposed to retain the requirement at §485.623(d)(7)(iii) related to protection against inappropriate access and redesignate it at §485.623(d)(5).
- Add a new requirement at §485.623(d)(6) to require a facility with a sprinkler system that is out of service for more than 4 hours in a 24-hour period to evacuate the building or portion of the building affected by the system outage, or establish a fire watch until the system is back in service, notwithstanding the lower standard of the 2012 LSC.
- Add a new requirement at §485.623(d)(7) to require facilities with windowless anesthetizing locations to have an air supply and exhaust system that automatically vents smoke and products of combustion, prevents recirculation of smoke originating within the surgical suite, and prevents the circulation of smoke entering the system intake.

CMS-3277-F

- Add a new requirement at §485.623(d)(8) to require a minimum 36 inch window sill, with the exception of newborn nurseries, rooms intended for occupancy for less than 24 hours, and special nursing care areas. Windows in atrium walls are considered outside windows for the purposes of this provision.

- Add a new paragraph at §485.623(e) requiring CAHs to comply with the 2012 edition of the NFPA 99.

- Chapters 7, 8, 12, and 13 of the NFPA 99 would not apply to CAHs.

- Allow for waivers of these provisions under the same conditions and procedures that we currently use for waivers of applicable provisions of the LSC.

### **III. Analysis of and Responses to Public Comments**

We received over 362 public comments concerning the LSC proposed rule, “Fire Safety Requirements for Certain Health Care Facilities” (79 FR 21552), which this rule is finalizing. The majority of the comments were from medical societies, hospital associations, hospitals, medical centers, LTC facilities, and advocate groups for different provider types. The remaining comments were from individual physicians, nurses, facility engineers, and private citizens. A summary of the major issues and our responses follow:

#### **LSC- Health Care Occupancies**

We note that only the following CMS-regulated facilities would be subject to these comments, unless otherwise specified: hospitals, CAHs, LTC facilities, hospices, RNHCIs, and PACE facilities.

Comment: One commenter recommended adding language to the LTC requirements at §483.70, similar to other provider sections, about establishing a firewatch

CMS-3277-F

or evacuating a building when a sprinkler system is out of service for more than 4 hours in a 24 hour period. The commenter stated that adding this requirement to the LTC regulations would provide protection for the residents of nursing homes when the sprinkler system is out of service.

Response: We thank the commenter for their comment. We agree that requiring additional safety measures when a sprinkler system is out of service for a significant amount of time is important in the LTC facility environment. We originally intended to include this regulatory requirement in the proposed rule; however, it was inadvertently left out of regulations text. We would like to clarify that we have removed the 4 hour requirement and are now following the LSC requirement of implementing a fire watch or building evacuation if the sprinkler system is out for more than 10 hours in a 24-hour period. We have made the appropriate correction in this final rule, and have included the appropriate language in the regulation text at §483.70(a)(8).

Comment: One commenter stated that the proposed rule does not address whether a hospital that is not fully sprinklered and provides swing beds needs to meet the more stringent requirements from S & C-13-55-LSC that applies to hospitals.

Response: The survey and certification memorandum that the commenter references is related to the requirements for the installation and maintenance of automatic sprinkler systems in LTC facilities. Swing beds are not considered to be LTC facilities. Rather, swing beds are part of a hospital or CAH and must meet the LSC provisions applicable to those facility-types. Therefore, swing beds are only required to meet certain specified regulations for LTC facilities, not including the LTC facility sprinkler system requirements.

CMS-3277-F

Comment: CMS solicited public comment to determine if a phase-in period of 12 years is enough time for facilities to install fully compliant sprinkler systems in high-rise buildings, and asked whether other provider types are, or may be, located in a high-rise building. We received very few responses to this solicitation. The majority of the commenters who responded stated that 12 years was enough time to fully sprinker a high-rise healthcare facility, and some commenters stated that 12 years was more than enough time. We did not receive any comments stating that this was not enough time to install sprinkler systems in high-rise buildings. Commenters also stated that ambulatory care and residential board and care occupancies may also be located within high-rise hospital buildings.

Response: We agree with commenters that 12 years is an appropriate phase-in period, and we are finalizing this proposal with a phase-in period of 12 years from the publication date of this rule. We thank the commenters for the input on other occupancy types that could be located in high-rise buildings. Since these occupancy types are located in hospital buildings, we have already accounted for them in our total number of high-rise hospital buildings.

Comment: One commenter asked whether an alternative care setting used to provide services to PACE participants would be required to meet the ABHR requirements and the sprinkler system outage requirement.

Response: All PACE center facilities are required to meet the requirements found at 42 CFR 460.72, "Physical Environment". This includes meeting all the requirements for the specific occupancy type they fall under within the LSC. This requirement also

CMS-3277-F

applies to the type of setting in which a center is located, which would include alternative care settings.

Comment: Some commenters have expressed concern regarding cooking facilities that are open to the corridor. One commenter did not support cooking facilities being open to the corridor and believes that it could increase the number of fires in these facilities due to misuse. Other commenters supported having cooking facilities that are open to the corridor and believed it would promote person-centered care and make for a more home-like atmosphere. A few commenters suggested changes to this requirement, including --

- Requiring that an operational exhaust hood for the cooking facility should not contribute to nor create an egress corridor return air plenum (an air pressure differential between different parts of a building);
- Requiring that the activate/deactivate switch be hidden from view;
- Requiring that staff must be present when a range hood or stovetop is in use; and
- Requiring that cooking facilities be screened off when not in use to prevent resident access.

Response: We appreciate the suggestions concerning cooking facilities in LTC facilities; however we feel that the LSC includes many requirements to make sure that cooking facilities are safe. All facilities are ultimately responsible for assuring the safety of all residents at all times, and they may choose to implement additional safety precautions, such as those described above, to further assure safety. Since other fire safety standards prohibit the use of a corridor as a plenum in the facility ventilation

CMS-3277-F

system, the introduction of a cooking exhaust fan would need to be accounted for in the design and not create a corridor plenum situation.

Comment: One commenter suggested that, in addition to installing sprinklers in existing high-rise health care occupancies, we should also require existing non high-rise health care occupancies to install sprinkler systems throughout their buildings.

Response: While we encourage all facilities to install sprinklers, there is not enough evidence for CMS to support requiring all facilities to be retrofitted for sprinklers. In the event that the NFPA should incorporate a requirement for universal sprinklers into a future edition of the LSC, we would strongly consider adopting such a change.

Comment: Some commenters stated that medical equipment should not be permanently fixed in the corridors. This could present a safety issue during a fire or evacuation and also makes the corridor smaller in size.

Response: We follow the LSC requirement for medical equipment in the corridors, which allows any equipment that is in use, including medical emergency equipment and patient lift and transportation equipment to be permitted to be kept in the corridors for more timely patient care. Facilities may place fixed furniture in the corridors, although the placement of furniture or equipment must not obstruct accessible routes required by the ADA. The potential risks of this change are low because the LSC has shifted to a “defend in place” approach that does not rely upon evacuation as the primary means of fire safety.

Comment: One commenter suggested that CMS only permit decorations in rooms that have sprinklers in them. Furthermore, the commenter stated that, with such sprinkler



CMS-3277-F

protection, there would not be a need to mandate a maximum percentage of space that could be covered by decorations.

Response: The NFPA, through its committee of experts and consensus process, determined that decorations may not exceed—(1) 20 percent of the wall, ceiling and doors, in any room that is not protected by an approved automatic sprinkler system; (2) 30 percent of the wall, ceiling and doors, in any room that is not protected by an approved, supervised automatic sprinkler system; and (3) 50 percent of the wall, ceiling and doors, in any room with a capacity of 4 people (the actual number of occupants in the room may be less than its capacity) that is not protected by an approved, supervised automatic sprinkler system. We believe that it is appropriate to adopt these consensus standards. We also note that the health care occupancy type that is most likely to have a significant amount of room décor is a LTC facility, given that patients reside in such facilities for longer periods of time, and that all LTC facilities are required to have sprinklers installed throughout their buildings.

Comment: One commenter recommended that two smoke detectors be located no closer than 20 feet and not further than 25 feet from a fireplace.

Response: There are currently no requirements for smoke detectors within a certain distance of a fireplace. If a facility wants to add additional smoke detectors closer to fireplaces they are free to do so. An electrically supervised (connected to the facility fire alarm panel) carbon monoxide detector is required in the room containing the fireplace to increase the level of safety for the residents or patients in the facility. We believe that the current requirements for sprinklers and smoke detectors are sufficient to assure resident safety, particularly because fireplaces are only in open areas and not

CMS-3277-F

permitted in resident rooms. The health care occupancy type that is most likely to have a fireplace is a LTC facility, because there are more options for the location of fireplaces in LTC facilities, making the facilities feel more home-like. All LTC facilities should be fully sprinklered, with smoke detectors in designated areas of the facilities, such as corridors and resident sleeping areas.

### **LSC- ASC**

We note that the only CMS-regulated facilities that would be subject to these comments would be ambulatory surgical centers, which are regulated under 42 CFR part 416.

Comment: One commenter believes that we should allow grandfathering for ASCs that meet previous editions of the LSC. The commenter states that trying to modify an existing facility to meet provisions in the 2012 edition of the LSC would have significant cost implications for existing ASCs, and may cause ASCs to close.

Response: For existing ASCs, most provisions in the 2012 edition of the LSC are similar to past editions. Furthermore, existing facilities in compliance with previous editions of the LSC are not required to upgrade to a later edition of the LSC for certain provisions, unless there is a building renovation, which could require compliance with new occupancy chapters. In addition, an ASC may also request a waiver for a specific provision of the LSC, further reducing the exposure to additional costs and burden for ASCs with unique situations that can justify the application of waivers and will not endanger the health and safety of patients. A waiver may be granted for a specific LSC requirement if we determine: (1) the waiver would not adversely affect patient and staff

CMS-3277-F

health and safety; and (2) it would impose an unreasonable hardship on the facility to meet a specific LSC requirement.

Comment: One commenter suggested an increase to Medicare reimbursements to freestanding ASCs, stating that the current reimbursement model is not sufficient.

Response: We thank the commenter for this comment; however, reimbursement rates are beyond the scope of this rule. We recommend submitting such comments separately to CMS or commenting on the next Outpatient Prospective Payment System/Ambulatory Surgical Centers (OPPS/ASC) proposed rule.

### **LSC- Board & Care**

We note that the only CMS-regulated facilities that would be subject to these comments would be intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs), which are regulated under 42 CFR part 483, subpart I.

Comment: One commenter expressed concern about a process that permits board and care occupancies to assess their own evacuation capacity. The commenter notes that facilities have strong incentive to overestimate their evacuation capability in order to avoid more stringent requirements. The commenter believes that this provision would undermine CMS' efforts to improve safety.

Response: CMS looks at the assessment of evacuation capabilities as part of the survey process to verify the accuracy of the self-evaluation. CMS requires surveyors to independently determine the evacuation difficulty score at each survey and use the determined evacuation difficulty score to perform the survey.

Comment: CMS solicited comments regarding whether or not CMS should require existing facilities to install smoke alarms in accordance with section 9.6.2.10,

CMS-3277-F

which would require the addition of smoke alarms inside sleeping rooms, outside every sleeping area, in the immediate vicinity of the bedrooms, and on all levels within the resident units. The commenters who responded to this solicitation unanimously agreed that CMS should not require existing residential board and care facilities to install smoke alarms inside sleeping rooms, outside every sleeping area, in the immediate vicinity of the bedrooms, and on all levels within the resident units. All of the commenters believed that it would be an undue burden, and suggested that, in order for them to meet this requirement, a payment rate adjustment would be in order.

Response: We agree that a regulation to require smoke alarms is not necessary at this time, as there is not enough evidence for us to make it a requirement to upgrade existing facilities. We strongly encourage existing residential board and care facilities to install smoke alarms inside sleeping rooms, outside every sleeping area, in the immediate vicinity of the bedrooms, and on all levels within the resident units to provide an additional level of safety. With regards to any payment rate adjustment, we remind commenters that payment rates are not within the scope of this rule, but recommend submitting comments on such issues separately to CMS.

Comment: The LSC requires newly constructed residential board and care occupancies to install sprinklers in habitable areas, closets, roofed porches, balconies and decks. In the proposed rule, CMS recommended that existing facilities also install sprinklers in the same areas. Commenters stated that CMS should continue to recommend, but not require, sprinklers for existing residential board and care. The commenters also stated that if CMS were to require the installation of sprinklers in those

CMS-3277-F

areas that they would need to have at least a 5 year phase-in period, and that a payment rate adjustment would be in order for affected facilities.

Response: We thank the commenters for their comments regarding this topic. We would like to clarify that sprinklers are only required for new residential board and care construction and existing facilities rated as impractical evacuation capability. The facility itself determines their evacuation capability, and must ensure that the appropriate safety protections are in place to protect the patients and staff within the building, if they are determined to have an impractical evacuation capabilities. CMS regulations require the use of NFPA 101A, Guide on Alternative Approaches to Life Safety, 2010 Edition, Chapter 6, Evacuation Capability Determination for Board and Care Occupancies to determine the evacuation difficulty index. CMS continues to recommend that existing facilities install sprinklers in habitable areas, closets, roofed porches, balconies and decks as an additional safety precaution. Decks being an exterior floor supported on at least two opposing sides by an adjacent structure and/or posts, piers, or other independent supports and, porches being an outside walking area having a floor that is elevated more than 8 in. (203 mm) above grade. With regards to any payment rate adjustment, we remind commenters that payment rates are not within the scope of this rule, but recommend submitting such comments separately to CMS.

Comment: A few commenters expressed concern with having to install sprinklers in attics used for living purposes, storage, or housing of fuel-fired equipment. Commenters also expressed concern with having to install either a heat detection system that activates the building fire alarm, or having automatic sprinklers, or constructing attics of noncombustible or limited-combustible construction or constructing attics of

CMS-3277-F

fire-retardant-treated-wood if the attic is used for other purposes. The commenters stated that compliance with this provision would be expensive and possibly warrant a payment rate adjustment. The commenters requested a minimum 5-year phase-in period to install new protection systems in attics.

Response: A 5-year phase-in period is, we believe, significantly more time than is actually needed to meet this requirement. According to the information gathered by CMS from the installation of sprinklers in LTC facilities requirement, which was required to be in compliance by August 13, 2013, most LTC facilities were able to install sprinklers throughout their entire buildings in 5 years. Attics have much less square footage than an entire building. We believe that 3 years from the effective date of this rule would be an ample amount of time to come into compliance with this requirement, therefore, we are finalizing a 3-year phase-in period. With regards to any payment rate adjustment, we remind commenters that payment rates are not within the scope of this rule, but recommend submitting such comments separately to CMS.

Comment: One commenter requested additional explanation regarding our proposed exclusion of the lock-up provisions contained within the board and care occupancy chapters of the LSC. The commenter proposed an alternative to this exclusion, which would allow lock-ups while requiring a specific staffing ratio requirement.

Response: Lock-ups are incidental use areas where occupants are restrained and such occupants are mostly incapable of self-preservation because of security measures not under the occupants' control. Lock-ups are prohibited in Medicare and Medicaid participating ICF-IID facilities. The health and safety regulations for ICF-IIDs at 42 CFR

CMS-3277-F

483.450 effectively prohibit the use of lock-up spaces as described in the LSC; therefore, there should be no lock-up space in the building.

### **LSC- GENERAL**

Comment: Some commenters questioned whether Tentative Interim Amendments (TIAs) that have been written with regards to the NFPA 101 and NFPA 99 apply, since some of them were published after CMS published the proposed rule.

Response: Because the TIAs are considered a component of the LSC, the following TIAs issued prior to the publication of the proposed rule on April 16, 2014, will apply to all facilities. We have also included language in the final regulations text to this effect. The following TIAs will apply:

- (i) TIA 12-1 to NFPA 101, issued August 11, 2011.
- (ii) TIA 12-2 to NFPA 101, issued October 30, 2012.
- (iii) TIA 12-3 to NFPA 101, issued October 22, 2013.
- (iv) TIA 12-4 to NFPA 101, issued October 22, 2013.
- (v) TIA 12-2 to NFPA 99, issued August 11, 2011.
- (vi) TIA 12-3 to NFPA 99, issued August 9, 2012.
- (vii) TIA 12-4 to NFPA 99, issued March 7, 2013.
- (viii) TIA 12-5 to NFPA 99, issued August 1, 2013
- (ix) TIA 12-6 to NFPA 99, issued March 3, 2014.

Comment: Some commenters agree with the continued prohibition of roller latches in facilities, as they are a safety concern. However, some commenters stated that some doors are not required to latch (that is, toilet rooms, bathrooms) and that roller latches should be allowed on those particular doors with no penalty. A few commenters

CMS-3277-F

also discussed the importance of roller latches in psychiatric units. Those commenters stated that roller latches have limited uses on psychiatric units to address patients barricading themselves in their rooms or using hanging points (on the levers) for potential suicides.

Response: CMS would like to clarify that roller latches are prohibited on all corridor doors. However, doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials would be allowed to have roller latches. We do not believe that permitting the use of roller latches in auxiliary spaces presents a danger to patients or staff. Therefore, we have revised the proposed regulatory requirement throughout this rule to clarify this distinction. We note that this requirement is different than the 2012 LSC requirement for door latching.

Comment: A few commenters expressed concern with Chapter 43, “Renovation”, of the NFPA 101. The commenters suggested that the date of submission of construction plans to the State for plan review should be the “trigger” to apply chapter 43. They also stated that facilities have no control over when plans are actually reviewed; for example, a building may be designed under the current 2000 NFPA 101 code, but may not be approved until after the final publication of this rule, which means they would have to meet the 2012 NFPA 101 code. Commenters also asked CMS to define “constructed” in reference to determining whether a building is consider new or existing.

Response: Buildings that have not yet received all pre-construction governmental approvals required by the jurisdictions in which the building is to be built before the rule’s effective date, or those buildings that begin construction after the effective date of



CMS-3277-F

this regulation, would be required to meet the New Occupancy chapters of the 2012 edition of the LSC. While we share the commenter's concern regarding plans that may be under review for a lengthy period of time, we do not believe that it is in the best interest of patient and staff safety to permit constructing of a building that does not meet the codes that are effective as of the day that construction begins.

Comment: One commenter suggested that hospitals and ASCs should be required to test their emergency generators when they are disconnected from the normal utility.

Response: Facilities are required to test their load emergency power systems on a monthly basis, per the requirements of section 8.4.1, 2010 edition of NFPA 110, Standard for Emergency and Standby Power Systems.

Comment: Some commenters suggested that CMS should provide training for surveyors and providers regarding the new codes, updated guidance, and forms. One commenter suggested that CMS not only provide training for State fire authorities, but also for architects, engineers, and building officials.

Response: CMS agrees that training is very important, and does provide training for state surveyors who work with CMS to enforce these regulations. However, we do not provide training for any provider/supplier type for any health and safety rules, including those related to the LSC. We encourage providers/suppliers, architects, engineers or building officials to contact the NFPA and their relevant industry associations to identify their specific training needs and appropriate offerings that may address those needs with regards to the LSC.

CMS-3277-F

Comment: Many commenters support the adoption of the 2012 NFPA 101 LSC. However, the majority of those commenters also stated that CMS should adopt the 2012 NFPA 101 in its entirety, without any changes to the provisions.

Response: Through our surveys, comments, and experience, we have determined that for the health and safety of patients and staff we could not adopt the LSC in its entirety. We believe that the provisions that we have not adopted are not appropriate for Medicare and Medicaid providers and suppliers. For example, we continue to prohibit roller latches on corridor doors because, in our view, they present a safety hazard. Also, we are not adopting the provision regarding lock-ups because lock-ups are prohibited in the ICF-IIDs regulations, separate from the LSC. This practice is permitted under the National Technology Transfer and Advancement Act (<http://www.gpo.gov/fdsys/pkg/PLAW-104publ113/pdf/PLAW-104publ113.pdf>), which does not mandate that we use an entire code without exceptions if we determine it is impractical or unnecessary to do so.

Comment: Several commenters requested CMS to revise the rule to allow health care facilities to choose other codes that are nationally recognized, such as the International Building Code and International Fire Code. The commenters asserted that referencing only the NFPA's LSC creates conflict for many jurisdictions that enforce other equivalent or more stringent fire and life safety requirements. The commenters further stated that, by not referencing other applicable codes, CMS favors one code to the detriment of other codes.

Response: We continue to specifically cite the LSC because under sections 1819(d)(2)(B) and 1919(d)(2)(B) of the Act, nursing homes must meet the provisions of "such

CMS-3277-F

edition (as specified by the Secretary in regulation) of the LSC of the National Fire Protection Association \*\*\*.” To avoid confusion, and to be consistent for all provider types, we require the LSC for all facilities. This is especially applicable for facilities with mixed occupancies. For example, a health care facility’s west wing could be a nursing home while the rest of the facility is a hospital. It would be impractical as well as burdensome for the facility to follow the LSC for the nursing home and another health and safety code for the hospital. The regulation reflects this by requiring a single code for all health care facilities. The NFPA and the IBC organizations try to align their respective requirements as much as possible and the 2012 LSC is a reflection of that effort. We also note that jurisdictions are permitted to enforce more stringent requirements on top of those required by the Federal LSC requirements.

Comment: Some commenters requested CMS to adopt updated versions of the LSC more quickly in the future. One commenter requested that CMS should adopt any updated version of the LSC within 90 days of the LSC publication.

Response: We cannot adopt the LSC within 90 days of the LSC publication because we are required to give notice to the public that we are proposing to revise a regulation. Once we notify the public of the proposal, the public must have the opportunity to comment on the revisions, and we must respond to the comments before the update becomes final and legally enforceable. We do review each edition of the NFPA 101 and NFPA 99 every 3 years to see if there are any significant provisions that we need to adopt and will continue to do so. We have reviewed the 2015 edition of the LSC and do not feel that there are any significant provisions that need to be addressed at this time.

CMS-3277-F

Comment: Many commenters have suggested that CMS develop a process to be able to permit a facility to apply for a waiver prior to being cited for a deficiency. The commenters stated that it is currently standard practice for CMS to decline to review any requests for waivers filed before there has been a deficiency cited during a survey.

Response: We agree and have implemented a process to approve categorical waivers. We do not consider it always necessary for a facility to be cited for a deficiency before it can apply for or receive a waiver. This is particularly the case when we have evaluated specific provisions of the LSC, determined that a waiver would apply to all similarly-situated facilities with respect to the LSC requirement in question, and issued a public communication describing the specifics of such a categorical waiver, including any particular requirements that must be met in order for the waiver to apply to a facility. Facilities may still submit requests for non-categorical waivers, which is currently done after a citation of a deficiency is found on a fire safety survey. The waiver request includes the reason why the waiver of a specific life safety requirement cannot be complied with, and is submitted as part of the facility Plan of Correction of Deficiencies found on the survey to the State Agency or Regional Office for review and approval/disapproval by the CMS Regional Office. For example, CMS released the following Survey & Cert (S&C) Memos on categorical waivers, and the application process:

- April 19, 2013 - S&C: 13-25: Relative Humidity (RH): Waiver of LSC Anesthetizing Location Requirements; Discussion of Ambulatory Surgical Center (ASC) Operating Room Requirements

CMS-3277-F

[http://www.cms.gov/Medicare/Provider-Enrollment-and-](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-25.pdf)

[Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-25.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-25.pdf)

- August 30, 2013 - S&C: 13-58: 2000 Edition National Fire Protection Association (NFPA) 101® LSC Waivers

[http://www.cms.gov/Medicare/Provider-Enrollment-and-](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-58.pdf)

[Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-58.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-58.pdf)

- September 26, 2014 - S&C: 14-46 Categorical Waiver for Power Strips Use in Patient Care Areas

[http://www.cms.gov/Medicare/Provider-Enrollment-and-](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-46.pdf)

[Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-46.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-46.pdf)

Comment: One commenter expressed concern with the proposal that facilities maintain antifreeze in their sprinkler systems in certain proportions. The commenter recommended that CMS withdraw this requirement, or reconsider its inclusion, until products become available which do not require more than 50 percent antifreeze (in compliance with the proposed rule), but which would still keep the sprinkler systems from freezing.

Response: Where traditional antifreeze solutions for existing systems remain an option, consideration should be given to alternatives to using antifreeze. Antifreeze is not required to prevent the freezing of systems. Owners should investigate alternative methods to prevent the freezing of wet pipe systems in environments or locations that may be subject to freezing.

Comment: A few commenters suggested that CMS allow facilities the opportunity to apply for a waiver rather than install sprinklers if they can show that staff and patients

CMS-3277-F

can be quickly evacuated or that they offer the same level of protection without the sprinklers.

Response: Sprinklers are considered to be a basic level of protection for new and certain rehabilitated buildings, and we do not believe that it would be in the best interest of building occupants to waive these sprinkler requirements. Furthermore, we only require universal retrofitting to add sprinklers in high-rise health care occupancies, LTC facilities, in the attics of board and care facilities. Impractical evacuation capability facilities are all required to be protected throughout by an approved automatic sprinkler system. There is strong evidence that sprinklers in these particular environments are an essential fire safety feature; therefore we do not believe it is in the best interest of patients and staff to waive these requirements under any circumstances.

<http://www.facilitiesnet.com/firesafety/article/Fire-Safety-Facilities-Management-Fire-Safety-Feature--1620>

Comment: Some commenters expressed concern with the use of the term “inappropriate access” in regards to the placement of ABHRs. The commenters requested clarification of what is meant by the regulatory requirement that dispensers are installed in a manner that adequately protects against inappropriate access.

Response: As stated in the ABHR final rule published in September 22, 2006 (71 FR 55326), there are certain patients or resident populations, such as residents of dementia wards, who may misuse ABHR solutions, which are both toxic and flammable. As a toxic substance, ABHR solutions are very dangerous if they are ingested, placed in the eyes, or otherwise misused. As a flammable substance, ABHR solutions could be used to start fires that endanger lives and destroy property. Due to disability or disease,

CMS-3277-F

some patients are more likely to harm themselves or others by inappropriately using ABHR solutions. In order to avoid any and all dangerous situations, a facility will have to take all appropriate precautions to secure the ABHR dispensers from inappropriate access. This may mean that facilities choose to not install ABHR dispensers in corridors in or near dementia or psychiatric units. It may also mean that facilities choose to install ABHR dispensers only in areas that can be easily and frequently monitored, such as in view of a nursing station or a continuously monitored security camera. These are just a few of the many options that facilities may choose to utilize in securing ABHR dispensers against inappropriate access.

Comment: A few commenters expressed concern with the requirement in Chapter 8 of the 2012 edition of NFPA 101, which stipulates that all penetrations of a fire-rated wall or floor must be protected by an “Approved Fire Stop System or Device,” instead of simply offering protection equivalent to the surfaces penetrated, as was required in the 2000 edition of NFPA 101. The commenters stated that this requirement would result in higher costs for new facilities required to use proprietary devices or systems. If CMS requires an existing facility to meet this new standard due to application for a new provider agreement, the cost implications could be even greater as existing wires and other penetrating elements would need to be removed then reinstalled as necessary in order to comply. The commenters requested that existing facilities be exempted from this requirement.

Response: The 2012 edition of NFPA 101, Section 8.3.5 states “The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing through-penetrations and existing membrane penetrations in fire walls,

CMS-3277-F

fire barrier walls, or fire resistance-rated horizontal assemblies, unless otherwise required by Chapters 11 through 43.” Section 8.3.5.1 requires firestop systems and devices; therefore, this requirement would not be applicable to existing installations.

Comment: Many commenters expressed concerns with our proposed regulation regarding fire watches. We proposed to require a fire watch if a sprinkler system is out for more than 4 hours. Commenters explained that most system maintenance extends over an 8-hour period of time during a normal workday, and that, during the outage additional staff with expertise in sprinkler system operation are present to address sprinkler system problems. Additionally, during a sprinkler system outage, the fire alarms are still functioning to detect a fire. Therefore, commenters recommend only requiring the fire watch if the system will be out of service for 10 hours or more.

Response: We agree that most sprinkler system outages occur during a regular work day with sufficient staff levels to provide appropriate monitoring and assure patient safety from fire. Therefore, we are withdrawing the proposal that all system shutdowns of more than 4 hours would require a fire watch. We believe a fire watch would consist of dedicated staff with no other duties constantly circulating throughout the facility or the portion of the facility affected by the sprinkler system impairment looking for a fire, fire hazards or hazardous conditions that may affect the fire safety of the facility. Facilities may wish to maintain documentation of the rounds of a fire watch, but this is not required.

Comment: The 2000 edition of the NFPA 99 required separate ventilation systems for windowless anesthetizing locations in all newly constructed health care occupancies. Although the NFPA removed the ventilation system requirement from the



CMS-3277-F

2012 edition of the NFPA 99, CMS proposed to retain the ventilation requirement for all hospitals and ASCs. Approximately one third of commenters who submitted comments on this rule commented on this proposal. With the exception of two commenters who supported the proposal, the vast majority of commenters who commented on this issue strongly disagreed with this proposal. The commenters stated that installing and maintaining separate ventilation systems in windowless anesthetizing locations in existing buildings would be a significant expense, with estimates of \$30,000 per system per anesthetizing location. The commenters stated that installing and maintaining separate ventilation systems as part of constructing a new building is also a significant expense, with estimates ranging from \$75,000 to \$100,000 per anesthetizing location. The commenters stated that installing and maintaining ventilation systems in windowless anesthetizing locations, and thus incurring this large expense, is unnecessary for the following reasons:

- Of the millions of surgical procedures performed each year, 0.00092 percent per year results in surgical fires;
  - Surgical fires are largely preventable, and training on prevention of and prompt response to fires is much more likely to be effective for patient safety than installing and maintaining ventilation systems;
  - While anesthetics used to be flammable, they are not flammable anymore, which significantly reduces the risk of fires in anesthetizing locations;
  - Most anesthetizing locations have quick response sprinklers present to extinguish any fire that may occur, eliminating the need for a smoke ventilation system.
- Healthcare occupancies required to install sprinklers to fulfill new construction or

CMS-3277-F

renovation requirements would need to install quick response sprinklers through smoke compartments containing patient rooms. If an anesthetizing location is located in the same compartment as the patient sleeping rooms, then the anesthetizing location would require quick response sprinklers;

- The types of fires that occur in anesthetizing locations produce such a small amount of smoke that the smoke would not compromise the ability of staff to implement emergency interventions to extinguish a fire;
- Staff in anesthetizing locations have training in updated techniques to quickly extinguish any fire that may occur;
- Some facilities have smoke purge systems that are just as capable of smoke control as the proposed ventilation system; and
- The proposed smoke ventilation system may, under certain circumstances, create an increased risk for surgical infections in the affected anesthetizing locations.

Response: In light of the concerns raised by commenters, we agree that requiring the installation of smoke ventilation systems would not be an effective use of hospital and ASC resources. We agree that a focus on preventing and quickly extinguishing surgical fires will likely have a more significant positive impact on patient safety, and encourage hospitals, CAHs, and ASCs to continue this important work. We also agree that the presence of quick response sprinkler heads, alternative smoke purge systems, which can continue to be used, and the use of non-flammable anesthetics all contribute to a very minimal risk of smoke requiring ventilation in the first place. Therefore, we have removed this requirement from the regulations text for hospitals, CAHs, and ASCs.

CMS-3277-F

Comment: The LSC applies a specific occupancy type to a facility that has 4 or more patients. Many commenters disagreed with our proposal to require all facilities to meet the occupancy requirements regardless of the number of patients because it would require small facilities to meet more stringent requirements. Commenters stated that there is no evidence to support the need for additional safety measures in these facilities.

Response: We agree with the commenters that meeting a more stringent occupancy classification is not necessary for very small health care occupancies with less than 4 patients at any given time, and therefore, are withdrawing our proposal. This will not affect any facilities as we are keeping the requirement as it was in the 2000 edition of the LSC and are not making any changes. ASCs continue to be required to meet the occupancy requirements for ambulatory care occupancies “regardless of the number of patients served.” While this requirement is different from the definition of ambulatory care occupancy in the LSC, it is consistent with the previous rule adopting the 2000 edition of the NFPA 101 (68 FR 1374), which applied the ambulatory care occupancy chapter to all ASCs, regardless of the number of patients served.

Comment: Many commenters expressed concern with the window sill height requirement. The 2000 edition of the LSC required that newly constructed health care occupancies cannot have a sill height exceeding 36 inches above the floor (with certain exceptions). The NFPA removed this requirement from the 2012 edition of the LSC. However, CMS proposed to retain this requirement and apply it to all facilities, whether they were new or existing construction. The vast majority of the commenters expressed concern with retrofitting existing facilities to meet this proposed requirement, and the

CMS-3277-F

financial burden they would incur. Commenters also disagreed with the justification for the proposal.

Response: We agree with commenters that requiring existing facilities to change their existing window structures to meet this requirement would be an undue burden. We have revised the regulation to assure that any facilities built after the effective date of this final rule will have to meet the 36 inch window sill height requirement, in accordance with the 2000 edition of the LSC. Existing facilities that were not required to meet this specification at the time of construction would not be required to change window sill heights at this time. The Secretary does not have statutory authority to require a minimum window sill requirement, however we believe that while window sill height is not directly associated with fire safety, but it is important to quality of life and beneficial to the healing process.

Comment: Many commenters expressed concern with the corridor projections requirement. The LSC allows for 6” corridor projections, but the 2010 ADA Standards for Accessible Design (2010 Standards) only allow 4” corridor projections. The commenters suggested only requiring 4” corridor projections in new construction and newly renovated construction. The commenters also noted that ABHR dispensers, TV/computer monitors, and computer kiosks often project more than 4” and would have to be moved. A few commenters stated that projections of 4” or more should be allowed if alternative means are used such as vertical guards. Some commenters also asked why the LSC and CMS allows fixed furniture in corridors of LTC facilities up to 2 feet, but will not allow projections of more than 4”. One commenter suggested not adopting section 7.2.2.4.4.5 regarding the installation of handrails. This section requires handrails

CMS-3277-F

be mounted to provide a clearance of not less than 2 ¼ inches from the wall. The commenter states that this is not ADA compliant or IBC compliant, there is no maximum distance from the wall, that this wider gap increases the risk of entrapment if a person's hand slips while going down the stairs, and that this should also apply to existing construction. One commenter also questioned whether or not the ADA 4" projections apply to areas that are not patient treatment areas, like mechanical or chemical rooms.

Response: As noted, CMS recognizes that the LSC is not an accessibility code and stresses that compliance with this code is not a substitute for compliance with the ADA. The 2010 ADA standards address many concerns raised by commenters, including the clear floor width of walking surfaces in corridors and handrail clearance. See Section 403.5 and 505.5 of the 2010 ADA standards at <http://www.ada.gov/regs2010/2010ADASTandards/2010ADASTandards.htm>. In addition to following the requirements of the LSC, health care facilities are also required to follow all requirements of the ADA. Where there are conflicts between the LSC and the ADA, the more stringent standard takes precedence. Therefore, facilities must comply with the ADA's requirements for protruding objects, which establishes more stringent protrusion limits so that a person using a cane may avoid bodily harm. See section 307.2 of the 2010 ADA standards, available at <http://www.ada.gov/regs2010/2010ADASTandards/2010ADASTandards.htm> (establishing a 4" limit for wall-mounted protruding objects and a 4 ½" limit for handrails). Title II of the ADA applies to health care programs and services of state and local governments; and Title III of the ADA applies to private entities providing health care services. When structural changes are made to existing facilities to provide program access required by

CMS-3277-F

Title II, the 2010 ADA standards are the applicable accessibility standard. Newly constructed or altered Title II and Title III facilities must also comply with the 2010 ADA standards. Existing Title III facilities are required to remove barriers to accessibility when barrier removal is readily achievable, and the 2010 ADA standards are the applicable accessibility standard. Changes to the 2010 ADA standards are beyond the scope of this rule. Any questions regarding the requirements of the ADA should be directed to DOJ. Technical assistance regarding ADA compliance can be obtained at <http://www.ada.gov> or 1-800-514-0301 (voice) and 1-800-514-0383 (TTY).

Comment: One commenter suggested that there be a requirement for each provider or supplier to conduct an annual inspection and maintenance of fire door assemblies. Another commenter explicitly disagreed with this recommendation, stating that the final rule should clarify that annual inspection of doors in an egress path is not required in healthcare, ambulatory care, and business occupancies. Specifically, the commenter stated that hospitals are already performing visual inspection of these door assemblies and already assure latching and smooth operation at all times. The commenter asserted that conducting an additional annual inspection would be unnecessarily burdensome.

Response: As proposed, we will maintain the required annual inspection and maintenance of door assemblies. This rule will thus require documentation that the facility actually inspected and performed maintenance necessary on this important fire protection feature. This inspection could be combined with any other maintenance effort that the facility may be performing.

CMS-3277-F

Comment: One commenter questioned whether the requirement that a recycling bin must be 96 gallons or less would apply to recycling bins that are stored outside.

Response: This requirement only applies to any recycling bins located within a building.

Comment: One commenter stated that 1 year is an adequate timeframe to allow facilities to make necessary changes to add smoke partitions around hazardous areas, and that this requirement will not require many facilities to make changes because building codes have required separation of hazardous areas for a long period of time.

Response: Since most building codes already require the separation of hazardous areas, and facilities are probably already meeting this requirement, we agree that a 1 year phase-in period from the effective date of this final rule is appropriate to enable affected facilities to comply with the requirement for hazardous areas separation. Affected facilities will have 1 year from the effective date of this final rule to add smoke partitions around hazardous areas that are not already protected by this feature.

Comment: We proposed to adopt the 2012 edition of the NFPA 101, which references the 2010 edition of NFPA 101A, Guide on Alternative Approaches to Life Safety. One commenter recommended that we adopt the 2013 edition of the NFPA 101A instead. The commenter believes that there are some very significant differences between the 2010 and 2013 editions of NFPA 101A, including:

- Section 4.3.2 “Selection of Zones to be Evaluated”
- Section 4.6.9.3 “Mechanically Assisted Systems”
- Section 4.7.10 “Step 10 – Determine Equivalency Conclusion”
- Worksheet 4.7.11 “Conclusions”

CMS-3277-F

Response: In order to be consistent with the 2012 edition of the LSC, we are not separately adopting the 2013 edition of the NFPA 101A. We will continue to follow the 2010 edition of the NFPA 101A. If we adopt a newer version of the LSC in the future that also adopts the 2013 edition of the NFPA 101A, we will review that document at that time.

Comment: One commenter suggested that CMS and, by extension, those accreditation organizations that perform deeming surveys, should not cite LSC deficiencies that are self-identified by the provider or supplier. The commenter believes that a survey policy which encourages non-citation of self-identified LSC deficiencies will provide an incentive to hospital facility managers to self-identify their LSC deficiencies, record them on a list, and manage the resolution of the deficiencies.

Response: We applaud facilities that self-identify LSC deficiencies; however, CMS is most concerned with the safety of patients and staff. Therefore, if the facility is able to self-identify deficiencies, they should be in the process of fixing those deficiencies and able to develop a suitable plan of correction for any deficiencies that are cited by surveyors.

Comment: A commenter is concerned that the 2012 edition of the LSC eases the requirements for smoke barriers in existing facilities with less than 30 beds. The commenter suggested that CMS should require any facilities with less than 30 beds that were originally built with or added a smoke barrier dividing the floor into at least two smoke compartments to keep that smoke barrier, even though the 2012 edition would allow the facility to remove the smoke barrier.



CMS-3277-F

Response: We appreciate the suggestion. We do not anticipate facilities actively taking steps to remove existing smoke barriers in light of this change in the LSC. Should facilities undertake construction at a future date, they would still be required to meet the 2012 edition of the LSC. We believe that the 2012 edition of the LSC assures the appropriate level of safety for all residents/patients.

### **NFPA 99- Health Care Facilities code**

Comment: Many commenters support the adoption of the 2012 NFPA 99 Health Care Facilities code. However, many commenters expressed confusion as to why the NFPA 99 is not being adopted in full, and some chapters are being excluded.

Response: As stated in the proposed rule, we will not be adopting Chapters 7, 8 and 13 because we have no authority to regulate these specific topics in health care facilities. Additionally, the content of Chapter 12, Emergency management, is already being addressed in a separate rule for emergency preparedness. Although, we have not adopted these chapters, providers may use these chapters for their individual facility needs.

Comment: Some commenters encouraged the adoption of the 2012 edition of the NFPA 99 Health Care Facilities code because it allows for the use of relocatable power taps, which provide additional electrical receptacles. The 1999 edition of the NFPA 99 does not allow the use of relocatable power taps.

CMS-3277-F

Response: We appreciate the support of the commenters, and agree that relocatable power taps can be appropriately used in health care environments. Therefore, we are finalizing this change as proposed.

Comment: A few commenters expressed concerns with multiple issues found in the 2012 edition of the NFPA 99 that they believe would require a facility to upgrade to be in compliance with the following: Ductwork, HVAC system designs, electrical and medical gas system requirements, ground fault protection requirements, piped medical gas systems, and receptacle requirements. The commenters suggested that these sections be applied only to new facilities and facilities being remodeled.

Response: We appreciate the opportunity to clarify the requirements of NFPA 99. The 2012 edition of the NFPA 99 does not divide its chapters and requirements into new and existing. We note that in the 2012 edition of NFPA 99 Section 1.3.2 states “Construction and equipment requirements shall be applied only to new construction and new equipment, except as modified in individual chapters.” The sections described in the comments do not have any modified requirements; therefore, in accordance with the requirements of NFPA 99, these requirements only apply to new construction and new equipment.

#### **General or other comments**

Comment: One commenter suggested that we add a list of acronyms at the beginning of the rule.

Response: We have added a list of acronyms to the beginning of the document. We have also spelled out each acronym the first time it is used in the rule.

#### **IV. Provisions of the Final Regulations**

CMS-3277-F

We are adopting the provisions of this rule as proposed, except for the following changes and clarifications:

**RNHCI-**

We are clarifying that our adoption of the 2012 edition of the NFPA 101 and NFPA 99, includes the following TIAs issued prior to April 16, 2014:

- (i) TIA 12-1 to NFPA 101, issued August 11, 2011.
- (ii) TIA 12-2 to NFPA 101, issued October 30, 2012.
- (iii) TIA 12-3 to NFPA 101, issued October 22, 2013.
- (iv) TIA 12-4 to NFPA 101, issued October 22, 2013.
- (v) TIA 12-2 to NFPA 99, issued August 11, 2011.
- (vi) TIA 12-3 to NFPA 99, issued August 9, 2012.
- (vi) TIA 12-4 to NFPA 99, issued March 7, 2013.
- (viii) TIA 12-5 to NFPA 99, issued August 1, 2013
- (ix) TIA 12-6 to NFPA 99, issued March 3, 2014.

- We are clarifying that the prohibition on roller latches applies only to doors to corridors and to rooms containing flammable or combustible materials.
- We are revising the requirements for the shutdown of a sprinkler system for an extended period of time.
- We are revising the window sill requirement for new construction only to indicate that such sills must not be higher than 36 inches above the floor.

**ASCs-**

CMS-3277-F

We are clarifying that our adoption of the 2012 edition of the NFPA 101 and NFPA 99, includes the following TIAs issued prior to April 16, 2014, regardless of the number of patients served:

- (i) TIA 12-1 to NFPA 101, issued August 11, 2011.
- (ii) TIA 12-2 to NFPA 101, issued October 30, 2012.
- (iii) TIA 12-3 to NFPA 101, issued October 22, 2013.
- (iv) TIA 12-4 to NFPA 101, issued October 22, 2013.
- (v) TIA 12-2 to NFPA 99, issued August 11, 2011.
- (vi) TIA 12-3 to NFPA 99, issued August 9, 2012.
- (vii) TIA 12-4 to NFPA 99, issued March 7, 2013.
- (viii) TIA 12-5 to NFPA 99, issued August 1, 2013.
- (ix) TIA 12-6 to NFPA 99, issued March 3, 2014.

- We are removing the requirements for the installation of a dedicated air supply and exhaust system in windowless anesthetizing locations.

- We are revising the requirements for door locking mechanisms on hazardous areas.

- We are revising the requirements for the shutdown of a sprinkler system for an extended period of time.

- We are revising the window sill requirements for new construction only to indicate that such sills must not be higher than 36 inches above the floor.

**Hospice-**

CMS-3277-F

We are clarifying that our adoption of the 2012 edition of the NFPA 101 and NFPA 99, includes the following TIAs issued prior to April 16, 2014:

- (i) TIA 12-1 to NFPA 101, issued August 11, 2011.
- (ii) TIA 12-2 to NFPA 101, issued October 30, 2012.
- (iii) TIA 12-3 to NFPA 101, issued October 22, 2013.
- (iv) TIA 12-4 to NFPA 101, issued October 22, 2013.
- (v) TIA 12-2 to NFPA 99, issued August 11, 2011.
- (vi) TIA 12-3 to NFPA 99, issued August 9, 2012.
- (vii) TIA 12-4 to NFPA 99, issued March 7, 2013.
- (viii) TIA 12-5 to NFPA 99, issued August 1, 2013.
- (ix) TIA 12-6 to NFPA 99, issued March 3, 2014.

- We are clarifying that the prohibition on roller latches applies only to doors to corridors and to rooms containing flammable or combustible materials.
- We are revising the requirements for the shutdown of a sprinkler system for an extended period of time.
- We are revising the window sill requirement for new construction only to indicate that such sills must not be higher than 36 inches above the floor.

**PACE-**

We are clarifying that our adoption of the 2012 edition of the NFPA 101 and NFPA 99, includes the following TIAs issued prior to April 16, 2014:

- (i) TIA 12-1 to NFPA 101, issued August 11, 2011.

CMS-3277-F

(ii) TIA 12-2 to NFPA 101, issued October 30, 2012.

(iii) TIA 12-3 to NFPA 101, issued October 22, 2013.

(iv) TIA 12-4 to NFPA 101, issued October 22, 2013.

(v) TIA 12-2 to NFPA 99, issued August 11, 2011.

(vi) TIA 12-3 to NFPA 99, issued August 9, 2012.

(vii) TIA 12-4 to NFPA 99, issued March 7, 2013.

(viii) TIA 12-5 to NFPA 99, issued August 1, 2013.

(ix) TIA 12-6 to NFPA 99, issued March 3, 2014.

- We are clarifying that the prohibition on roller latches applies only to doors to corridors and to rooms containing flammable or combustible materials.
- We are revising the requirements for the shutdown of a sprinkler system for an extended period of time.

### **Hospitals-**

We are clarifying that our adoption of the 2012 edition of the NFPA 101 and NFPA 99, includes the following TIAs issued prior to April 16, 2014:

(i) TIA 12-1 to NFPA 101, issued August 11, 2011.

(ii) TIA 12-2 to NFPA 101, issued October 30, 2012.

(iii) TIA 12-3 to NFPA 101, issued October 22, 2013.

(iv) TIA 12-4 to NFPA 101, issued October 22, 2013.

(v) TIA 12-2 to NFPA 99, issued August 11, 2011.

(vi) TIA 12-3 to NFPA 99, issued August 9, 2012.

(vii) TIA 12-4 to NFPA 99, issued March 7, 2013.

(viii) TIA 12-5 to NFPA 99, issued August 1, 2013.

CMS-3277-F

(ix) TIA 12-6 to NFPA 99, issued March 3, 2014.

- We are clarifying that the prohibition on roller latches applies only to doors to corridors and to rooms containing flammable or combustible materials.
- We are clarifying that all outpatient surgical departments must meet applicable provisions in Ambulatory Health Care occupancy chapter, regardless of the number of patients served.
- We are revising the requirements for the shutdown of a sprinkler system for an extended period of time.
- We are removing the requirement for installation of a dedicated air supply and exhaust system in windowless anesthetizing locations.
- We are revising the window sill requirement for new construction only to indicate that such sills must not be higher than 36 inches above the floor.

#### **LTC-**

We are clarifying that our adoption of the 2012 edition of the NFPA 101 and NFPA 99, includes the following TIAs issued prior to April 16, 2014:

- (i) TIA 12-1 to NFPA 101, issued August 11, 2011.
- (ii) TIA 12-2 to NFPA 101, issued October 30, 2012.
- (iii) TIA 12-3 to NFPA 101, issued October 22, 2013.
- (iv) TIA 12-4 to NFPA 101, issued October 22, 2013.
- (v) TIA 12-2 to NFPA 99, issued August 11, 2011.
- (vi) TIA 12-3 to NFPA 99, issued August 9, 2012.

CMS-3277-F

(vii) TIA 12-4 to NFPA 99, issued March 7, 2013.

(viii) TIA 12-5 to NFPA 99, issued August 1, 2013.

(ix) TIA 12-6 to NFPA 99, issued March 3, 2014.

- We are clarifying that the prohibition on roller latches applies only to doors leading into corridors and leading into rooms containing flammable or combustible materials.

- We are revising the requirements for the shutdown of a sprinkler system for an extended period of time.

#### **ICF-IIDs-**

We are clarifying that our adoption of the 2012 edition of the NFPA 101 and NFPA 99, includes the following TIAs issued prior to April 16, 2014:

(i) TIA 12-1 to NFPA 101, issued August 11, 2011.

(ii) TIA 12-2 to NFPA 101, issued October 30, 2012.

(iii) TIA 12-3 to NFPA 101, issued October 22, 2013.

(iv) TIA 12-4 to NFPA 101, issued October 22, 2013.

(v) TIA 12-2 to NFPA 99, issued August 11, 2011.

(vi) TIA 12-3 to NFPA 99, issued August 9, 2012.

(vii) TIA 12-4 to NFPA 99, issued March 7, 2013.

(viii) TIA 12-5 to NFPA 99, issued August 1, 2013.

(ix) TIA 12-6 to NFPA 99, issued March 3, 2014.



CMS-3277-F

- We are clarifying that the prohibition on roller latches applies only to doors to corridors and to rooms containing flammable or combustible materials.
- We are revising the exclusion of provisions related to “Lockups.”
- We are revising the requirements for the shutdown of a sprinkler system for an extended period of time.
- We are revising the window sill requirement for new construction only to indicate that such sills must not be higher than 36 inches above the floor.

**CAHs-**

We are clarifying that our adoption of the 2012 edition of the NFPA 101 and NFPA 99, includes the following TIAs issued prior to April 16, 2014:

- (i) TIA 12-1 to NFPA 101, issued August 11, 2011.
  - (ii) TIA 12-2 to NFPA 101, issued October 30, 2012.
  - (iii) TIA 12-3 to NFPA 101, issued October 22, 2013.
  - (iv) TIA 12-4 to NFPA 101, issued October 22, 2013.
  - (v) TIA 12-1 to NFPA 99, issued August 11, 2011.
  - (vi) TIA 12-2 to NFPA 99, issued August 11, 2011.
  - (vii) TIA 12-3 to NFPA 99, issued August 9, 2012.
  - (viii) TIA 12-4 to NFPA 99, issued March 7, 2013.
  - (ix) TIA 12-5 to NFPA 99, issued August 1, 2013.
  - (x) TIA 12-6 to NFPA 99, issued March 3, 2014.
- We are clarifying that the prohibition on roller latches applies only to doors to corridors and to rooms containing flammable or combustible materials.

CMS-3277-F

- We are revising the requirements for the shutdown of a sprinkler system for an extended period of time.
- We are removing the requirement for installation of a dedicated air supply and exhaust system in windowless anesthetizing locations.
- We are revising the window sill requirement for new construction only to indicate that such sills must not be higher than 36 inches above the floor.

#### **V. Collection of Information Requirements**

This final rule does not impose any new reporting, recordkeeping or third-party disclosure requirements. However, this final rule does reference the NFPA 99 that has several non-reported recordkeeping requirements for medical gas and vacuum systems, and electrical equipment. We believe that documenting maintenance and testing is a usual and customary business practice in accordance with the implementing regulations of the Paperwork Reduction Act of 1995 (PRA) at 5 CFR 1320.3(b)(2), and it would not impose any additional information collection burden beyond that associated with the normal course of business. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

#### **VI. Regulatory Impact Analysis**

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

##### A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory

CMS-3277-F

Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). The overall economic impact for this rule is estimated to be \$18 million in the first year of implementation, \$12 million, annually, for years 2 and 3 of implementation, and \$6 million, annually, for years 4-12 of implementation. We estimate that this rulemaking is not “economically significant” as measured by the \$100 million threshold, and hence not a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis (RIA) that, to the best of our ability, presents the costs and benefits of rulemaking.

#### B. Statement of Need

The 2012 edition of the LSC includes new provisions that we believe are vital to the health and safety of all patients and staff. Our intention is to ensure that patients and staff continue to experience the highest degree of fire safety possible. The use of earlier editions of the code can become problematic due to advances in safety and technology

CMS-3277-F

and changes made to each edition of the code. Newer buildings are typically built to comply with the newer versions of the LSC because state and local jurisdictions, as well as non-CMS-approved accreditation programs, often adopt and enforce newer versions of the code as they become available. We believe that adopting the 2012 LSC would simplify and modernize the construction and renovation process for affected health care providers and suppliers, reduce compliance-related burdens, and allow for more resources to be used for patient care. Many health care facilities complete unnecessary work and incur unnecessary expense without any gain in fire safety by continuing to comply with the 2000 edition of the LSC.

The 2012 edition of the NFPA 99, “Health Care Facilities Code,” addresses requirements for both health care occupancies and ambulatory care occupancies, and serves as a resource for those who are responsible for protecting health care facilities from fire and associated hazards. The purpose of this Code is to provide minimum requirements for the installation, inspection, testing, maintenance, performance, and safe practices for health care facility materials, equipment and appliances. This Code is a compilation of documents that have been developed over a 40-year period by NFPA, and is intended to be used by those persons involved in the design, construction, inspection, and operation of health care facilities, and in the design, manufacture, and testing of appliances and equipment used in patient care areas of health care facilities. Many requirements of the LSC already cross reference the NFPA 99, and it addresses additional building safety topics that are related to important fire safety issues specific to health care facilities.

We believe that it is in the best interest of CMS to adopt the more recent 2012

CMS-3277-F

edition of the NFPA 101 and the 2012 edition of the NFPA 99, in order to be up to date with all of the latest upgrades to health care facilities and safety requirements.

C. Summary of Impacts

**Table 1- Total annual cost of implementation for all years**

Year 1 of implementation	\$18
Years 2-3 of implementation	\$24
Years 4-12 of implementation	\$53
<b>TOTAL Years 1-12 of implementation</b>	<b>\$95 million</b>

**NOTE:** This cost may be less depending on the number of States that have already adopted the 2012 edition of the LSC.

**Table 2—Total annual cost for implementation in year 1.**

<b>Requirement</b>	<b>Provider type affected</b>	<b>Cost per affected provider</b>	<b>Cost for all providers</b>
High-rise sprinkler installation	Hospitals, partially sprinklered	\$34,075	\$4,429,783
High-rise sprinkler installation	Hospitals, non-sprinklered	\$117,028	\$1,053,253
Self-closing or automatic closing doors on hazardous areas	ASCs	\$1,047	\$1,763,148
Sprinklers in Attics (used for living purposes, storage or fuel fired equipment)	ICF-IIDs	\$4,500	\$5,980,500
Heat detection systems in attics (not used for living purposes)	ICF-IIDs	\$1,000	\$212,333
Hazardous areas separated by smoke partitions	ICF-IIDs	\$1,000	\$4,624,000
Upgrade existing or install new fire alarm system	ICF-IIDs	\$1,000	\$384,000
<b>TOTAL</b>			<b>\$18,447,017</b>

**Table 3- Total annual cost of implementation for years 2-3**

<b>Requirement</b>	<b>Provider type affected</b>	<b>Cost per affected provider</b>	<b>Cost for all providers</b>
High-rise sprinkler installation	Hospitals, partially sprinklered	\$34,075	\$4,429,783
High-rise sprinkler installation	Hospitals, non-sprinklered	\$117,028	\$1,053,253
Upgrade existing or install new fire alarm system	ICF-IIDs	\$1,000	\$384,000
Sprinklers in Attics (used for living purposes, storage or fuel fired equipment)	ICF-IIDs	\$4,500	\$5,980,500
Heat Detection systems in attics (not used for living purposes)	ICF-IIDs	\$1,000	\$212,333
<b>TOTAL ANNUALLY</b>			<b>\$12,059,869</b>
<b>OVERALL TOTAL YEARS 2-3</b>			<b>\$24,119,738</b>

**Table 4- Total cost of implementation for years 4-12**

<b>Requirement</b>	<b>Provider type affected</b>	<b>Cost per affected provider</b>	<b>Cost for all providers</b>
High-rise sprinkler installation	Hospitals, partially sprinklered	\$34,075	\$4,429,783
High-rise sprinkler installation	Hospitals, non-sprinklered	\$117,028	\$1,053,253
Upgrade existing or install new fire alarm system	ICF-IIDs	\$1,000	\$384,000
<b>TOTAL ANNUALLY</b>			<b>\$5,867,036</b>
<b>OVERALL TOTAL YEARS 4-12</b>			<b>\$52,803,324</b>

#### D. Detailed Economic Analysis

##### 1. Burden Assessment

##### Sprinklers in High-rise Buildings

Section 19.4.2 of the LSC requires that all existing high-rise buildings containing health care occupancies be protected throughout by an approved, supervised automatic sprinkler system. We feel that this requirement will only affect hospitals and any other provider type located in the same building as a hospital (for example, an ASC that is located in a hospital building). This provision was added to the LSC in 2012 and we anticipate that there would be a cost associated with installing the sprinklers. Since this is a new provision for the 2012 edition of the LSC, 14 states have adopted this requirement, accounting for an estimated 142 high-rise facilities.

To develop the most accurate estimate possible for this provision, we requested data from all 50 states regarding the sprinkler status of high-rise buildings containing



CMS-3277-F

health care occupancies, and the average square footage needing to be sprinklered. Of the 50 states, we received some data from 30 states<sup>4</sup>. We calculated the average number of high-rise hospitals for all of the states that responded. Overall, 15.64 percent of hospitals were located in high-rise buildings. We also used the data submitted to determine the average number of fully, partially and non-sprinklered high-rise buildings in each state for which we have data. First, we calculated the percentages of fully, partially, and non-sprinklered hospitals for each state. We then averaged the percentage of fully, partially and non-sprinklered buildings across all states for which there was data, with a result of 84.66 percent of hospitals in high-rise buildings being fully sprinklered, 14.6 percent being partially sprinklered and 0.74 percent being non-sprinklered.

Next, we applied these percentages to the states that did not respond to our data request or that provided a limited amount of data. For example, Alabama has a total of 125 hospitals. Based on the data from states that submitted information, we know that, on average, 15.64 percent of hospitals have high-rise buildings, for an estimated 20 high-rise hospitals in Alabama. We used this same methodology to estimate the average number of high-rise hospitals in all of the states that did not respond to our data request or that provided only a limited amount of data, for a total of 179 high-rise hospitals. Of the 179 estimated high-rise hospitals in states that did not respond, we estimate there are 151 fully sprinklered, 26 partially sprinklered, and 2 non-sprinklered. We note that these numbers do not directly match because there was limited actual data available for the

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<sup>4</sup> The following states submitted data regarding the sprinkler status of high-rise buildings containing health care facilities – Arizona, Arkansas, California, Colorado, Delaware, Hawaii, Idaho, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Virginia, Washington, and Wyoming.

CMS-3277-F

state of Massachusetts. The number of high-rise hospitals in Massachusetts is included in the count of states for which we have reported data. However, because we did not receive a breakdown of those high-rise hospitals by their current sprinkler status, we used the methodology described to estimate the distribution of fully sprinklered, partially sprinklered, and non-sprinklered high-rise hospitals in that state.

We combined this information with the information from the states that submitted data to develop an estimate of 515 high-rise facilities with health care occupancies throughout all 37 states and the District of Columbia that have not adopted the 2012 NFPA 101 (336 high-rise facilities in states that submitted data + 179 estimated high-rise facilities in states that did not submit data). We estimate that 376 of those high-rise facilities are fully sprinklered, 130 are partially sprinklered, and 9 are not sprinklered.

We also requested that the 50 states and the District of Columbia submit information regarding the area (measured in square feet) per partially sprinklered and non-sprinklered facility that does not currently have sprinklers. Only 8 states supplied data regarding the area to be sprinklered in partially sprinklered facilities.<sup>5</sup> In addition, 3 states supplied data regarding the area to be sprinklered in non-sprinklered facilities.<sup>6</sup> We did not specify size and age data. Of the states that responded with square footage data, we estimate that an average partially sprinklered facility would need to install sprinklers to protect 37,173 square feet, and an average non-sprinklered facility would need to install sprinklers to protect 127,667 square feet. Regardless of the square footage, any

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<sup>5</sup> The following states provided data regarding the average square footage for partially sprinklered high-rise facilities containing health care facilities - California, Hawaii, Iowa, Kansas, Nebraska, Pennsylvania, Virginia, and Washington.

<sup>6</sup> The following states provided data regarding the average square footage for non-sprinklered high-rise facilities containing health care facilities- California, Hawaii, and Iowa.

CMS-3277-F

facility in a high-rise building 75' or over is required to be sprinklered. We applied all of the data submitted and averages calculated to figure out the total average area that will need to be sprinklered in all partially sprinklered facilities and non-sprinklered facilities, and the cost associated with that installation. Based on the information provided by the public in comments received on the hospital conditions of participation (76 FR 65891), the cost per square foot to install sprinklers is approximately \$11. We estimated that there are 130 partially sprinklered facilities that would install sprinklers to cover an average of 37,173 square feet per facility, for a total of 4,832,490 square feet. At an estimated cost of \$11 per square foot to install sprinklers, we estimate a total cost of \$53,157,390 for all partially sprinklered facilities (4,832,490 square feet x \$11 per square foot). We estimate that an average partially sprinklered facility would spend \$408,903 to complete the sprinkler installation (37,173 square feet per facility x \$11 per square foot).

We estimated that there are 9 non-sprinklered facilities nationwide, and that an average non-sprinklered facility would install sprinklers for, 127,667 square feet, for a total of 1,149,003 square feet (9 facilities x 127,667 square feet per facility). At an estimated cost of \$11 per square foot to install sprinklers, we estimate that it would cost \$12,639,033 for all non-sprinklered facilities to install sprinklers in their facilities. We estimate that an average non-sprinklered facility would spend \$1,404,337 per facility (127,667 square feet x \$11 per square foot).

Therefore, we estimate the total cost associated with the installation of sprinklers in partially sprinklered and non-sprinklered facilities to be \$65,796,423 (\$53,157,390 for all partially sprinklered facilities + \$12,639,033 for all non-sprinklered facilities). This

CMS-3277-F

cost would be distributed over a phase-in period of 12 years, per the phase-in period established within the LSC, or an average yearly cost of \$5.5 million.

#### Sprinklers out of service for more than 10 hours

We have removed the requirement for a fire watch or building evacuation if the sprinkler system is out of service for more than 4 hours, and have adopted the LSC requirements of a fire watch or building evacuation if the sprinkler system is out for more than 10 hours in a 24-hour period. Based on comments received from stakeholders, associations and the public, sprinkler systems are generally only out of service for 8 hours in a 24-hour period. Therefore, we do not anticipate additional costs associated with this requirement. If there is an event where the sprinkler system would be out of service for more than 10 hours in a 24-hour period, we feel that it would be considered a standard business practice to implement a fire watch or building evacuation, as the previous requirement was more stringent and required a fire watch or building evacuation after the sprinkler system is out of service for more than 4 hours.

#### Doors to hazardous areas

Sections 20.3.2.1 and 21.3.2.1 of the LSC requires all doors to hazardous areas to be self-closing or automatic-closing. This requirement is only located in sections 20.3.2.1 and 21.3.2.1, which applies to Ambulatory health care. This provision was added to the LSC in 2003, and we anticipate that there would be a cost associated with installing the self-closing or automatic closing doors. Since 2003, 35 states have adopted this requirement, accounting for an estimated 3,684 ASCs. As of December 2013, there were 5,368 total Medicare and applicable Medicaid participating ASCs. The 1,684 remaining facilities would be required to upgrade their door closing mechanisms to meet

CMS-3277-F

this requirement. The estimated cost per door is \$349, and we would assume the average facility has 3 hazardous areas that would require a replacement door closing mechanism for a total cost of \$1,047 per facility. The anticipated cost is \$1,763,148.

#### Sprinklers or Heat Detection Systems in Attics

Sections 32.2.3.5.7 and 33.2.3.5.7 of the LSC requires attics of new and existing residential board and care occupancies, which, for our purposes, are ICF-IIDs to be sprinklered if the attic space is used for living purposes, including storage and fuel fired equipment. Facilities that do not use their attics for living purposes may choose to install a heat detection system in place of the sprinklers. This provision was added to the LSC in 2012. Since this is a new provision for the 2012 edition of the LSC, only 14 states have adopted this requirement, accounting for an estimated 1,750 ICF-IIDs. We are not including those 1,750 facilities in our analysis. For purposes of this analysis only, we assume that about 10 percent (637) of facilities will install a heat detection system because they do not use the attic for living purposes. As of December 2013, there were 6,374 total Medicare participating ICF-IIDs. After excluding those facilities located in states that have already adopted this requirement and those that would install a heat detection system instead of sprinklers, the 3,987 remaining facilities would be required to install sprinklers in their attics to meet this requirement. Installing sprinklers into an unfinished attic is less complicated than installing sprinklers in a finished hospital, therefore the cost per square foot would be less to install in attics than hospitals. The estimated cost per square foot to install sprinklers in an attic is \$3.00, and the average estimated square footage per attic per facility is 1500 square feet, for a total of \$4,500 per ICF-IID. We estimate that all ICF-IIDs would spend \$17,941,500 to install sprinklers in

CMS-3277-F

their attic spaces. After soliciting public comment, we have decided to finalize a 3 year phase-in period, which would make the cost \$5,980,500 per year over 3 years.

Facilities that do not use their attics for living purposes may choose to install a heat detection system in the attic instead of sprinklers. As stated, for the purposes of this analysis only, we assume that about 10 percent (637) of facilities will install a heat detection system because they do not use the attic for living purposes. We estimate the cost to install a heat detection system to be \$1,000 per facility. The anticipated cost would be \$637,000 for all affected facilities to install heat detection systems. After soliciting public comment, we have decided to finalize a 3 year phase-in period, which would make the cost \$212,333 per year over 3 years.

#### Hazardous Area Separation

Section 33.3.3.2.3 of the LSC requires all hazardous areas in existing residential board and care occupancies (which, under our regulations, are ICF-IIDs) with impractical evacuation capabilities to be separated from other parts of the building by a smoke partition. This provision was added to the LSC in 2012 and we anticipate there being a cost associated with installing the smoke partition. Since this is a new provision for 2012, only 14 states have adopted this requirement, accounting for 1,750 ICF-IIDs. As of December 2013, there were 6,374 total Medicare and applicable Medicaid participating ICF-IIDs. We do not collect data regarding the evacuation capability of each ICF-IID. Therefore, for purposes of this analysis only, we assume that the 4,624 remaining facilities will need to install a smoke partition around all hazardous areas to meet this requirement. The estimated cost per smoke partition is \$500, and we assume that an

CMS-3277-F

average ICF-IID would need to install 2 smoke partitions for a total of \$1,000 per facility.

The anticipated cost is \$4,624,000.

#### Fire Alarm System Upgrade

Section 33.3.3.4.6.2 of the LSC requires that, when an existing residential board and care occupancy (that is, ICF-IIDs) installs a new fire alarm system, or the existing fire alarm system is replaced, notification of emergency forces should be handled in accordance with section 9.6.4. Section 9.6.4 states that notification of emergency forces should alert the municipal fire department and fire brigade (if provided) of fire or other emergency. This provision was added to the LSC in 2012, and we anticipate there being a cost associated with upgrading a new or existing fire alarm system. Since this is a new provision for 2012, only 14 states have adopted this requirement, accounting for 1,750 ICF-IIDs. As of December 2013, there were 6,374 total Medicare participating ICF-IIDs. The 4,624 remaining facilities would be required to add emergency notifications capabilities when they choose to update or install a new fire alarm system. The estimated cost per upgrade is \$1,000. For purposes of this analysis only, we assume that about 8.3 percent (384) of facilities will do this in any given year, for an annual cost of \$384,000 over a 12 year period.

(\$1,000 per upgraded alarm system x 384 facilities in any given year = \$384,000)

#### 2. Benefits to Patients/Residents

As a result of this rule, we believe that there would be a decreased risk of premature death. A decreased risk of premature death is valuable to people and that value is symbolized by their willingness to pay for such benefits. The Department of Transportation found in a recent literature review that willingness to pay for reductions in

CMS-3277-F

the risk of premature death equivalent to saving one life in expectation is typically over \$9 million (<http://www.dot.gov/sites/dot.dev/files/docs/VSL%20Guidance%202013.pdf>).

Although we are not quantifying the number of lives that would be saved upon implementation of this rule due to the lack of data that could provide a reliable point estimate, we believe that there is potential for such a result. In order to “break even” on the cost of this rule- in other words, in order for the total costs of implementing this rule to equal the total benefits of doing so- this rule would need to save 1.3 lives per year for 12 years at a 7 percent discount rate and a value of \$9 million per life saved would cause the rule to break even. It would take about 1.1 lives per year for 12 years at a 3 percent discount rate. Given our review of the current literature on fire safety in health care facilities, we are confident that implementing the 2012 LSC will save at least that number of lives.



CMS-3277-F

#### E. Alternatives Considered

As a regulatory alternative, we could have chosen not to update our fire safety provisions. We believe that this is not an acceptable alternative because many health care facilities complete unnecessary work and incur unnecessary expense without any gain in fire safety by continuing to comply with the 2000 edition of the LSC. Many states have adopted subsequent editions of the LSC. This has caused confusion for, and imposed additional burdens on, health care facilities, that must request waivers or modify designs to meet the requirements of both the state- and federally-adopted editions of the LSC. Updating the LSC would not only relieve the regulatory burden on health care providers, but also assist in ensuring the health and safety of patients and staff.

We considered an alternative phase-in period for the requirement to install sprinklers in high rise health care occupancies. The LSC allows for a 12-year phase-in period, which would begin on the day a final rule is published. We considered shortening this period in order to accelerate compliance. However, based on our recent experience with requiring LTC facilities to install sprinklers within 5 years, and the difficulties that several facilities have faced in meeting this deadline, we have learned that a shorter phase-in period is not always feasible for facilities. We also considered a longer phase-in period, but believe that extending beyond 12 years set out in the LSC may not sufficiently convey the importance of this requirement to improving patient and staff safety in these buildings.

We considered not including separate requirements for window sill heights. Although the NFPA has removed these requirements from the LSC, because the total concept approach of all health care facilities should be designed, constructed, maintained

CMS-3277-F

and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants can be achieved without reliance on such window sill requirements, we felt that this was an important issues that still needed to be required for the safety of patients, visitors, and staff. Window sill height requirements were eliminated from the 2012 edition of the LSC. We believe that this requirement is essential to allow easier access for emergency personnel in the event of a fire or other emergency situation and it is important to quality of life and the healing process. This will, however, only be required in new facilities.

We considered not including the adoption of the NFPA 99 Health care Facilities code. However, many requirements of the LSC already cross-reference the NFPA 99, therefore we decided to adopt the NFPA 99 because it addresses additional building safety topics that are related to important fire safety issues specific to health care facilities. The requirements of NFPA 99, like those in NFPA 101, will be legally enforceable to the extent specified in this rule.

We also considered adoption of chapters 7, 8, 12, and 13 of the NFPA 99, related to information technology, plumbing, emergency management, and security management. We believe that information technology, plumbing and security management are not within the scope of the conditions of participation and conditions for coverage. In addition, emergency management topics are addressed in our December 27, 2013 proposed rule, “Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers” (78 FR 79081).

#### F. Accounting Statement

CMS-3277-F

As required by OMB Circular A-4 (available at [http://www.whitehouse.gov/omb/circulars\\_a004\\_a-4](http://www.whitehouse.gov/omb/circulars_a004_a-4)), we have prepared an accounting statement in Table X showing the classification of the transfers and costs associated with the provisions of this rule for CY 2015.

**TABLE 5: Accounting Statement: Classification of Estimated Costs between 2016 and 2027**

Category	Estimates	Units		
		Year Dollar	Discount Rate	Period Covered
<b>Costs*</b>				
Annualized Monetized (\$million/year)	8.6	2015	7%	2016 - 2027
	8.2	2015	3%	2016 - 2027

\*. Costs are associated with the provisions of the life safety code.

#### G. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Individuals and states are not included in the definition of a small entity. For purposes of the RFA, most of the providers and suppliers that would be affected by this rule (hospitals, ASCs, and ICF-IIDs) are considered to be small entities, either by virtue of their nonprofit or government status or by having yearly revenues below industry threshold established by the Small Business Administration (for details, see the Small Business Administration's Web site at <http://www.sba.gov/content/small-business-size-standards>).

- We estimate that the following affected facilities are expected to spend less than \$3,500 in any given year on a per average facility basis; all LTC facilities, all hospices with inpatient care facilities, all PACE facilities, all RNHCIs, all existing ASCs, all existing CAHs, and all existing fully sprinklered hospitals.
- We estimate that the average affected ICF-IID will spend \$5,400- \$8,900

CMS-3277-F

in the first year, which requires the most significant investment and, by year four, that amount drops to \$3,400 per year.

- We estimate that the average affected partially sprinklered high-rise hospital and the average affected non-sprinklered high-rise hospitals will spend \$36,475-\$119,428 each year during the 12 year phase-in period to install sprinklers. After the installation of sprinklers, we estimate that the annual cost decreases to \$2,400 per year.
- We estimate that newly constructed hospitals will spend \$2,400, newly constructed CAHs will spend \$2,400 and newly constructed ASCs will spend \$2,400, respectively, in any given year.

The Department of Health and Human Services uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent. Therefore, the Secretary proposes to certify that this rule will not have a significant impact on a substantial number of small entities, since the impact will be less than 3 percent of the revenue. The preceding economic analysis, together with the remainder of this preamble, constitutes that analysis.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We believe that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

#### H. Unfunded Mandates Reform Act (UMRA)

CMS-3277-F

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2015, that threshold is approximately \$144 million. This rule will not have an impact on the expenditures of state, local, or tribal governments in the aggregate, or on the private sector of \$144 million in any one year.

#### I. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This rule has no Federalism implications.

#### J. Congressional Review Act

This regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and has been transmitted to the Congress and the Comptroller General for review.

In accordance with the provisions of Executive Order 12866, this rule was reviewed by the Office of Management and Budget.

CMS-3277-F

## **List of Subjects**

### 42 CFR Part 403

Health insurance, Hospitals, Intergovernmental relations, Incorporation by reference, Medicare, Reporting and recordkeeping requirements.

### 42 CFR Part 416

Health facilities, Kidney diseases, Incorporation by reference, Medicare, Reporting and recordkeeping requirements.

### 42 CFR Part 418

Health facilities, Hospice care, Incorporation by Reference, Medicare, Reporting and recordkeeping requirements.

### 42 CFR Part 460

Aged, Health, Incorporation by reference, Medicare, Medicaid, Reporting and record keeping requirements.

### 42 CFR Part 482

Grant programs-health, Hospitals, Incorporation by reference, Medicaid, Medicare, Reporting and recordkeeping requirements.

### 42 CFR Part 483

Grant programs-health, Health facilities, Health professions, Health records, Incorporation by reference, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

### 42 CFR Part 485

Grant programs-health, Health facilities, Incorporation by reference, Medicaid, Medicare, Reporting and recordkeeping requirements.

CMS-3277-F

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

**PART 403—SPECIAL PROGRAMS AND PROJECTS**

1. The authority citation for part 403 continues to read as follows:

**Authority:** 42 U.S.C. 1395b-3 and Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Amend §403.744 by—
  - a. Revising paragraphs (a)(1)(i) and (ii).
  - b. Revising paragraph (a)(4).
  - c. Adding paragraphs (a)(5) and (6).
  - d. Revising paragraphs (b)(1) and (c).

The revisions and additions read as follows:

**§403.744 Condition of participation: Life safety from fire.**

(a)

(1) \* \* \*

(i) The RNHCI must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).

(ii) Notwithstanding paragraph (a)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

\* \* \* \* \*



CMS-3277-F

(4) The RNHCI may place alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.

(5) When a sprinkler system is shut down for more than 10 hours the RNHCI must:

(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

(ii) Establish a fire watch until the system is back in service.

(6) Building must have an outside window or outside door in every sleeping room, and for any building constructed after **[Insert date 60 days after the date of publication in the Federal Register]** the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.

(b) \* \* \*

(1) In consideration of a recommendation by the State survey agency or Accrediting Organization, or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a RNHCI facility, but only if the waiver will not adversely affect the health and safety of the patients.

\* \* \* \* \*

(c) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the **Federal Register** in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the

CMS-3277-F

National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to:

*[http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html)*

. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the **Federal Register** to announce the changes.

(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, [www.nfpa.org](http://www.nfpa.org), 1.617.770.3000.

(i) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;

(ii) TIA 12-1 to NFPA 101, issued August 11, 2011.

(iii) TIA 12-2 to NFPA 101, issued October 30, 2012.

(iv) TIA 12-3 to NFPA 101, issued October 22, 2013.

(v) TIA 12-4 to NFPA 101, issued October 22, 2013.

(2) [Reserved]

3. Add §403.745 to read as follows:

**§403.745 Condition of participation: Building Safety**

(a) Standard: Building Safety. Except as otherwise provided in this section the RNHCI must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6).

(b) Standard: Exceptions. Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a RNHCI.

(c) Waiver. If application of the Health Care Facilities Code required under paragraph (a) of this section would result in unreasonable hardship for the RNHCI, CMS

CMS-3277-F

may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of individuals.

(d) Incorporation by reference. The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the **Federal Register** in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html). If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the **Federal Register** to announce the changes.

(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, [www.nfpa.org](http://www.nfpa.org), 1.617.770.3000.

(i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011.

(ii) TIA 12-2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.

(v) TIA 12-5 to NFPA 99, issued August 1, 2013.

(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.

(2) [Reserved]

CMS-3277-F

**PART 416—AMBULATORY SURGICAL SERVICES**

4. The authority citation for part 416 continues to read as follows:

**Authority:** Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

5. Amend §416.44 by—

- a. Revising paragraphs (b)(1) and (2).
- b. Removing paragraph (b)(4).
- c. Redesignating paragraph (b)(5) as paragraph (b)(4).
- d. Revising newly redesignated paragraph (b)(4).
- e. Adding new paragraphs (b)(5), and (6).
- f. Redesignating paragraphs (c) and (d) as paragraphs (d) and (e).
- g. Adding new paragraphs (c) and (f).

The revisions and additions read as follows:

**§416.44 Condition for coverage—Environment**

\* \* \* \* \*

(b) \* \* \*

(1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Occupancies and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).

(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in

CMS-3277-F

unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.

\* \* \*

(4) An ASC may place alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.

(5) When a sprinkler system is shut down for more than 10 hours, the ASC must:

(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

(ii) Establish a fire watch until the system is back in service.

(6) Beginning July 5, 2017, an ASC must be in compliance with Chapter 21.3.2.1, Doors to hazardous areas.

(c) Standard: Building Safety. Except as otherwise provided in this section, the ASC must meet the applicable provisions and must proceed in accordance with the 2012 edition of the Health Care Facilities Code (NFPA 99, and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6).

(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to an ASC.

(2) If application of the Health Care Facilities Code required under paragraph (c) of this section would result in unreasonable hardship for the ASC, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.

\* \* \* \* \*

CMS-3277-F

(f) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the **Federal Register** in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

*[http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html)*

. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the **Federal Register** to announce the changes.

(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, [www.nfpa.org](http://www.nfpa.org), 1.617.770.3000.

(i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011.

(ii) TIA 12-2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.

(v) TIA 12-5 to NFPA 99, issued August 1, 2013.

(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.

(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;

(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.

(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.

(x) TIA 12-3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.

CMS-3277-F

(2) [Reserved]

**PART 418—HOSPICE CARE**

6. The authority citation for part 418 continues to read as follows:

**Authority:** Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

**§418.108 [Amended]**

7. Amend §418.108 by—

a. Amending paragraph (a)(2) by removing the reference “§418.110(b) and (e)” and by adding in its place the reference “§418.110(b) and (f)”.

b. Amending paragraph (b)(1)(ii) by removing the reference “§418.110(e)” and by adding in its place the reference “§418.110(f)”.

8. Amend §418.110 by –

a. Revising paragraphs (d)(1)(i) and (ii).

b. Revising paragraphs (d)(2) and (4).

c. Adding paragraphs (d)(5) and (6).

d. Redesignating paragraphs (e) through (o) as (f) through (p).

e. Adding new paragraph (e).

f. Amending newly redesignated paragraph (g)(4) introductory text by removing the reference “paragraph (f)(2)(iv) and (f)(2)(v) of this section” and adding in its place the reference “paragraphs (g)(2)(iv) and (g)(2)(v) of this section”.

CMS-3277-F

g. Amending newly redesignated paragraph (n)(9) by removing the reference “paragraph (n) of this section” and adding in its place the reference “paragraph (o) of this section”.

h. Amending newly redesignated paragraph (n)(13) by removing the reference “§418.110(m)(11)” and adding in its place the reference “paragraph (n)(11) of this section”.

i. Adding paragraph (q).

The revisions and additions read as follows:

**§418.110 Condition of participation: Hospices that provide inpatient care directly.**

\* \* \* \* \*

(d) \* \* \*

(1) \* \* \*

(i) The hospice must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.)

(ii) Notwithstanding paragraph (d)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospice facility, but only if the waiver will not adversely affect the health and safety of the patients.



CMS-3277-F

\* \* \* \* \*

(4) A hospice may place alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against access by vulnerable populations.

(5) When a sprinkler system is shut down for more than 10 hours, the hospice must:

(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

(ii) Establish a fire watch until the system is back in service.

(6) Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after **[Insert date 60 days after the date of publication in the Federal Register]** the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.

(e) Standard: Building Safety. Except as otherwise provided in this section, the hospice must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6).

(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a hospice.

(2) If application of the Health Care Facilities Code required under paragraph (e) of this section would result in unreasonable hardship for the hospice, CMS may waive

CMS-3277-F

specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.

\* \* \* \* \*

(q) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the **Federal Register** in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

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(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, [www.nfpa.org](http://www.nfpa.org), 1.617.770.3000.

(i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011.

(ii) TIA 12-2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.

(v) TIA 12-5 to NFPA 99, issued August 1, 2013.

(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.

(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;

(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.

CMS-3277-F

(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.

(x) TIA 12-3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.

(2) [Reserved]

**PART 460—PROGRAMS OF ALL INCLUSIVE CARE FOR THE ELDERLY  
(PACE)**

9. The authority citation for part 460 continues to read as follows:

**Authority:** Secs. 1102, 1871, 1894(f), and 1934(f) of the Social Security Act (42 U.S.C. 1302 and 1395, 1395eee(f), and 1396u-4(f)).

10. Amend §460.72 by—

- a. Revising paragraphs (b)(1)(i) and (ii).
- b. Revising paragraph (b)(2)(ii)
- c. Removing paragraphs (b)(3) and (4).
- d. Redesignating paragraph (b)(5) as paragraph (b)(3).
- e. Revising newly redesignated paragraph (b)(3).
- f. Adding new paragraphs (b)(4), (d), and (e).

The revisions and addition read as follows:

**§460.72 Physical environment.**

\* \* \* \* \*

(b) \* \* \*

(1) \* \* \*

CMS-3277-F

(i) A PACE center must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.)

(ii) Notwithstanding paragraph (b)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

(2) \* \* \*

(ii) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a PACE facility, but only if the waiver will not adversely affect the health and safety of the patients.

(3) A PACE center may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.

(4) When a sprinkler system is shut down for more than 10 hours in a 24-hour period, the PACE must:

(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

(ii) Establish a fire watch until the system is back in service.

\* \* \* \* \*

(d) Standard: Building Safety. Except as otherwise provided in this section, a PACE center must meet the applicable provisions and must proceed in accordance with

CMS-3277-F

the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6).

(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a PACE center.

(2) If application of the Health Care Facilities Code required under paragraph (d) of this section would result in unreasonable hardship for the PACE center, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.

(e) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the **Federal Register** in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

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(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, [www.nfpa.org](http://www.nfpa.org), 1.617.770.3000.

(i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011.

(ii) TIA 12-2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.

CMS-3277-F

- (iv) TIA 12-4 to NFPA 99, issued March 7, 2013.
- (v) TIA 12-5 to NFPA 99, issued August 1, 2013.
- (vi) TIA 12-6 to NFPA 99, issued March 3, 2014.
- (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;
- (viii) TIA 12-1 to NFPA 101, issued August 11, 2011.
- (ix) TIA 12-2 to NFPA 101, issued October 30, 2012.
- (x) TIA 12-3 to NFPA 101, issued October 22, 2013.
- (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.
- (2) [Reserved]

#### **PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS**

11. The authority citation for part 482 continues to read as follows:

**Authority:** Secs. 1102, 1871, and 1881 of the Social Security Act (42 U.S.C.

1302, 1395hh, and 1395rr), unless otherwise noted.

12. Amend §482.41 by—

- a. Revising paragraphs (b)(1)(i) and ii).
- b. Revising paragraph (b)(2).
- c. Removing paragraphs (b)(4) and (b)(5).
- d. Redesignating paragraphs (b)(6) through (9) as paragraphs (b)(4) through (7), respectively.
- e. Revising newly redesignated paragraph (b)(7).
- f. Adding new paragraphs (b)(8), and (9).
- g. Redesignating paragraph (c) as paragraph (d).
- h. Adding new paragraphs (c) and (e).

CMS-3277-F

The revisions and additions read as follows:

**§482.41 Condition of participation: Physical environment.**

\* \* \* \* \*

(b) \* \* \*

(1) \* \* \*

(i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.)

(ii) Notwithstanding paragraph (b)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients.

\* \* \* \* \*

(7) A hospital may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access;

(8) When a sprinkler system is shut down for more than 10 hours, the hospital must:

(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

CMS-3277-F

(ii) Establish a fire watch until the system is back in service.

(9) Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after **[Insert date 60 days after the date of publication in the Federal Register]** the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.

(i) The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.

(ii) The sill height in special nursing care areas of new occupancies must not exceed 60 inches.

(c) Standard: Building safety. Except as otherwise provided in this section, the hospital must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6).

(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a hospital.

(2) If application of the Health Care Facilities Code required under paragraph (c) of this section would result in unreasonable hardship for the hospital, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.

\* \* \* \* \*

(e) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the **Federal Register** in



CMS-3277-F

accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

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(i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011.

(ii) TIA 12-2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.

(v) TIA 12-5 to NFPA 99, issued August 1, 2013.

(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.

(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;

(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.

(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.

(x) TIA 12-3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.

(2) [Reserved]

CMS-3277-F

**PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE  
FACILITIES**

13. The authority citation for part 483 continues to read as follows:

**Authority:** Secs. 1102, 1128I, 1819, 1871 and 1919 of the Social Security Act  
(42 U.S.C. 1302, 1320a-7, 1395i, 1395hh and 1396r).

**§483.15 [Amended]**

14. In §483.15, amend paragraph (h)(4) by removing the reference “§483.70(d)(2)(iv) of this part” and by adding in its place the reference “§483.70(e)(2)(iv)”.

15. Amend §483.70 by—

- a. Revising paragraphs (a)(1)(i) and ii).
- b. Revising paragraph (a)(2).
- c. Removing paragraphs (a)(4) and (5).
- d. Redesignating paragraphs (a)(6) through (8) as paragraphs (a)(4) through (6), respectively.
- e. Revising newly redesignated paragraph (a)(4).
- f. Adding new paragraphs (a)(7) and (8).
- g. Redesignating paragraphs (b) through (h) as paragraphs (c) through (i).
- h. Adding new paragraphs (b) and (j).

The revisions read as follows:

**§ 483.70 Physical environment.**

\* \* \*

CMS-3277-F

(a) \* \* \*

(1) \* \* \*

(i) The LTC facility must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.)

(ii) Notwithstanding paragraph (a)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a long-term care facility, but only if the waiver will not adversely affect the health and safety of the patients.

\* \* \* \* \*

(4) A long-term care facility may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.

\* \* \* \* \*

(7) Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after **[Insert date 60 days after the date of publication in the Federal Register]** the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.

CMS-3277-F

(8) When a sprinkler system is shut down for more than 10 hours, the ASC must:

(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

(ii) Establish a fire watch until the system is back in service.

(b) Standard: Building safety. Except as otherwise provided in this section, the LTC facility must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6).

(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a LTC facility.

(2) If application of the Health Care Facilities Code required under paragraph (b) of this section would result in unreasonable hardship for the LTC facility, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of residents.

\* \* \* \* \*

(j) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the **Federal Register** in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

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CMS-3277-F

. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the **Federal Register** to announce the changes.

(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.

(i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011.

(ii) TIA 12-2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.

(v) TIA 12-5 to NFPA 99, issued August 1, 2013.

(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.

(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;

(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.

(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.

(x) TIA 12-3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.

(2) [Reserved]

16. Amend §483.470 by—

a. Revising paragraphs (j)(1)(i) and (ii).

b. Adding paragraphs (j)(1)(iii) and (iv).

c. Removing paragraphs (j)(5) and (6).

d. Redesignating paragraph (j)(7) as paragraph (j)(5).

CMS-3277-F

e. Revising newly redesignated paragraph (j)(5).

f. Adding paragraph (m).

The revisions and additions read as follows:

**§483.470 Condition of participation: Physical environment.**

\* \* \* \*

(j) \* \* \*

(1) \* \* \*

(i) The facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.)

(ii) Notwithstanding paragraph (j)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

(iii) Chapters 32.3.2.11.2 and 33.3.2.11.2 of the adopted 2012 Life Safety Code do not apply to a facility.

(iv) Beginning July 5, 2019, an ICF-IID must be in compliance with Chapter 33.2.3.5.7.1, Sprinklers in attics, or Chapter 33.2.3.5.7.2, Heat detection systems in attics of the Life Safety Code.

\* \* \* \* \*

(5) Facilities that meet the Life Safety Code definition of a health care occupancy. (i) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods

CMS-3277-F

deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a residential board and care facility, but only if the waiver will not adversely affect the health and safety of the patients.

(ii) A facility may install alcohol-based hand rub dispensers if the dispensers are installed in a manner that adequately protects against inappropriate access.

(iii) When a sprinkler system is shut down for more than 10 hours, the ICF-IID must:

(A) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

(B) Establish a fire watch until the system is back in service.

(iv) Beginning July 5, 2019, an ICF-IID must be in compliance with Chapter 33.2.3.5.7.1, sprinklers in attics, or Chapter 33.2.3.5.7.2, heat detection systems in attics of the Life Safety Code.

(v) Except as otherwise provided in this section, ICF-IIDs must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6).

(A) Chapter 7,8,12 and 13 of the adopted Health Care Facilities Code does not apply to an ICF-IID.

(B) If application of the Health Care Facilities Code required under paragraph (j)(5)(iv) of this section would result in unreasonable hardship for the ICF-IID, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of clients.

CMS-3277-F

\* \* \* \* \*

(m) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the **Federal Register** in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to:

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(ii) TIA 12-2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.

(v) TIA 12-5 to NFPA 99, issued August 1, 2013.

(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.

(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;

(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.

(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.

(x) TIA 12-3 to NFPA 101, issued October 22, 2013.



CMS-3277-F

(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.

(2) [Reserved]

**PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS**

17. The authority citation for part 485 continues to read as follows:

**Authority:** Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

18. Amend §485.623 by—

- a. Revising paragraphs (d)(1)(i) and (ii).
- b. Revising paragraph (d)(2).
- c. Removing paragraphs (d)(5) and (6).
- d. Redesignating paragraph (d)(7) as paragraph (d)(5).
- e. Revising newly redesignated paragraph (d)(5).
- f. Adding paragraphs (d)(6), (7), (e), and (f).

The revisions and additions read as follows:

**§485.623 Condition of participation: Physical plant and environment.**

\* \* \* \* \*

(d) \* \* \*

(1) \* \* \*

(i) The CAH must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.)

CMS-3277-F

(ii) Notwithstanding paragraph (d)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a CAH, but only if the waiver will not adversely affect the health and safety of the patients.

\* \* \* \* \*

(5) A CAH may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.

(6) When a sprinkler system is shut down for more than 10 hours, the CAH must:

(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

(ii) Establish a fire watch until the system is back in service.

(7) Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after [Insert date 60 days after the date of publication in the **Federal Register**] the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.

(i) The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.

(ii) Special nursing care areas of new occupancies shall not exceed 60 inches.

CMS-3277-F

(e) Standard: Building safety. Except as otherwise provided in this section, the CAH must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6).

(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a CAH.

(2) If application of the Health Care Facilities Code required under paragraph (e) of this section would result in unreasonable hardship for the CAH, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.

(f) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the **Federal Register** in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

*[http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html)*

. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the **Federal Register** to announce the changes.

(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, [www.nfpa.org](http://www.nfpa.org), 1.617.770.3000.

(i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011.

## CMS-3277-F

- (ii) TIA 12-2 to NFPA 99, issued August 11, 2011.
- (iii) TIA 12-3 to NFPA 99, issued August 9, 2012.
- (iv) TIA 12-4 to NFPA 99, issued March 7, 2013.
- (v) TIA 12-5 to NFPA 99, issued August 1, 2013.
- (vi) TIA 12-6 to NFPA 99, issued March 3, 2014.
- (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;
- (viii) TIA 12-1 to NFPA 101, issued August 11, 2011.
- (ix) TIA 12-2 to NFPA 101, issued October 30, 2012.
- (x) TIA 12-3 to NFPA 101, issued October 22, 2013.
- (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.
- (2) [Reserved]

CMS-3277-F

Dated: March 11, 2016

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**Andrew M. Slavitt,**  
Acting Administrator,  
Centers for Medicare & Medicaid Services.

Dated: March 30, 2016

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**Sylvia M. Burwell,**  
Secretary,  
Department of Health and Human Services.

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