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Part III

## Department of Health and Human Services

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Centers for Medicare & Medicaid Services

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

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

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

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

[CMS–3277–P]

RIN 0938–AR72

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

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

**ACTION:** Proposed rule.

**SUMMARY:** This proposed rule would 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 proposed rule would adopt the 2012 edition of the Life Safety Code (LSC) and eliminate references in our regulations to all earlier editions. It would also adopt the 2012 edition of the Health Care Facilities Code, with some exceptions. We are providing the LSC citation, a description of the 2012 requirement, and an explanation of its benefits for health care facilities, patients, staff, and visitors over the 2000 version in each occupancy section.

**DATES:** To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 16, 2014.

**ADDRESSES:** In commenting, please refer to file code CMS–3277–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

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

2. *By regular mail.* You may mail written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3277–P, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3277–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments only to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

**FOR FURTHER INFORMATION CONTACT:** Kristin Shifflett, (410) 786–4133. Danielle Shearer, (410) 786–6617.

**SUPPLEMENTARY INFORMATION:** *Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

**I. Background**

*A. Overview of the Life Safety Code and the Health Care Facilities Code*

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 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 by reference these requirements, along with Secretarial waiver authority. The statutory basis for incorporating NFPA’s LSC for our providers and suppliers is the Secretary’s authority to stipulate health and safety regulations for each type of Medicare and (if applicable) Medicaid-participating facilities, as well as the Secretary’s general rulemaking authority set out at sections 1102 and 1871 of the Social Security Act (the Act).

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. Currently, the Secretary may waive specific provisions of the LSC for any type of facility, if application of the rule would result in unreasonable hardship for the facility, and if the health and safety of its patients would not be compromised.

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 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 the 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 applicable 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 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 burdens of applying the requirements of the LSC to all affected health care facilities.

On January 10, 2003, we published a final rule in the **Federal Register** (68 FR 1374) adopting the 2000 edition of the LSC. In this final rule, we required that all affected providers and suppliers meet the provisions of the 2000 edition of the LSC, with certain exceptions. 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 are a safety hazard under all circumstances and prohibit their use 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 an initial set of hand hygiene guidelines for health care settings on its Web site (<http://www.cdc.gov/handhygiene/Guidelines.html>). 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 final 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 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 cited sprinklers as the single most effective fire protection feature for LTC facilities.

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 newest edition of the LSC would clarify several issues and would be beneficial to facilities.

#### *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 2013 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 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. Limiting the choice of ABHRs creates barriers to improve 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 allowing for more resources to be used for patient care.

The 2012 edition of the LSC contains several significant changes from the 2000 edition. First, the format of the LSC has been altered. The LSC has eliminated the use of “exceptions” throughout the entire code to provide more consistency and easier reading. There was also a change in measurement systems, from centimeters to millimeters. Using a smaller unit of measurement allows for more precision and consistency throughout the LSC.

The 2000 LSC requires minor renovation projects to meet the same stringent requirements as those applied to completely new construction. However, the 2012 edition of the LSC contains a new chapter entitled, “Chapter 43—Building Rehabilitation.” This new chapter replaces the requirements that all modernizations/renovations meet the requirements for new construction. The degree to which requirements for new construction must be met now varies with the rehabilitation work category. 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. We believe that this clarification will assist health care facilities by reducing costs for minor construction projects.

Buildings that have not received all pre-construction governmental approvals required by the jurisdiction(s) 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 this regulation, would be required to meet the New Occupancy chapters of the 2012 edition of the LSC. Buildings constructed before the effective date of this regulation would be required to meet the Existing Occupancy chapters of the 2012 edition of the LSC. Changes made to buildings would be required to comply with Chapter 43—Building Rehabilitation, which could require compliance with the New Occupancy chapters, depending on the changes being made.

In instances where mandatory LSC references do not include existing chapters, existing occupancies must ensure buildings and equipment are in compliance with provisions previously adopted by CMS at the time they were constructed or installed.

#### Health Care Occupancies

The following are provisions that appear in the 2012 edition of the LSC, but that did not exist in the 2000 edition of the LSC, for Chapter 18, “New Health Care Occupancies,” and Chapter 19, “Existing Health Care Occupancies.” We are providing the LSC citation, a description of the 2012 requirement, and an explanation of its benefits for health care facilities, patients, staff, and visitors over the 2000 version.

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

#### 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 are also required to follow the requirements of the Americans with Disabilities Act (ADA). Section 307 of the “ADA Accessibility Guidelines for Buildings and Facilities” (<http://www.ada.gov/regs2010/2010ADAStandards/2010ADAstandards.htm#c4>) requires that projections be no more than 4

inches from the corridor wall. Therefore, while the LSC allows facilities to have 6 inch projections, so long as the ADA standard is 4 inches then facilities should only have 4 inch projections to comply with the more stringent requirement set forth by the ADA.

#### Sections 18.2.5.7 and 19.2.5.7—Suites

This new provision has enlarged the size of permissible sleeping suites for patients to potentially allow ‘more comfort and space for patients’ if the facilities choose to use the larger size patient rooms. The provision requires that new construction sleeping suites cannot exceed 7500 square feet. Previously sleeping suites could not exceed 5000 square feet. Sleeping suites greater than 7500 square feet, and not exceeding 10,000 square feet, may be permitted where there is direct visual supervision and a complete smoke detection system. This change allows health care facilities to have more patients in a single area, reducing the number of staff that are necessary to visually monitor patients and allowing facilities to accommodate additional pieces of medical equipment or visitor space. This could improve facility staffing flexibility and reduce costs by allowing this increase in size thereby reducing the number of suites to treat the same number of patients.

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

#### 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 would not 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. Therefore, roller latches would be prohibited in existing and new Health Care Occupancies, and corridor doors would be required to have positive latching devices.

#### Sections 18.4.2 and 19.4.2—Sprinklers in High-Rise Buildings

This is a new provision for existing health care occupancies. 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 would have 12 years following publication of the final rule adopting the 2012 LSC to install sprinklers. We propose to adopt this new provision because high-rise buildings require more time to evacuate, and sprinklers would very likely allow additional time to safely evacuate a facility.

We believe that this provision would mainly affect hospitals. However, we are specifically soliciting public comment to determine if other provider types are, or may be, located in a high-rise building. We would also like to solicit public comments regarding the phase-in period of 12 years, including if 12-years is enough time for the installation of sprinklers in high-rise buildings.

#### Sections 18.2.2.2.5.2 and 19.2.2.2.5.2—Door Locking

This new provision requires that, where the special needs of patients require specialized protective measures for their safety, door-locking arrangements are permitted. This provision allows interior doors to be locked to reduce the risk of infant abductions and individuals who may wander, subject to the following requirements: (1) All staff must have keys; (2) smoke detection systems must be in place; and (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. This provision would improve the security of health care facilities with

specialized needs and improve patient safety.

#### Sections 18.3.2.6 and 19.3.2.6—Alcohol Based Hand Rubs (ABHRs)

This provision now 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 provision further defines prior language regarding "above or adjacent to an ignition source" as being "within 1 inch" of the ignition source. These new provisions would allow for more hand hygiene dispenser options for all facilities.

#### Sections 18.3.5 and 19.3.5—Extinguishment Requirements

This provision is related to sprinkler system requirements and cross references section 9.7 of the LSC, "Automatic sprinklers and other extinguishing equipment." Section 9.7 further cross references the 2011 edition of NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-based Fire Protection Systems. Section 9.7.5 of the LSC states "All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested and maintained in accordance with NFPA 25. . . ." Section 15.5.2, of the 2011 edition of NFPA 25, which is cross-referenced by the 2012 edition of the LSC, 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. However the 1998 edition of NFPA 25, which is cross-referenced by the 2000 edition of the LSC, has the same requirement when a sprinkler system is out of service for only 4 hours. Because of the increased reliance upon a facility sprinkler

protection system in the 2012 edition of the LSC, and to ensure a facility is adequately monitored when a sprinkler system is out of service, we propose to retain the requirement for evacuation or a fire watch when a sprinkler system is out of service for more than 4 hours. This provision is set out in the applicable sections of this proposed rule.

#### 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. The 2012 edition of NFPA 99 eliminated an important requirement that was in the 1999 edition of NFPA 99. The 1999 edition of NFPA 99, which is cross-referenced in the 2000 LSC, requires a smoke control ventilation system in anesthetizing locations (for example, Operating Rooms). The 1999 edition of NFPA 99 requires that 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 room(s). The smoke control is intended to protect the anesthetizing location until surgical procedures can be completed and patients can be safely evacuated from the operating rooms. As fires in operating rooms continue to occur, we propose to retain the requirement for smoke control in anesthetizing locations, notwithstanding the lower standard in the 2012 LSC. <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm282810.htm>.

#### Sections 18.2.3.4 and 19.2.3.4—Corridors

This new provision allows for storage of medical equipment in the corridors. Any equipment that is in use, including medical emergency equipment, and patient lift and transportation equipment is permitted to be stored in the corridors for more timely patient care. This provision also allows facilities to place fixed furniture in the corridors. This creates resting points in the corridors for patients and families in facilities and makes for a more home-like setting.

#### Sections 18.3.2.5.3 and 19.3.2.5.3—Cooking Facilities

This provision is a new section, which further supports a more home-like setting in health care 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 has been revised to allow combustible decor in any health care occupancy as long as they are flame-retardant or treated with approved fire-retardant coating that is listed and labeled, and meet fire test standards. The décor (such as photographs, paintings and other art) may be attached directly to the walls, ceilings, and non fire-rated doors as long as it does not interfere with the operation of the doors. 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 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. These changes would allow individuals to bring in their own furnishings and decor, which helps to provide a more home-like setting.

#### Sections 18.5.2.3 and 19.5.2.3—Fireplaces

This provision has been revised to allow 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. This provision allows for more options for the location of fireplaces in health care facilities, which makes the facilities feel more home-like.

#### Outside Window or Door Requirements

The 2000 edition of the LSC required that every health care occupancy patient sleeping room shall have an outside window or outside door, with new health care occupancies having an allowable sill height not to exceed 36 inches above the floor with certain exceptions. This requirement no longer exists in the 2012 edition of the LSC; however, as outside windows and doors may be used for smoke control, building entry, patient and resident evacuation, and other emergency forces operations during an emergency situation, we propose to retain this requirement. We propose the following exceptions to the outside window or door requirement, as included in the 2000 edition of the LSC:

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

#### Ambulatory Health Care Occupancies

The following are new 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 are providing the LSC citation, a description of the requirement, and an explanation of its benefits for health care facilities, patients, staff, and visitors.

Both the 2000 and 2012 edition of the LSC define 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 20.1.6.4 and 21.1.6.5—Interior Nonbearing Walls

This new provision allows all interior nonbearing walls that are required to have a minimum 2 hour fire resistance

rating to be constructed of fire-retardant treated wood enclosed within noncombustible or limited combustible materials, provided that these walls are not used as shaft enclosures. The use of fire-retardant treated wood allows for more flexibility during construction and could reduce the cost of construction.

#### Sections 20.3.2.1 and 21.3.2.1—Doors

This new provision requires all doors to hazardous areas to be self-closing or close automatically. This provision was added to provide an extra level of protection for all patients. Adding this provision aligns the requirements for both ASCs and Health care occupancies to assure the same basic level of protection for all patients.

#### Sections 20.3.2.6 and 21.3.2.6—ABHRs

This provision now 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. Automatic dispensers are also now permitted in health 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 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. These new provisions allow for more hand hygiene dispenser options for all facilities.

#### Sections 20.3.5 and 21.3.5—Extinguishment Requirements

This provision is related to sprinkler system requirements and cross references section 9.7 of the LSC, “Automatic sprinklers and other extinguishing equipment.” Section 9.7 also cross references the 2011 edition of NFPA 25, “Standard for the Inspection, Testing and Maintenance of Water-based Fire Protection Systems.” Section 9.7.5 of the LSC states, “All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested and maintained in accordance with NFPA 25. . . .”

Section 15.5.2, of the 2011 edition of NFPA 25, which is cross-referenced by the 2012 edition of the LSC, 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. The 1998 edition of NFPA 25, which is cross-referenced by the 2000 edition of the LSC, has the same requirement when a sprinkler system is out of service for only 4 hours. With the increased reliance upon a facility sprinkler protection system in the 2012 edition of the LSC, and to ensure a facility is adequately monitored when a sprinkler system is out of service, we propose to retain the requirement for evacuation or a fire watch when a sprinkler system is out of service for more than 4 hours.

#### 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 eliminated an important requirement that was in the 1999 edition of NFPA 99. The 1999 edition of NFPA 99, which is cross-referenced by the 2000 LSC, requires a smoke control ventilation system in anesthetizing locations (for example, Operating Rooms). The 1999 edition of NFPA 99 requires that 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 room. The smoke control is intended to protect the anesthetizing location until surgical procedures can be completed and patients can be safely evacuated from the operating rooms. As fires in operating rooms continue to occur, we propose to retain the requirement for smoke control in anesthetizing locations.

#### Residential Board and Care Occupancies

The LSC requirements for residential care facilities are differentiated based on the evacuation capability of the facility in question. The term “evacuation capability” refers to the ability of occupants, residents, and staff as a group either to evacuate a building, or to relocate from one point of occupancy to a point of safety. An “impractical evacuation capability” means that a group is unable to reliably move to a point of safety in a timely manner. A “prompt evacuation capability” means that a group is able to move reliably to

a point of safety in a timely manner that is equivalent to the capacity of a household in the general population. A “slow evacuation capability” means that a group is able to move reliably to a point of safety in a timely manner, but not as rapidly as members of a household in the general population. The LSC requirements for a facility that has a prompt evacuation capability may be different from those for a facility that has an impractical evacuation capability. Those differences are reflected in the following provisions.

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 by blood or marriage to the owners or operators, for the purpose of providing personal care services.” However, for CMS regulatory purposes, unless specifically noted, the conditions of participation and conditions for coverage for all affected health care providers and suppliers apply to all patients in a facility, regardless of the number of patients served. These basic requirements are established to assure a core level of safety and quality for all patients, regardless of where they receive health care services. We continue to believe that patients in very small facilities should be assured the same level of fire safety as those residing in very large facilities. Therefore, the LSC “4 or more” criteria would not apply to any Medicare and applicable Medicaid certified facilities. All residential board and 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.

The following are provisions that appear in the 2012 edition of the LSC, but that did not exist in the 2000 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, a description of the requirement, and an explanation of its benefits for health care facilities, patients, staff, and visitors.

#### 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 facilities. Although this section of the LSC does not apply to existing facilities, we strongly encourage all existing facilities be sprinklered in all habitable areas in the same manner that newly constructed facilities are required to be sprinklered.

#### 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. The attics of new board and care facilities are required to be protected in accordance with sections 32.2.3.5.7.1 or 32.2.3.5.7.2 of the LSC. The attics of existing board and care facilities are required to be protected in accordance with sections 33.2.3.5.7.1 or 33.2.3.5.7.2 of the LSC. 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 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. We are requesting public comment on the length of time needed to install sprinklers in attics. This provision was added after fire investigations demonstrated that fires in attics pose a high hazard in this type of occupancy. For example, one well-known case would be the fire in a board and care facility in Wells, New York on March 21, 2009. The fire started on the screened porch and spread to the unsprinklered attic where it quickly engulfed the facility. Despite the prompt evacuation by staff, 4 of the 9 clients perished in the fire. ([http://www.prevention1st.org/documents/Wells\\_Fire\\_GrandJuryReport.pdf](http://www.prevention1st.org/documents/Wells_Fire_GrandJuryReport.pdf))

#### Sections 32.2.2 and 33.2.2—Means of Escape

This new provision requires designated means of escape to be continuously maintained free of all obstructions or impediments to full instant use in the case of a fire or emergency. This provision was added because there were no provisions within the occupancy chapter to prohibit an obstructed means of escape, and to emphasize that all means of escape are required to be free of obstructions to allow use without delay.

#### Section 32.3.3.4.7—Smoke Alarms

This new provision would only affect newly constructed facilities. Approved smoke alarms are required to be installed in accordance with 9.6.2.10 of the LSC inside every sleeping room, outside every sleeping area, in the immediate vicinity of the bedrooms, and on all levels within a resident unit. This

requirement is located in Chapter 32, which only applies to newly constructed facilities. We are soliciting public comments about whether or not CMS should also require existing facilities to have smoke alarms that meet the requirements of this section.

#### Sections 32.7.6 and 33.7.6—Staff

This new provision for both newly constructed and existing facilities requires staff to be on duty and in the facility at all times when residents requiring evacuation assistance are present. This provision was added because staff assistance during evacuation is a necessity in this occupancy. This would increase safety for patients that are unable to independently exit the building in an emergency situation.

#### Sections 32.3.2.2.2 and 33.3.2.2.2—Access-Controlled Egress Doors

New and existing facilities must be permitted to have access-controlled egress doors that are in accordance with 7.2.1.6.2 of the LSC. When using the term “egress,” we are describing, for example, hallways or corridors, interior and exterior stairways, entrance ways or lobbies, and escalators. Section 7.2.1.6.2 of the LSC permits means of egress to be equipped with electrical lock hardware to prevent egress. This provision was added to improve safety while allowing for more flexibility.

#### Section 33.3.3.2.3—Hazardous Areas

This new provision is for existing facilities with impractical evacuation capabilities. All hazardous areas must be separated from other parts of the building by smoke partitions, and also in accordance with section 8.4 of the LSC. Section 8.4 of the LSC addresses the continuity of smoke partitions and requires that they be placed appropriately. We are requesting public comment on the length of time needed to install smoke partitions in hazardous areas. This new provision provides a higher level of safety for facilities with impractical evacuation capabilities, and allows more time for individuals using facilities with slower evacuation capabilities to exit the building.

#### Section 33.3.3.4.6.2—Emergency Forces Notification

This new provision is only for existing facilities. Where a new fire alarm system is installed, or the existing fire alarm system is replaced, notification of emergency forces must be handled in accordance with section 9.6.4 of the LSC, which states that, where required by another section of this code, notification of emergency

forces should alert the municipal fire department and fire brigade (if provided) of fire or other emergency. This new provision would increase safety for residents and staff by assuring that the appropriate emergency force is quickly notified of an emergency situation, enabling the emergency force to arrive in the fastest time possible to aid residents and staff.

#### Waiver Authority

We are proposing 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. 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, and we have periodically issued communications regarding specific provisions of the LSC that we evaluated and for which we have determined that a waiver would generally apply, subject to documentation maintained by the facility and verification of the applicability of the waiver when a survey of the facility is conducted. We plan to continue this approach.

In cases where a provider or supplier has been cited for a LSC deficiency, the provider or supplier may request a waiver from its State Survey Agency or Accrediting Organization (AO) with a CMS-approved Medicare and applicable Medicaid accreditation program. The State Survey Agency or AO reviews the request and makes a recommendation to the appropriate CMS Regional Office. The CMS Regional Office would review the waiver request and the recommendation and make a final decision. A waiver cannot be granted if patient health and safety is compromised.

The LSC recognizes alternative systems, methods, or devices approved as equivalent by the authority having jurisdiction as being in compliance with the LSC. CMS, as the authority having jurisdiction 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, which we are

proposing to adopt in this rule. The state must submit the request to the appropriate CMS Regional Office, and the Regional Office would forward the request to CMS central office for final determination. We would retain our authority to apply the Fire Safety Evaluation System (FSES) as an alternative approach to meeting the requirements of the LSC.

#### C. 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 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 such as medical gas and vacuum systems, electrical systems, electrical equipment, and gas equipment.

The NFPA 99, which is a cross-referenced document in the LSC, has undergone some significant changes. The NFPA 99 has been upgraded from a standard to a code. A code, as used by the NFPA describes what to do, whereas a standard describes how to comply with the code. In addition to the upgrade, the format of the code has changed from specific provisions that are directed by different chapters in the NFPA 99 to provisions that apply to all health care facilities. The applicability of any specific provision is determined in accordance with the results of a risk based methodology. Previous editions utilized occupancy chapters to determine which systems were required in a health care facility. Requirements were applied based upon the facility type (that is, Hospital, Nursing Home, Limited Care Facility, Other Health Care Facilities). In the 2012 edition, requirements are based upon the possible risks to patients and residents, regardless of the type of facility.

Although NFPA 99 is a reference document of the 2012 edition of the



LSC, the health care occupancy chapters of the LSC do not reference NFPA 99 requirements for all areas within a health care facility. In order to ensure the minimum level of protection afforded by NFPA 99 is applicable to all patient and resident care areas within a health care facility, CMS is proposing the adoption of the 2012 edition of NFPA 99, with the exception of chapters 7, 8, 12, and 13. 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 also definitions.

#### Chapter 4—Fundamentals

Chapter 4 is new to the 2012 edition and provides guidance on how to apply NFPA 99 requirements to health care facilities based upon “categories” determined when using a risk-based 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. This approach will ensure that patients and residents in all types of health care facilities are provided with a minimum level of protection. In addition, the risk-based approach will allow a facility to determine the appropriate level of protection required in individual areas throughout a facility based upon each area’s risk to patients or residents, and would no longer require the facility to implement requirements in discriminately throughout an entire facility. Based upon a risk assessment conducted by qualified facility personnel, implementation of less stringent requirements may be appropriate for areas presenting a lower risk to patients or residents, while implementation of more stringent requirements is reserved for areas presenting a higher risk. This will allow health care facilities to apply the most appropriate level of protection in an efficient and economical manner.

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 would require that each facility that is a health care or ambulatory occupancy define its risk assessment methodology, implement the methodology and document the results. We do not propose to require the use of any particular risk assessment procedure. Section A.4.2 provides examples of appropriate risk assessment procedures, such as ISO/IEC31010, *Risk management—Risk Assessment*, or NFPA 551, *Guide for the Evaluation of Fire Risk Assessments*.

#### Chapter 5—Gas and Vacuum Systems

The hazards addressed in Chapter 5 include the ability of oxygen and nitrous 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. Adopting Chapter 5 would ensure a minimal level of the performance, maintenance, installation, and testing of piped medical gas and vacuum systems in all patient and resident care areas (for example, operating rooms, intensive care units, critical care units, procedure rooms, and sleeping rooms). Chapter 5 would not mandate the installation of any systems; rather, if they are installed or are required to be installed, the systems would 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.

The NFPA 99 defines key terms that are used frequently throughout this chapter as follows:

#### Section 3.3.108—Medical Gas Systems

Medical gas systems are an assembly of equipment and piping for the

distribution of nonflammable medical gases such as oxygen, nitrous oxide, compressed air, carbon dioxide, and helium.

#### Section 3.3.110—Medical-surgical Vacuum

Medical-surgical vacuum systems are used to provide a source of drainage, aspiration, and suction in order to remove body fluids from patients.

#### Section 3.3.183—Waste Anesthetic Gas Disposal Systems (WAGD)

A WAGD system is the process of capturing and carrying gases vented from the patient breathing circuit during the normal operation of gas anesthesia or analgesia equipment.

#### Section 3.3.111—Medical-Surgical Vacuum System

A medical-surgical vacuum system is an assembly of central vacuum-producing equipment and a network of piping for patient suction in medical, surgical, and WAGD applications.

#### Section 3.3.102—Manufactured Assembly

A manufactured assembly is a factory-assembled product that contains medical gas or vacuum outlets, piping, or other devices related to medical gas.

Chapter 5 is organized by category as described in Chapter 4. The NFPA Technical Committee on Medical Gas did not find there was a need for Category 4 requirements, as Category 4 facilities would not ordinarily have piped medical gas or vacuums. Chapter 5 includes several sections, described below, which are significant to managing the hazards associated with gas and vacuum systems.

#### Section 5.1.3—Category 1 Sources

This section includes information on the management of the sources for the medical gas, vacuum, WAGD, and instrument supply systems. It requires facilities to identify and label storage containers and other system components. It also contains requirements related to areas used to store gas and equipment, and how to handle gas cylinders and containers. Facilities would be required to design and construct systems and storage locations in accordance with the requirements for this section. This section also regulates the requirements for construction materials and placement of system components, and requirements for emergency power and quality assurance.

### Section 5.1.9—Category 1 Warning Systems

This section includes information on the requirements for warning systems that monitor piped gas and vacuum systems. Warning systems monitor and alert the facility if a condition exists that could have a negative effect on the health and safety of patients, staff, and visitors. This section regulates the functions, capabilities, placement, labeling, emergency power, wiring, computer systems, initiating devices, and monitoring requirements for master, area, and local alarm systems.

### Section 5.1.10—Category 1 Distribution

This section includes information on the requirements for the piping system for medical gas, vacuum, and WAGD systems. It regulates piping system installation, location, assembly, cleaning, and materials of construction, inspection, and installer qualifications.

### Section 5.1.14—Category 1 Operation and Management

This section includes information on the operation and maintenance of medical gas, vacuum, WAGD and support gas systems. Issues addressed in this section include system limitations, maintenance programs, inspection and testing, management of flexible connections, piping and valve labeling, and recordkeeping. This section allows facilities flexibility in meeting the maintenance program requirements by focusing on the basic goals, timing, and qualifications for performing the work. NFPA 99 would not require a specific schedule, allowing a facility to determine the frequency of maintenance based on the original quality, age and longevity, and known characteristics of the equipment.

### Section 5.2 Category—2 Piped Gas and Vacuum Systems and 5.3 Category 3 Piped Gas and Vacuum Systems

Category 2 requirements apply to facilities treating patients who might require the gases occasionally, but ordinarily would not require them. When the use of gas is required for patient care, the need is short term. The provisions for Category 2 are virtually the same as for Category 1, except some equipment is permitted to be simplex rather than duplex. Category 3 applies to office-based care, where gases are used in such a manner that the life of the patient is never at issue in the event of failure of gas. Many requirements in the Category 3 section are similar to the requirements in Category 1 and Category 2.

### 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. Although these threats are present in any facility, the vulnerabilities of patients or residents in health care facilities, coupled with the complexity of the systems involved, create a need for distinct considerations.

Chapter 6 covers the performance, maintenance, and testing of both the normal and essential electrical systems (EES) in health care facilities. The normal electrical system is comprised of a normal power supply, typically provided by a public utility, connected to the facility electrical distribution system and ancillary equipment. The normal electrical system supplies power to the health care facility under normal operating conditions. An EES is comprised of an alternate source of power, typically a generator, connected to the facility's separate essential electric distribution systems and ancillary equipment. An EES is designed to ensure continuity of electrical power to designated areas and functions of a health care facility during a disruption of the normal power sources, and also to minimize disruptions with the internal wiring system (3.3.48).

Certain provisions in Chapter 6 related to the normal power system are defined by category as described in Chapter 4; however, all EES provisions are organized by "Type." Category 1 systems are the most reliable and complex, because patients being served by these systems are the most dependent on this system to function properly and will be at the greatest risk if the system fails. Category 2 systems are a step down from Category 1 systems, and Category 3 systems are another step down. Critical care rooms (Category 1) would be required to be served by a Type 1 EES, general care rooms would be required to be served by a Type 1 or Type 2 EES, and basic care rooms and non-patient care rooms are not required to be served by any EES.

Chapter 6 includes several sections, which are significant to managing the hazards associated with the normal electrical system. Subject areas include:

#### Section 6.3.1—Sources

This section requires each line-powered electrical appliance in a health care facility to be supported by sources

and distribution systems that provide power adequate for each service.

#### Section 6.3.2—Distribution

This section includes information on the electrical distribution systems within a health care facility. Some of the issues addressed include:

- Electrical system installation;
- Specific requirements for patient care rooms (circuits, overcurrent protection, receptacles, wet locations);
- Ground-fault protection; and
- Isolated power systems.

#### Section 6.3.3—Performance Criteria and Testing

This section includes information on electrical system performance criteria. Electrical systems that support patient rooms would be required to be tested in order to ensure that they are safe and reliable. Some of the issues addressed include:

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

#### Section 6.3.4—Administration of Electric System

This section includes information on the frequency of electrical system component testing and record keeping requirements. Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing must be performed after initial installation, replacement, or servicing of the device. Receptacles not listed as hospital-grade must be tested in intervals not exceeding 12 months. The minimum acceptable documentation would identify what was tested, when it was tested, and whether it performed successfully.

Chapter 6 also includes several sections related to managing the hazards associated with the EES, including but not limited to:

#### Section 6.4.1—Sources (Type 1 EES)

This section includes specific information for on-site generators used as an alternate source of power. Generator requirements focus on design considerations, generator types, allowable uses, generator placement and protection, capacity, rating, heating, cooling, ventilating, battery maintenance, fuel supply, and generator monitoring. In addition, this section addresses batteries used as alternate sources of power, as permitted.

### Section 6.4.2—Distribution (Type 1 EES)

This section includes information on the EES distribution systems and ancillary equipment in a health care facility. It covers topics such as transfer switches; division of distribution system into three branches—life safety, critical, and equipment; and wiring requirements.

### Section 6.4.3—Performance Criteria and Testing (Type 1 EES)

This section includes information on EES performance criteria to assure that the EES is safe and reliable. It includes a requirement that all functions of the life safety branch and critical branches must be automatically restored to operation within 10 seconds after interruption of the normal power source. It also includes specific transfer switch requirements related to placement, voltage drop, load transfer, and normal power restoration.

### Section 6.4.4—Administration (Type 1 EES)

This section includes general information on the maintenance, inspection and testing of the EES alternate power source, including generator testing criteria, test conditions, and testing personnel qualifications. Specific maintenance, inspection and testing requirements are also required through reference to NFPA 110, Standard for Emergency and Standby Power Systems. In addition, this section addresses the maintenance and testing of EES circuitry and record keeping requirements.

### Section 6.5—Essential Electrical System Requirements—Type 2

Section 6.5 addresses Type 2 EES requirements, which share many of the Type 1 EES requirements related to maintenance, inspection, and testing. The major difference between a Type 1 and Type 2 EES is that a Type 2 EES only requires two separate branches—a Life Safety branch and an Equipment branch. A Type 2 EES does not require a branch to supply a limited amount of lighting and power service that is considered essential for life safety and effective operation to critical care areas during the time the normal electrical service is interrupted.

### Section 6.6—Essential Electrical System Requirements—Type 3

Section 6.6 addresses Type 3 EES requirements, which share many of the Type 1 EES requirements related to maintenance, inspection, and testing. The major difference between a Type 1 or Type 2 EES and a Type 3 EES system

is that a Type 3 EES system comprises only one electrical branch to supply a limited amount of lighting and power service that is considered essential for life safety and orderly cessation of procedures during the time normal electrical service is interrupted. Type 3 EES systems are not permitted in areas where surgery is performed. In addition, the alternative power for a Type 3 system can be a generator, battery system, or self-contained battery integral with the equipment.

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

Chapter 9 is a newly added chapter to the 2012 edition of the NFPA 99 and requires HVAC systems serving spaces or providing health care functions to be in accordance with the American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE) Standard 170—Ventilation of Health Care Facilities (2008 edition) (<http://www.ashrae.org>). The purpose of a HVAC system is to create acceptable indoor air quality. Heating is the process of bringing heat to different spaces using a variety of sources. Ventilating is the process of removing or changing air in a space to create a different temperature or to reduce or remove moisture, odors, smoke, dust, gases and microbes within a space. Air conditioning is the removal of heat from a space.

Chapter 9 does not apply to existing HVAC systems, but would apply to the construction of new health care facilities, and the altered, renovated, or modernized portions of existing systems or individual components. Chapter 9 would ensure 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;
- and
- Ventilation during construction.

Chapter 9 includes several sections, which are of significant importance to managing the hazards associated with HVAC systems, including but not limited to:

#### Section 9.3.1—Heating, Cooling, Ventilating, and Process Systems

The purpose of this section is to define design requirements for

ventilation systems in order to assure an environment that is comfortable and clean, and that minimizes odors in health care facilities. These requirements also apply to patient care areas and other related support areas within a health care facility. This section considers chemical, physical and biological contaminants that can affect the delivery of medical care to patients, the recovery of patients, and the safety of patients, health care workers, and visitors.

#### Section 9.3.3—Commissioning

This section requires HVAC system commissioning to follow ASHRAE Guideline 0, The Commissioning Process, and ASHRAE Guideline 1.1, HVAC & R Technical Requirements for the commissioning process, or other publically viewed documents acceptable to the authority having jurisdiction. Commissioning is a quality-oriented process for verifying new HVAC systems and assemblies meet performance objectives and criteria. For purposes of this rule, we would consider ASHRAE Guideline 0 and ASHRAE Guideline 1.1 as the only acceptable documents guiding the commissioning process.

#### Section 9.3.5—Ductwork

This section requires health care facilities to use ductwork systems that comply with NFPA 90, Standard for the Installation of Air-Conditioning and Ventilation Systems or other mechanical codes. NFPA 90 covers the construction, installation, operation, and maintenance of HVAC systems to protect life and property from fire, smoke, and gases resulting from a fire. NFPA 90A is also cross-referenced in the 2012 edition of the LSC.

#### Section 9.3.7—Medical Gas Storage or Transfilling

This section addresses the ventilation requirements for both medical gas storage and transfilling areas. Transfilling is the process of transferring a medical gas in gaseous or liquid state from one container or cylinder to another container or cylinder (3.3.176). Some of the requirements included in this section are for natural and mechanical ventilation.

#### Section 9.3.8—Waste Gas

This section requires the removal of gases vented from the patient breathing circuit during the normal operation of gas anesthesia or analgesia equipment by a WAGD system, as described in chapter 5, or by an active or passive scavenging ventilation system.

### Section 9.3.10—Emergency Power System Room

This section requires operation of the emergency power supply to be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 addresses ventilation requirements including, maintaining room temperature, adequate supply of air for generator combustion and cooling, air supply quality, and generator radiator and exhaust discharge. NFPA 110, in its entirety, is also cross-referenced in the 2012 edition of the LSC.

### 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. There has been an increased need for electrical equipment safety requirements due to the increase in the use of electrical circuits and multiple appliances that are located close to the patient's body, including situations where they enter the patient's body (such as internal defibrillators, and neurostimulators). Chapter 10 includes several sections, which may reduce the instances of patient injuries and death due to electrical appliances and equipment, including, but not limited to:

#### Section 10.2—Performance Criteria and Testing for Patient Care—Related Electrical Appliances and Equipment

This section includes information on the connection of equipment, grounding of equipment, power cords, and the proper use of electrical plug adapters and extension cords. This section also discusses the proper materials to use to ensure electrical safety.

#### Section 10.3—Testing Requirements—Fixed and Portable

This section discusses the proper testing procedure for patient care electrical equipment, both visually and physically, to ensure that leakage currents, which may cause electrical shocks, are minimized or eliminated.

#### Section 10.4—Nonpatient Electrical Appliances and Equipment

This section discusses the proper testing procedure of equipment that may not be patient care related, but may be in the vicinity of the patient and could pose an electrical hazard to the patient, if not properly inspected. Nonpatient electrical appliances may include:

Entertainment devices, computers, displays and such.

### Section 10.5—Administration

This section requires facilities to ensure that there are policies in place for the testing and maintenance of equipment, for the proper use of electrical equipment in the administration of oxygen therapy, and for the proper use of electrical equipment in an oxygen enriched environment. This section also includes requirements for the use, inspection, and maintenance of equipment found in laboratories. Section 10.5.6 requires that a facility would keep records related to the performance testing and repairs of patient care equipment. Section 10.5.8 would require that equipment be used and maintained by qualified and trained personnel.

### 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. Fire and explosions may be caused by incidents involving oxygen, frequently used in health care facilities, or nitrous oxide, frequently used as an inhalation anesthetic. Many materials commonly used in health care facilities are not flammable in room air, but become flammable or extremely flammable when the concentration of oxygen is raised in a room. Mechanical hazards are often associated with compressed gas cylinders, which are generally under high pressures and are very heavy in weight. The cylinders can cause injury, if not properly secured or mishandled. If there is physical damage to regulators or valves, such damage may cause escaping gas to propel the cylinder. Use of Chapter 11 would ensure a minimal level of performance, maintenance, testing, storage, and management of gas equipment in all patient and resident care areas.

Chapter 11 includes several sections, which may reduce the instances of patient injuries and death due to gas equipment. The following are important provisions of this section:

#### Section 11.1—Applicability

This section includes information on the types of medical gases included in this chapter such as nonflammable medical gases, and vapors and aerosols.

#### Section 11.2—Cylinder and Container Source

This section includes information on the proper connection of regulators and gauges to various types of gas sources to prevent cross connections and leakage.

### Section 11.3—Cylinder and Container Storage Requirements

This section includes information on the proper storage of cylinders and containers, including cryogenic liquid containers. It discusses the types of enclosures required for storage and signage that facility must display.

### Section 11.4—Performance Criteria and Testing

This section includes information on the proper testing of portable patient care gas equipment that is found in health care facilities, proper handling of gas containers for respiratory therapy, and non-patient gas equipment safety procedures. The section also addresses special requirements regarding the proper handling of gas equipment in laboratories.

### Section 11.5—Administration

This section includes requirements for the elimination of potential sources of ignition, as well as the servicing and maintenance of equipment. There are also special handling requirements in this section for gases in cylinders, liquefied gases in containers, and transfilling of cylinders, including the transfilling of liquid oxygen.

### Section 11.6—Operation and Maintenance of Cylinders

This section includes requirements for the proper procedures for safe handling of cylinders and containers. This section also requires special precautions for handling oxygen cylinders and manifolds, and making cylinder and container connections.

### Section 11.7—Liquid Oxygen Equipment

This section includes information on the safe storage and handling of liquid oxygen portable containers and base reservoir containers.

### Chapter 14—Hyperbaric Facilities

Hyperbaric facilities house hyperbaric chambers and auxiliary equipment. Hyperbaric medicine is the medical use of oxygen at a level higher than atmospheric pressure. The hyperbaric chamber is necessary to adjust the ambient pressure required for hyperbaric oxygen therapy. Chapter 14 addresses the hazards associated with hyperbaric facilities in health care facilities, including electrical, explosive, implosive, as well as 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.

However, there are some requirements, ones that are generally operational in nature, that are applicable to existing facilities. The 2000 edition of the LSC required that all occupancies containing hyperbaric facilities must comply with NFPA 99; therefore, Chapter 14 is not expected to impose a significant burden upon existing health care facilities.

Hyperbaric chambers are classified according to the number of human occupants in order to establish appropriate minimum safeguards in construction and operation. Class A chambers have multiple occupants, Class B chambers are single occupancy, and Class C chambers are for animals only (no human occupancy ever).

Chapter 14 includes several sections, which are important to managing the hazards associated with hyperbaric facilities, including, but not limited to:

#### Section 14.2—Construction and Equipment

This section includes information on the construction and management of hyperbaric facilities and hyperbaric chambers, including topics such as:

- Fabrication of the hyperbaric chamber;
- Illumination;
- Ventilation;
- Fire protection;
- Electrical wiring;
- Electrical equipment;
- Communication systems;
- Gas detection and monitoring; and
- Chamber equipment and fixtures.

#### Section 14.3—Administration and Maintenance

This section includes information on the administration and maintenance of hyperbaric facilities and hyperbaric chambers, including topics such as:

- Recognition of hazards associated with hyperbaric facilities;
- Establishing programs and assigning responsibilities to ensure safety;
- Restrictions on ignition sources;
- Limitations on flammables;
- Antistatic procedures and grounding;
- Limitations on combustibles;
- Restrictions and compatibility of equipment;
- Proper handling of gases;

- Installation, inspection, and maintenance of chamber equipment; and
- Electrical and electrostatic safeguards.

The hazards involved in the use of hyperbaric facilities can be mitigated successfully only when all of the areas of hazard are fully recognized by all personnel and when the physical protection provided is complete and is augmented by attention to detail by all personnel of administration and maintenance having any responsibility for the functioning of the hyperbaric equipment. This section addresses the administration and maintenance of the hyperbaric chamber with requirements such as the having a Safety Director, developing management policies and emergency procedures, and fire training of personnel involved with the use of the chamber. This section also includes policies describing what types of medical devices or equipment can be used in the chamber, along with the safe use of medical gases, electrical equipment, and fire protection equipment used within the chamber itself.

#### 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;
- 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; and
- Testing of water based fire protection systems.

These sections have requirements for inspection, testing and maintenance

which would apply to all facilities, as well as specific requirements for existing systems and equipment that would also apply to all facilities.

Section 15.13 addresses fire loss prevention in operating rooms. This section includes requirements for a hazard assessment, fire prevention procedures, procedures for handling flammable germicides and antiseptics, emergency procedures, and orientation and training. This section sets out requirements that may reduce the risk of surgical fires, as described below:

#### Section 15.13.1—Hazard Assessment

This section includes information on the assessment of hazards that a facility could encounter during a surgical procedure, and the periodic review of surgical operations and procedures.

#### Section 15.13.2—Fire Prevention Procedures

This section requires that fire prevention procedures be established in facilities, but does not prescribe any particular procedures. The exact procedures to be used are left to the discretion of each facility based on its unique circumstances, features, and needs, and applicable State licensure laws and local ordinances

#### Section 15.13.3—Germicides and Antiseptics

This section includes information on the procedures for the safe handling of flammable materials in operating rooms. This section also outlines operational procedures to address the fire hazards of these flammable materials, including packaging and material handling, removing solution-soaked materials, preventing pooling of material, preoperative “time-out” period to allow for drying before patient draping, and establishing policies and procedures to outline safety precautions.

#### Section 15.13.3.9—Emergency Procedures

This section requires emergency procedures to be in place in case of fire, or chemical spills in the operating room, as well as the procedures for alarm activation, evacuation and equipment shutdown.

#### Section 15.13.3.10—Orientation and Training

This section includes requirements for the orientation and training of new operating room/surgical suite staff for issues such as:

- Safe practices related to the area and equipment;
- Continuing education;
- Incident reviews;

- Procedure updates; and
- Fire drills.

## II. Proposed Requirements for Health Care Facilities

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)

We propose to maintain most of the current provisions for Religious Nonmedical Health Care Institutions (RNHCI) published in the **Federal Register** on January 10, 2003 (68 FR 1374), except if it conflicts with the 2012 LSC and the requirements are not within the provisions detailed in Section I of this preamble regardless of the number of patients the facility serves.

Specifically, we propose to retain the requirements at § 403.744(a)(1)(ii) related to the prohibition of roller latches in health care facilities. We propose 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”.

We propose to 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 propose to remove the requirements at § 403.744(a)(4)(i), (ii), (iv) and (v). We propose to retain the requirements at § 403.744(a)(4)(iii) related to protection against inappropriate access, and would redesignate it at § 403.744(a)(4).

We propose to add a new requirement at § 403.744(a)(5) that would 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 LSC.

We also propose to add a new requirement at § 403.744(a)(6) that would retain the 36 inch window sill requirement that was in the 2000 edition of the LSC.

In addition, we propose to retain the requirement at § 403.744(b) related to the Secretary’s waiver authority and state imposed codes. We do not propose to make any changes to this section.

Furthermore, we propose to 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 all facilities should be in compliance. Therefore, this phase-in provision is no longer a necessary regulatory requirement.

We are proposing to add a new Condition of Participation at § 403.745 that would require RNHCIs to comply with the 2012 edition of the NFPA 99. We propose that chapters 7, 8, 12, and 13 would not apply to RNHCIs. We also propose to 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)

We propose 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 believe the protection provided in the Ambulatory Health Care Centers chapter is necessary to protect the health and safety of patients who are incapable of caring for themselves at any point in time. However, we do not believe that the Business Occupancy chapter of the LSC (applied by some authorities having jurisdiction to ASCs treating fewer than 4 patients at a time) affords an adequate level of protection to patients in an ASC.

Specifically, we propose to retain the provision at § 416.44(b)(2) and (3) related to the Secretary’s waiver authority and state imposed codes. We do not propose to make any changes to this section.

We propose to remove the requirements at § 416.44(b)(4) 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 all facilities should be in compliance. Therefore, this phase-in provision is no longer a necessary regulatory requirement.

We propose to modify the requirements specific to ABHRs since most of the requirements are now included in the 2012 edition of the LSC. Specifically, we propose to remove the requirements at § 416.44(b)(5)(i), (ii), (iv), (A) through (G), and (v). We also propose to retain the requirements at § 416.44(b)(5)(iii) related to protection

against inappropriate access, and would redesignate it at § 416.44(b)(4).

We propose to add a new requirement at § 416.44(b)(5) that would 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.

We propose to add a new requirement at § 416.44(b)(6) that would require facilities with windowless anesthetizing locations to have a 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.

We are proposing to add a new paragraph at § 416.44(c) that would require ASCs to comply with the 2012 edition of the NFPA 99. We propose that chapters 7, 8, 12, and 13 would not apply to ASCs. We also propose to 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 Provide Inpatient Care Directly (§ 418.110)

We propose 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. 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.

We propose to retain the requirements at § 418.110(d)(1)(ii) related to the prohibition of roller latches in health care facilities. We are proposing 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.” In addition, we propose to retain the provision at § 418.110(d)(2) and (3) related to the Secretary’s waiver authority and state imposed codes. We do not propose to make any changes to this section.

We also propose to modify the requirements specific to ABHRs because most of the requirements are now included in the 2012 edition of the LSC. Specifically, we propose to remove the requirements at § 418.110(d)(4)(i), (ii) and (iv). We also propose to retain the

requirements at § 418.110(d)(4)(iii) related to protection against inappropriate access, and would redesignate this requirement at § 418.110(d)(4).

We propose to add a new requirement at § 418.110(d)(5) that would 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.

We also propose to add a new requirement at § 418.110(d)(6) that would retain the 36 inch window sill requirement that was in the 2000 edition of the LSC.

We are proposing to add a new paragraph at § 418.110(e) that would require hospices to comply with the 2012 edition of the NFPA 99. We propose that chapters 7, 8, 12, and 13 would not apply to hospices. We also propose to 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)*

We propose 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 would 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).

Specifically, we propose to retain the requirements at § 460.72(b)(1)(ii) related to the prohibition of roller latches in health care facilities. We are proposing 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.”

We propose to retain the provision at § 460.72(b)(2)(i) and (ii) related to the Secretary’s waiver authority and state imposed codes. We do not propose to make any changes to this section.

We propose to remove the requirement at § 460.72(b)(3) 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 all facilities

should be in compliance. Therefore, this phase-in provision is no longer a necessary regulatory requirement.

We also propose to remove the requirements at § 460.72(b)(4) related to the prohibition of roller latches in health care facilities. In the 2003 final rule, we allowed facilities until March 13, 2006, to replace their existing roller latches. This phase-in period has now ended, and all facilities should be in compliance. Therefore, this phase-in provision is no longer a necessary regulatory requirement.

We propose to modify the requirements specific to ABHRs because most of the requirements are now located in the 2012 edition of the LSC. Specifically, we proposed to remove the requirements at § 460.72(b)(5)(i), (ii), (iv) and (v). In addition, we propose to retain the requirements at § 460.72(b)(5)(iii) related to protection against inappropriate access, and would redesignate it at § 460.72(b)(3).

We propose to add a new requirement at § 460.72(b)(4) that would 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.

We are proposing to add a new paragraph at § 460.72(d) that would require PACE centers to comply with the 2012 edition of the NFPA 99. We propose that chapters 7, 8, 12, and 13 would not apply to PACEs. We also propose to 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)*

We propose that the hospital must 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 with the Multiple Occupancies provisions in 18.1.3 and 19.1.3. In addition, we believe 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.

We propose 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). Specifically, we propose to retain the requirements at § 482.41(b)(1)(ii) related to the prohibition of roller latches in health care facilities. We are proposing 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.”

We propose to retain the provision at § 482.41(b)(2) and (3) related to the Secretary’s waiver authority and state imposed codes. We do not propose to make any changes to this section.

We propose to remove the requirements at § 482.41(b)(4) 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 ended, and all facilities should be in compliance. Therefore, this phase-in provision is no longer a necessary regulatory requirement.

We propose to remove the requirements at § 482.41(b)(5) related to phase-in period of the prohibition on roller latches in health care facilities. This provision allowed hospitals a 3 year period to replace all existing roller latches. This phase-in period has now expired and all facilities should be in compliance. Therefore, this phase-in provision is no longer a necessary regulatory requirement.

We propose to retain the requirements at § 482.41(b)(7) through (b)(8), and would redesignate them at § 482.41(b)(4) through (b)(6), without changes.

In addition, we propose to modify the requirements specific to ABHRs since most of the 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 propose to retain the requirement at § 482.41(b)(9)(iii) related to protection against inappropriate access, and would redesignate it at § 482.41(b)(7).

We are proposing to add a new requirement at § 482.41(b)(8) that would 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.

We are also proposing to add a new requirement at § 482.41(b)(9) that would require facilities with windowless anesthetizing locations to have a 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.

We also propose to add a new requirement at § 482.41(b)(10) that would retain the majority of the 36 inch window sill requirement that was in the 2000 edition of the LSC. Newborn nurseries and rooms intended for occupancy for less than 24 hours, such as those housing obstetrical labor beds, and recovery beds would be exempt from the window sill height requirement. The 2000 edition of the LSC allowed for observation beds in the emergency department to be exempt from the 36 inch window sill requirement. However, we do not propose to incorporate an exemption for observation beds, because they are frequently occupied for greater than 24 hours. Therefore, observation beds would be required to meet the 36 inch window sill requirement. Window sills in special nursing care areas, such as those housing an intensive care unit, critical care unit, hemodialysis, and neonatal patients, would not exceed 60 inches.

We are proposing to add a new paragraph at § 482.41(c) that would require hospitals to comply with the 2012 edition of the NFPA 99. We propose that chapters 7, 8, 12, and 13 would not apply to hospitals. We also propose to allow for waivers of these provisions under the same conditions and procedures that we currently use for waivers of applicable provisions of the LSC.

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

We propose to retain most of the provisions of the existing final regulation for long-term care facilities published in the **Federal Register** on January 10, 2003 (68 FR 1374) regardless of the number of residents the facility serves. We propose to retain the requirements at § 483.70(a)(1)(ii) related to the prohibition of roller latches in health care facilities. We are proposing 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.”

We propose to retain the provision at § 483.70(a)(2) and (3) related to the Secretary’s waiver authority and state imposed codes. We do not propose to make any changes to this section.

We propose to remove the requirements at § 483.70(a)(4) 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 all facilities should be in compliance. Therefore, this phase-in provision is no longer a necessary regulatory requirement.

We also propose to remove the requirements at § 483.70(a)(5) related to the phase-in period for the prohibition of roller latches in health care facilities. In the 2003 final rule, we allowed facilities until March 13, 2006, to upgrade their door latching equipment. This phase-in period has now ended and all facilities should be in compliance. Therefore, this phase-in provision is no longer a necessary regulatory requirement.

We propose to modify the requirements specific to ABHRs since most of the requirements are now included in the 2012 edition of the LSC. Specifically, we propose to remove the requirements at § 483.70(a)(6)(i), (ii), (iv) and (v). We propose to retain the requirement at § 483.70(a)(6)(iii) related to protection against inappropriate access, and would redesignate it at § 483.70(a)(4).

We propose to 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 are proposing to redesignate these requirements at § 483.70(a)(5) (i), (ii), (iii) (A) and (B).

In addition, we propose to 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 propose to redesignate these requirements as § 483.70(a)(6)(i) and (ii), without changes.

We also propose to add a new requirement at § 483.70(a)(7) that would retain the 36 inch window sill requirement that was in the 2000 edition of the LSC.

We are proposing to add a new paragraph at § 483.70(b) that would require LTCs to comply with the 2012 edition of the NFPA 99. We propose that chapters 7, 8, 12, and 13 would not apply to LTCs. We also propose to 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)*

We propose to retain most of the provisions of the existing regulation for ICFs/ID. ICFs/ID would continue to be

permitted to meet either the Residential Board and Care Occupancies chapter or the Health Care Occupancy chapter of the LSC, as appropriate, regardless of the number of patients the facility serves.

However, we propose not to adopt the provisions at Chapters 32.3.2.11.2 and 33.3.2.11.2, related to “lockups.” This is a new provision that has not been addressed in this chapter in prior editions of the LSC. Lock-ups are incidental use areas where occupants are secluded or restrained, and; therefore, incapable of self-preservation in any emergency situation because of security measures and other circumstances no longer under the person’s control. We do not believe that lock-ups as described in the LSC are appropriate under any circumstances for board and care facilities.

In addition, we propose to retain the requirements at § 483.470(j)(1)(ii) related to the prohibition of roller latches in health care facilities. We are proposing 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.”

We propose to retain the requirements at § 483.470(j)(2), (3), and (4). We do not propose any changes to the content of these sections.

We propose to remove the requirements at § 483.470(j)(5) 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 expired and all facilities should be in compliance. Therefore, this phase-in provision is no longer a necessary regulatory requirement.

We propose to remove § 483.470(j)(6) related to the phase-in period for the prohibition of roller latches in health care facilities. In the 2003 final rule, we allowed facilities until March 13, 2006, to upgrade their door latching equipment. This phase-in period has now ended and all facilities should be in compliance. Therefore, this phase-in provision is no longer a necessary regulatory requirement.

We also propose to retain the provision at § 483.470(j)(7)(A) and (B) related to the Secretary’s waiver authority and state imposed codes. We propose to redesignate these provisions at § 483.470(j)(5)(A) and (B) without change.

In addition, we propose to 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 § 483.470(j)(7)(ii)(A),



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

We propose to add a new requirement at § 483.470(j)(5)(iii) that would 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.

We are proposing to add a new paragraph at § 483.470(j)(5)(iv) that would require ICF–IIDs to comply with the 2012 edition of the NFPA 99. We propose that chapters 7, 8, 12, and 13 would not apply to ICF–IIDs. We also propose to 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)*

We propose 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. Specifically, we propose to retain the requirements at § 485.623(d)(1)(ii) related to the prohibition of roller latches in health care facilities. We are proposing 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.”

We propose to retain the requirements at § 485.623(d)(2) through (d)(4). We do not propose to make any changes to these sections.

We propose to remove the requirement at § 485.623(d)(5) 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 all facilities should be in compliance. Therefore, this phase-in provision is no longer a necessary regulatory requirement.

We propose to 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 provision allowed CAHs a 3 year period to replace all existing roller latches. This phase-in period has also expired and all facilities should be in compliance. Therefore, this phase-in

provision is no longer a necessary regulatory requirement.

In addition, we propose to 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 propose to retain the requirement at § 485.623(d)(7)(iii) related to protection against inappropriate access, and would redesignate it at § 485.623(d)(5).

We are proposing to add a new requirement at § 485.623(d)(6) that would 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.

We are proposing to add a new requirement at § 485.623(d)(7) that would require facilities with windowless anesthetizing locations to have a 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.

We also propose to add a new requirement at § 485.623(d)(8) that would retain the 36 inch window sill requirement that was in the 2000 edition of the LSC. With the exception of newborn nurseries and rooms intended for occupancy for less than 24 hours, every sleeping room must have an outside window or outside door, and the sill height must not exceed 36 inches above the floor. Special nursing care areas shall not exceed 60 inches. Windows in atrium walls are considered outside windows for the purposes of this requirement.

We are proposing to add a new paragraph at § 485.623(e) that would require CAHs to comply with the 2012 edition of the NFPA 99. We propose that chapters 7, 8, 12, and 13 would not apply to CAHs. We also propose to 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. Collection of Information Requirements**

This proposed rule does not impose any new reporting, recordkeeping or third-party disclosure requirements. However, this proposed rule does reference the NFPA 99 that has several 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 5 CFR 1320.3(b)(2), and 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.

#### **IV. Response to Comments**

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

#### **V. Regulatory Impact Statement**

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 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 \$41,437,279 in the first year of implementation and \$7,109,914

after the first year of implementation, and annually thereafter for an 11 year period. Therefore, this is not an economically significant or major rule.

#### B. Alternatives Considered

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 Life Safety Code. Many states have adopted subsequent editions of the Life Safety Code. 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 proposing 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 long term care 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 proposing 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. Therefore, we have proposed to maintain the phase-in length that is already part of the LSC, and we are specifically requesting public comment on the appropriateness of this timeframe.

We considered not proposing separate requirements for anesthetizing locations, out-of-service sprinkler systems, and window sill heights. Although the NFPA has removed these requirements from the LSC, we felt that these were important issues that still needed to be required for the safety of patients, visitors, and staff. We believe that smoke detection systems in anesthetizing locations are important because there continue to be operating room fires and this requirement will maintain the safety in operating rooms

for staff and patients. CMS believes that allowing a sprinkler system to be out of service for 12 hours before evacuating patients or establishing a fire watch is too long. Therefore, CMS will continue to require the shorter 4 hour timeframe that was in the 2000 edition of the LSC. Lastly, 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.

We considered not proposing 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 propose adopting the NFPA 99 because it addresses additional building safety topics that are related to important fire safety issues.

We also considered proposing 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).

#### C. Anticipated Effects

##### 1. Hospitals

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. 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, only 3 states have adopted this requirement, accounting for 21 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 health care occupancies, and the average square footage needing to be sprinklered. Of the 50 states, we received some data from 30 states.<sup>1</sup> We

<sup>1</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,

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 386 high-rise hospitals. Of the 386 estimated high-rise hospitals in states that did not respond, we estimate there are 339 fully sprinklered, 56 partially sprinklered, and 3 non-sprinklered. We note that these numbers do not directly match because there was limited actual data available for the 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 above 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 858 high-rise facilities with health care occupancies throughout all 50 states (472 high-rise facilities in states that submitted data + 386 estimated high-rise facilities in states that did not submit data). We estimate that 682 of those high-rise facilities are fully

Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Virginia, Washington, and Wyoming.

sprinklered, 169 are partially sprinklered, and 7 are not sprinklered.

We also requested that the 50 states 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>2</sup> In addition, 3 states supplied data regarding the area to be sprinklered in non-sprinklered facilities.<sup>3</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 facility in a high-rise building 75' and over is required to be sprinklered. We recognize that these averages are based on very limited data submitted by the states, and we welcome public comment and/or additional data submission that would help us improve the accuracy of these estimates.

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 169 partially sprinklered facilities that would install sprinklers to cover an average of 37,173 square feet per facility, for a total of 6,282,237 square feet. At an estimated cost of \$11 per square foot to install sprinklers, we estimate a total cost of \$69,104,607 for all partially sprinklered facilities (6,282,937 square feet  $\times$  \$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  $\times$  \$11 per square foot).

We estimated that there are 7 non-sprinklered facilities nationwide, and that an average non-sprinklered facility would install sprinklers for, 127,667

square feet, for a total of 893,669 square feet (7 facilities  $\times$  127,667 square feet per facility). At an estimated cost of \$11 per square foot to install sprinklers, we estimate that it would cost \$9,830,359 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  $\times$  \$11 per square foot).

We estimate the total cost associated with the installation of sprinklers in partially sprinklered and non-sprinklered facilities to be \$78,934,966 (\$69,104,607 for all partially sprinklered facilities + \$9,830,359 for all non-sprinklered facilities). This 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 \$6.6 million.

## 2. Ambulatory Surgical Centers

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 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 4,149 ASCs. As of December 2012, there were 5,444 total Medicare and applicable Medicaid participating ASCs. The 1,295 remaining facilities would be required to upgrade their door closing mechanisms to meet 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 \$1,355,865.

## 3. Intermediate Care Facilities for Individuals With Intellectual Disabilities

Sections 32.2.3.5.7 and 33.2.3.5.7 of the LSC requires attics of new and existing facilities 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 3 states have adopted this requirement, accounting for 78 ICF-IIDs. We are not including those 78 facilities in our analysis. For purposes of this analysis only, we assume that about 10 percent (639) of facilities will install a heat detection system because they do not

use the attic for living purposes. As of December 2012, there were 6,460 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 5,743 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 \$25,843,500 to install sprinklers in their attic spaces.

Facilities that do not use their attics for living purposes may choose to install a heat detection system in the attic instead of sprinklers. We assume that 639 facilities will install a heat detection system. We estimate the cost to install a heat detection system to be \$1,000 per facility. The anticipated cost would be \$639,000 for all affected facilities to install heat detection systems.

Section 33.3.3.2.3 of the LSC requires all hazardous areas in existing facilities 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 3 states have adopted this requirement, accounting for 78 ICF-IIDs. As of December 2012, there were 6,460 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 6,382 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 average ICF-IID would need to install 2 smoke partitions for a total of \$1,000 per facility. The anticipated cost is \$6,382,000.

Section 33.3.3.4.6.2 of the LSC requires that, when an existing facility 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, which states that notification of emergency forces should alert the municipal fire department and fire

<sup>2</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>3</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.

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 3 states have adopted this requirement, accounting for 78 ICF-

IIDs. As of December 2012, there were 6,460 total Medicare participating ICF-IIDs. The 6,382 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 \$1000. For purposes of this

analysis only, we assume that about 8.3 percent (532) of facilities will do this in any given year, for an annual cost of \$532,000 over a 12 year period.  
(\$1,000 per upgraded alarm system × 532 facilities in any given year = 532,000)

TABLE 1—TOTAL COST FOR IMPLEMENTATION IN YEAR 1

Requirement	Provider type affected	Cost per affected provider	Cost for all providers
High-rise sprinkler installation *	Hospitals, partially sprinklered	\$34,075	\$5,758,717
High-rise sprinkler installation *	Hospitals, non-sprinklered	117,028	819,197
Self-closing or automatic closing doors on hazardous areas.	Ambulatory surgical centers	1,047	1,355,865
Sprinklers in Attics (used for living purposes, storage or fuel fired equipment).	Intermediate care for individuals with intellectual disabilities.	4,500	25,843,500
Heat detection systems in attics (not used for living purposes).	Intermediate care for individuals with intellectual disabilities.	1,000	639,000
Hazardous areas separated by smoke partitions	Intermediate care for individuals with intellectual disabilities.	1,000	6,382,000
Upgrade existing or install new fire alarm system with emergency forces notification capabilities*.	Intermediate care for individuals with intellectual disabilities.	1,000	532,000
<b>Total</b>			<b>41,437,279</b>

\* Data presented for a single year of the 12 year phase-in period.

TABLE 2—TOTAL COST OF IMPLEMENTATION FOR YEARS 2–12

Requirement	Provider type affected	Cost per affected provider	Cost for all providers
High-rise sprinkler installation	Hospitals, partially sprinklered	\$34,075	\$5,758,717
High-rise sprinkler installation	Hospitals, non-sprinklered	117,028	819,197
Upgrade existing or install new fire alarm system with emergency forces notification capabilities	Intermediate care for individuals with intellectual disabilities	1,000	532,000
<b>TOTAL ANNUALLY</b>			<b>7,109,914</b>
<b>OVERALL TOTAL YEARS 2–12</b>			<b>78,209,054</b>

TABLE 3—TOTAL COST OF IMPLEMENTATION FOR ALL YEARS

Year 1 of implementation	\$41,437,279
Years 2–12 of implementation	78,209,054
<b>TOTAL</b>	<b>119,646,333</b>

4. 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 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 proposed rule due to the lack of data that could provide a reliable point estimate, we believe that there is potential for such a result.

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 implementation of the high-rise sprinkler requirements of this rule will cost all affected hospitals approximately \$6.6 million total in any 1 year. That's a total of \$408,903 per individual facility that is partially sprinklered or \$34,075 per year over the 12 year phase-in period and \$1.4 million per individual facility that is non-sprinklered or \$117,028 per year over the 12 year phase-in period. We estimate the implementation of this rule will cost affected ASCs approximately \$1.4 million in the first year of implementation, or \$1,047 per ASC. We estimate that implementation of this rule will cost affected ICF-IIDs approximately \$32.9 million in the first year of implementation, or \$6,500 per affected ICF-IID. 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.

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 603 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.

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 2013, that threshold is approximately \$141 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 \$141 million.

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.

## 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, 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 record keeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 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:** Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. Amend § 403.744 by—

- A. Revising paragraph (a)(1)(i).
- B. Amending paragraph (a)(1)(ii) by removing the reference to “Chapter 19.3.6.3.2, exception number 2” and adding in its place “Chapter 19.3.6.3.5 numbers 1 and 2 and Chapter 19.3.6.3.6 number 2”.
- C. Revising paragraph (a)(4).
- D. Adding paragraphs (a)(5) and (6).
- E. Removing paragraph (c).

The revisions and additions read as follows:

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

(a)(1) \* \* \*

(i) Except as otherwise provided in this section, the RNHCI must meet the applicable provisions of the 2012 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of individuals served. The Director of the Office of the Federal Register has approved the NFPA 101® 2012 edition of the Life Safety Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

\* \* \* \* \*

(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 out of service for more than 4 hours in a 24-hour period, 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) Every sleeping room must have an outside window or outside door, and 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.

\* \* \* \* \*

■ 3. Add § 403.745 to read as follow:

### § 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 of the 2012 edition of the Health Care Facilities Code of the National Fire Protection Association,

regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 99® 2012 edition of the Health Care Facilities Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

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

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

#### 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 paragraph (b)(1).
- 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 (d) and (e).
- G. Adding new paragraph (c).

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 Centers of the 2012 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 101® 2012 edition of the Life Safety Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(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 out of service for more than 4 hours in a 24-hour period, 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) In windowless anesthetizing locations, the ASC must have a supply and exhaust system that—
- (i) Automatically vents smoke and products of combustion,
  - (ii) Prevents recirculation of smoke originating within the surgical suite, and
  - (iii) Prevents the circulation of smoke entering the system intake.

(c) *Standard: building safety.* Except as otherwise provided in this section, the ASC must meet the applicable provisions of the 2012 edition of the Health Care Facilities Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 99® 2012 edition of the Health Care Facilities Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(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 upon 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.

\* \* \* \* \*

#### 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 paragraph (d)(1)(i).
  - B. Amending paragraph (d)(1)(ii) by removing the reference to “Chapter 19.3.6.3.2, exception number 2” and adding in its place “Chapter 19.3.6.3.5 numbers 1 and 2 and Chapter 19.3.6.3.6 number 2”.
  - C. Revising paragraph (d)(4).
  - D. Adding paragraphs (d)(5) and (6).
  - E. Redesignating paragraphs (e) through (o) as (f) through (p).
  - F. Adding new paragraph (e).

The revisions and additions read as follows:

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

\* \* \* \* \*

(d)(1) \* \* \*

(i) Except as otherwise provided in this section, the hospice must meet the

provisions applicable to health care occupancies of the 2012 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 101® 2012 edition of the Life Safety Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the code is available for inspection 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/federalregister/codeoffederalregulations/ibrlocations.html>. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in the edition of the Code are incorporated by reference, CMS will publish a notice in the **Federal Register** to announce the changes.

\* \* \* \* \*

(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 out of service for more than 4 hours in a 24-hour period, 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) Every sleeping room must have an outside window or outside door, and 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 of the 2012 edition of the Health Care Facilities Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 99® 2012 edition of the Health Care Facilities Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(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 upon the hospice, 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.

\* \* \* \* \*

#### **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 paragraph (b)(1)(i).

■ B. Amending paragraph (b)(1)(ii) by removing the reference to “Chapter 19.3.6.3.2, exception number 2” and adding in its place “Chapter 19.3.6.3.5 numbers 1 and 2 and Chapter 19.3.6.3.6 number 2”.

■ 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 paragraph (b)(4) and paragraph (d).

The revisions and addition read as follows:

#### **§ 460.72 Physical environment.**

\* \* \* \* \*

(b) \* \* \*

(1) \* \* \*

(i) Except as otherwise provided in this section, a PACE center must meet the applicable provisions of the 2012 edition of the Life Safety Code (LSC) of the National Fire Protection Association that apply to the type of setting in which the center is located, regardless of the number of PACE enrollees served. The Director of the Office of the Federal Register has approved the NFPA 101®

2012 edition of the Life Safety Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

\* \* \* \* \*

(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 out of service for more than 4 hours in a 24-hour period, the PACE center 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 of the 2012 edition of the Health Care Facilities Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 99® 2012 edition of the Health Care Facilities Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will

publish notice in the **Federal Register** to announce the changes.

(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 upon 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.

\* \* \* \* \*

**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 1395fr), unless otherwise noted.

■ 12. Amend § 482.41 by—

- A. Revising paragraph (b)(1)(i).
- B. Amending paragraph (b)(1)(ii) by removing the reference to “Chapter 19.3.6.3.2, exception number 2” and adding in its place “Chapter 19.3.6.3.5 numbers 1 and 2 and Chapter 19.3.6.3.6 number 2”.
- C. Removing paragraphs (b)(4) and (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), (9), and (10).
- G. Redesignating paragraph (c) as paragraph (d).
- H. Adding new paragraph (c).

The revisions and additions read as follows:

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

\* \* \* \* \*

(b) \* \* \*

(1) \* \* \*

(i) Except as otherwise provided in this section, the hospital must meet the applicable provisions of the 2012 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 101® 2012 edition of the Life Safety Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

\* \* \* \* \*

(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 out of service for more than 4 hours in a 24-hour period, 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
- (ii) Establish a fire watch until the system is back in service.

(9) In windowless anesthetizing locations, the hospital must have a supply and exhaust system that—

- (i) Automatically vents smoke and products of combustion.
- (ii) Prevents recirculation of smoke originating within the surgical suite.
- (iii) Prevents the circulation of smoke entering the system intake.

(10) Except for, newborn nurseries and rooms intended for occupancy for less than 24 hours, every sleeping room must have an outside window or outside door, and the sill height must not exceed 36 inches above the floor. Special nursing care areas shall not exceed 60 inches. Windows in atrium walls are considered outside windows for the purposes of this requirement.

(c) *Standard: building safety.* Except as otherwise provided in this section, the hospital must meet the applicable provisions of the 2012 edition of the Health Care Facilities Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 99® 2012 edition of the Health Care Facilities Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(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 upon 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.

\* \* \* \* \*

**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, 1128l and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

**§ 483.15 [Amended]**

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

■ 15. Amend § 483.70 by—

- A. Revising paragraph (a)(1)(i).
- B. Amending paragraph (a)(1)(ii) by removing the reference to “Chapter 19.3.6.3.2, exception number 2” and adding in its place “Chapter 19.3.6.3.5 numbers 1 and 2 and Chapter 19.3.6.3.6 number 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 paragraphs (a)(4).
- F. Adding new paragraph (a)(7).
- G. Redesignating paragraphs (b) through (h) as paragraphs (c) through (i).
- H. Adding new paragraph (b).

The revisions read as follows:

**§ 483.70 Physical environment.**

\* \* \* \* \*

(a)(1) \* \* \*

(i) Except as otherwise provided in this section, the long term care facility must meet the applicable provisions of the 2012 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of residents served. The Director of the Office of the Federal Register has



approved the NFPA 101® 2012 edition of the Life Safety Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

\* \* \* \* \*

(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) Every sleeping room must have an outside window or outside door, and 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) *Standard: building safety.* Except as otherwise provided in this section, the long term care facility must meet the applicable provisions of the 2012 edition of the Health Care Facilities Code of the National Fire Protection Association, regardless of the number of residents served. The Director of the Office of the Federal Register has approved the NFPA 99® 2012 edition of the Health Care Facilities Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

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

(2) If application of the Health Care Facilities Code required under paragraph (b) of this section would result in unreasonable hardship upon the long term care 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.

\* \* \* \* \*

■ 16. Amend § 483.470 by—

- A. Revising paragraph (j)(1)(i).
- B. Amending paragraph (j)(1)(ii) by removing the reference to “Chapter 19.3.6.3.2, exception number 2” and adding in its place “Chapter 19.3.6.3.5 numbers 1 and 2 and Chapter 19.3.6.3.6 number 2”.
- C. Adding a new paragraph (j)(1)(iii).
- D. Removing paragraphs (j)(5) and (6).
- E. Redesignating paragraph (j)(7) as paragraph (j)(5).
- F. Revising newly redesignated paragraph (j)(5).

The revisions and additions read as follows:

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

\* \* \* \* \*

(j) \* \* \*

(1) \* \* \*

(i) Except as otherwise provided in this section, the facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the 2012 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of clients served. The Director of the Office of the Federal Register has approved the NFPA 101® 2012 edition of the Life Safety Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

\* \* \* \* \*

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

\* \* \* \* \*

(5) *Facilities that meet the LSC definition of a health care occupancy.*

(i) After consideration of State survey agency recommendations, CMS may waive, for appropriate periods, specific provisions of the Life Safety Code if the following requirements are met:

(A) The waiver would not adversely affect the health and safety of the clients.

(B) Rigid application of specific provisions would result in an unreasonable hardship for the facility.

(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 out of service for more than 4 hours in a 24-hour period, the facility 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) Except as otherwise provided in this section, ICF-IIDs must meet the applicable provisions of the 2012 edition of the Health Care Facilities Code of the National Fire Protection Association, regardless of the number of clients served. The Director of the Office of the Federal Register has approved the NFPA 99® 2012 edition of the Health Care Facilities Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(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 (iv) of this section would result in unreasonable hardship upon

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.

\* \* \* \* \*

**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 paragraph (d)(1)(i).
- B. Amending paragraph (d)(1)(ii) by removing the reference to “Chapter 19.3.6.3.2, exception number 2” and adding in its place “Chapter 19.3.6.3.5 numbers 1 and 2 and Chapter 19.3.6.3.6 number 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), and (8) and (e).

The revisions and additions read as follows:

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

\* \* \* \* \*

- (d) \* \* \*
- (1) \* \* \*

(i) Except as otherwise provided in this section, the CAH must meet the applicable provisions of the 2012 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 101® 2012 edition of the Life Safety Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

\* \* \* \* \*

(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 out of service for more than 4 hours in a 24-hour period, 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) In windowless anesthetizing locations, the CAH must have a supply and exhaust system that—

(i) Automatically vents smoke and products of combustion,

(ii) Prevents recirculation of smoke originating within the surgical suite, and

(iii) Prevents the circulation of smoke entering the system intake.

(8) Except for, newborn nurseries and rooms intended for occupancy for less than 24 hours, every sleeping room must have an outside window or outside door, and the sill height must not exceed 36 inches above the floor. Special nursing care areas shall not exceed 60 inches. 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 CAH must meet the applicable

provisions of the 2012 edition of the Health Care Facilities Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 99® 2012 edition of the Health Care Facilities Code, issued August 11, 2011, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection 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). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(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 upon 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.

\* \* \* \* \*

Dated: August 22, 2013.

**Marilyn Tavenner,**

*Administrator, Centers for Medicare & Medicaid Services.*

Approved: March 7, 2014.

**Kathleen Sebelius,**

*Secretary, Department of Health and Human Services.*

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