


PHCA Fall 2016

Department of Health Update

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Facility and Survey Data 01/01/16 – 06/30/16

Facilities

- 704 Facilities
- 88,404 Beds

Surveys Completed

- 2,567 Total surveys
- 359 Re-licensure/recertification surveys (Full Health Surveys)
- 797 Revisits (to all types of surveys)
- 2,017 On-site visits (includes complaint visits)




Facility and Survey Data 2015

Facilities

- 702 Facilities
- 88,233 Beds

Surveys Completed

- 4,277 Total surveys
- 711 Re-licensure/recertification surveys (Full Health Surveys)
- 1,316 Revisits (to all types of surveys)
- 3,327 On-site visits (includes complaint visits)



Facility and Survey Data 2014

Facilities

- 703 Facilities
- 88,034 Beds

Surveys Completed

- 3,712 Total surveys
- 709 Re-licensure/recertification surveys (Full Health Surveys)
- 1,109 Revisits (to all types of surveys)
- 2,805 On-site visits (includes complaint visits)



Surveys with Scope & Severity D & Above

	2013	2014	2015	2016 1/1/16 through 6/30/16
Standard Surveys	651	629	650	331
Complaint Surveys	390	455	703	481
Substandard Quality of Care	6	1	3	5



01/01/16 – 06/30/16 Frequency of DNCF Visits

Number of Visits % of PA facilities

20 +	0.00%
10 to 19	1.85%
6 to 9	11.93%
2 to 5	51.70%
1	21.31%
0	13.21%



2015 Frequency of DDCF Visits

Number of Visits % of PA facilities

20 +	1.00%
10 to 19	8.83%
6 to 9	21.51%
<i>2 to 5</i>	<i>53.85%</i>
1	14.10%
0	0.71%



2014 Frequency of DDCF Visits

Number of Visits % of PA facilities

20 +	0.28%
10 to 19	5.12%
6 to 9	18.35%
<i>2 to 5</i>	<i>56.47%</i>
1	18.92%
0	0.85%



Provisional Licenses Issued


- 2007 – 14
- 2008 – 22
- 2009 – 29
- 2010 – 10
- 2011 – 18
- 2012 – 2
- 2013 – 2
- 2014 – 9
- 2015 – 19
- 2016 -5 (1/1-6/30)



State Actions


	2012	2013	2014	2015	2016 (1/1/16 – 6/30/16)
PI/CMP =	0	1	1	6	2
PII/CMP =	0	0	2	2	0
PIII/CMP =	0	0	0	0	0
PIV/CMP =	0	0	0	0	0
PI only =	2	1	4	7	3
PII only =	0	0	2	2	0
PIII only =	0	0	0	1	0
PIV only =	0	0	0	1	0
Ban =	0	0	0	1	0
CMP only =	0	11	8	23	17

PI = Provisional I license
 PII = Provisional II license
 Ban = Ban on Admissions
 PIII = Provisional III license
 PIV = Provisional IV license
 CMP = Civil Monetary Penalty




01/01/16 – 06/30/16 Incidents

- Total number of incident reports received:
10,974
- Most Frequently reported events:
 - Transfer to Hospital – **5,064**
 - Abuse – **1,674**
 - Other – **1,446**



2015 Incidents

- Total number of incident reports received:
21,788
- Most Frequently reported events:
 - Transfer to Hospital – 10,432
 - Abuse – 2,941
 - Other – 2,547



2014 Incidents

- Total number of incident reports received: 19,411
- Most Frequently reported events:
 - Transfer to Hospital – 9,822
 - Abuse – 2,375
 - Other – 2,185



01/01/16 – 06/30/16 Complaint Data

Complaint Data

- Total received= 1,592
- Total substantiated= 549 (34.48%)
- Onsite investigations conducted= 90.14%
- Substantiated complaints with citations issued at "G" or above= 3.89%

Most Frequently Filed

- Care or Services 65.53%
- Resident Rights 17.34%
- Environment 10.72%



2015 Complaint Data

Complaint Data

- Total received= 2,591
- Total substantiated= 863 (33.31%)
- Onsite investigations conducted= 89.93%
- Substantiated complaints with citations issued at "G" or above= 2.82%

Most Frequently Filed

- Care or Services 66.77%
- Resident Rights 14.73%
- Environment 9.32%



2014 Complaint Data

Complaint Data

- Total received= 1,930
- Total substantiated= 487 (25.03%)
- Onsite investigations conducted= 89.38%
- Substantiated complaints with citations issued at "G" or above= 1.50%

Most Frequently Filed

- Care or Services 65.99%
- Resident Rights 16.98%
- Environment 8.79%



IDR

2015

98 Tags disputed
 27% deleted (26)
 10% revised (10)
 63% upheld (62)

2014

83 Tags Disputed
 16% deleted (13)
 17% revised (14)
 67% upheld (56)

2013

92 Tags disputed
 14% deleted (13)
 7% revised (6)
 79% upheld (73)

2016 (1/1-6/30)

60 Tags disputed
 15 Deleted 25%
 8 Revised 13%
 37 Upheld 62%



State IIDR

2016 (1/1-6/30)

21 Tags disputed
 5% deleted (1)
 76% upheld (16)
 5% revised (1)
 14% withdrawn (3)

2015

28 Tags disputed
 21% deleted (6)
 68% upheld (19)
 11% revised (3)

2014

26 Tags disputed
 23% deleted (6)
 4% revised (1)
 73% upheld (19)




Federal IIDR


<u>2015</u> 1 tag disputed 100% upheld	<u>2016</u> 0
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2014
1 tag disputed
100% upheld (1)

2013
10 tags disputed
100% upheld (10)




Additional Updates




Overview

- CMS Adoption of the 2012 Life Safety Code (LSC) and 2012 Health Care Facilities Code (HCFC)
- 2000 LSC – 2012 LSC Crosswalk
- Major Changes to Referenced NFPA Codes
- Building Rehabilitation
- CMS Emergency Preparedness Rule
- House Bill 264 – Carbon Monoxide Law




CMS 2012 LSC Adoption

- CMS adopted the 2012 LSC and HCFC with an effective date of July 5, 2016
- The 2012 LSC will be replacing the 2000 edition, which has been in use since September 2003
- PADOH state licensure requirements adopted to follow CMS adoption for survey consistency




CMS 2012 LSC Adoption

- What is the importance of the July 5, 2016 effective date:
 - The date determines whether the building component is surveyed as new or existing
 - Those with a plan approval date on or before the effective date are considered existing
 - Those with a plan approval date after the effective date are considered new




CMS 2012 LSC Adoption

- Different than the effective date, the implementation date is November 1, 2016
- The implementation date is the date that the state agencies and CMS Regional Offices will begin to complete surveys of health care facilities to the 2012 code requirements
- Between July 5 and November 1, surveys continue to be completed using the 2000 code requirements




CMS 2012 LSC Adoption

- Familiar with the LSC, but what is HCFC???
- HCFC is NFPA 99, which has been enforced through mandatory reference in NFPA 101 LSC
- Currently, the 1999 edition of NFPA 99 is referenced by 2000 NFPA 101
- This adoption, CMS has decided to formally adopt the 2012 edition of NFPA 99, rather than through LSC reference
- Note that NFPA 101 and LSC, as well as NFPA 99 and HCFC are interchangeable terms





CMS 2012 LSC Adoption

- The purpose of the LSC is to provide minimum requirements, with due regard to function, for the design, operation, and maintenance of buildings and structures for safety to life from fire and similar emergencies
- The purpose of the HCFC is to provide minimum requirements for the installation, inspection, testing, maintenance, performance, and safe practices for facilities, material, equipment, and appliances, including other hazards associated with the primary hazards




CMS 2012 LSC Adoption




CMS 2012 LSC Adoption

- The HCFC is an important NFPA document for health care facilities and provides information on such subjects as medical gas and vacuum systems, electrical equipment, gas equipment, and similar health facility-related topics




CMS 2012 LSC Adoption

- CMS made modifications to the adoption of the 2012 LSC and HCFC
- These can be found in the final rule:
 - <https://www.federalregister.gov/articles/2016/05/04/2016-10043/medicare-and-medicaid-programs-fire-safety-requirements-for-certain-health-care-facilities>



CMS 2012 LSC Adoption

- A major change to the survey process is the organization of LSC deficiency tags
- All K-tags will be three digits and are organized by LSC section, LSC sub-section and then numerical order in that sub-section
- For example:
 - K18 ... K363
 - K29 ... K321



CMS 2012 LSC Adoption


- K363

Section
Subsection
Numerical Order

system in accordance with 19.3.5.7.

19.3.6.3* Corridor Doors.

19.3.6.3.1* Doors protecting corridor openings in required enclosures of vertical openings, exits, or lobbies shall be doors constructed to resist the passage of fire and shall be constructed of materials such as the following:



CMS 2012 LSC Adoption


- K321

Section
Subsection
Numerical Order

held open under the conditions specified in 19.2.2.2.8.


19.3.2 Protection from Hazards.

19.3.2.1 Hazardous Areas. Any hazardous area shall be guarded by a fire barrier having a 1-hour fire rating or shall be provided with an automatic extinguisher in accordance with 8.7.1.




CMS 2012 LSC Adoption

- A number of 2012 code changes were permitted to be used by CMS through the categorical waiver process
- The categorical waivers are based on the 2012 LSC and are no longer required upon adoption of the 2012 LSC




CMS 2012 LSC Adoption

- Categorical waivers permitted by S&C 12-21:
 - Non-continuous corridor projections
 - Patient lift and transport equipment in corridors
 - Furniture in exit corridors
 - Alternative cooking facilities
 - Gas fireplaces
 - Decorations




CMS 2012 LSC Adoption

- Categorical waivers permitted by S&C 13-58:
 - Medical Gas Alarm Panels
 - Openings in Exit Enclosures
 - Emergency Generators
 - Door Locking Arrangements
 - Suites
 - Testing of Waterflow Devices and Pumps
 - Recycling Containers




CMS 2012 LSC Adoption

- There are numerous changes to the 2012 codes that were not emphasized by the categorical waiver process
- Some are changes that facilities may find advantageous but others may be found to be more stringent or an increase in workload compared to previous requirements




CMS 2012 LSC Adoption

- Clarification of use of fire-retardant-treated (FRT) wood
 - Sections 18/19.1.6.6 permits FRT that serves as support for the installation of fixtures and equipment when the FRT is installed behind noncombustible or limited-combustible sheathing
 - Examples would be wall mounted computer kiosks, handrails, etc.


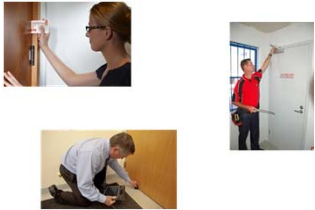


CMS 2012 LSC Adoption

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




CMS 2012 LSC Adoption




CMS 2012 LSC Adoption

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




CMS 2012 LSC Adoption

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




CMS 2012 LSC Adoption

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




CMS 2012 LSC Adoption

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




CMS 2012 LSC Adoption

- Hazardous area clarification
- The 2000 LSC stated that soiled linen and trash collection rooms must be 1 hour fire-rated
- The 2012 LSC states that soiled linen and trash collection rooms with a volume exceeding 64 gallons must be 1 hour fire-rated




CMS 2012 LSC Adoption

- Fire watch confusion
- CMS Final Rule stated multiple times that CMS was permitting the sprinkler system to be out of service for 10 hours in a 24 hour period prior to evacuation or a fire watch
- Section 9.6.1.6 of the 2012 LSC still states that fire alarm systems must have a fire watch or evacuation if the system is down for 4 or more hours in a 24 hour period
- Since NFPA 25 already permits 10 hours, there is speculation that CMS meant fire alarm systems and not sprinkler systems in the Federal Register Posting




CMS 2012 LSC Adoption

- Fire watch confusion
- Until such time that CMS clarifies otherwise, a fire watch or evacuation is required when:
 - The fire alarm system is out of service for more than 4 hours in a 24 hour period
 - The sprinkler system is out of service for more than 10 hours in a 24 hour period
 - Note that this could be for maintenance or system failure




CMS 2012 LSC Adoption

- The 2012 edition added one component to the Fire Safety Plan requirements
 - Use of alarms
 - Transmission of alarms to the fire department
 - **Emergency phone call to the fire department (new to 2012 for existing and new facilities)**
 - Response to alarms
 - Isolation of fire
 - Evacuation of immediate area
 - Evacuation of smoke compartment
 - Preparation of floors and building for evacuation
 - Extinguishment of fire




CMS 2012 LSC Adoption

- Being that the Fire Safety Plan requirement is for new and existing, it is important to revise facility plans and train staff accordingly
- This is an item that will be reviewed starting November 1st




CMS 2012 LSC Adoption

- Mattresses and upholstered furniture requirements became more stringent between the 2000 and 2012 LSC
- In the 2000 LSC, if the newly introduced mattress or furniture was located in a sprinklered room or space, it was exempt from further fire testing requirements
- The 2012 LSC states fully sprinklered building in lieu of room or space




CMS 2012 LSC Adoption

- Upholstered furniture testing:
 - The peak rate of heat release for the single upholstered furniture item shall not exceed 80 kW
 - The total heat released by the single upholstered furniture item during the first 10 minutes of the test shall not exceed 25 MJ




CMS 2012 LSC Adoption

- Mattress testing:
 - The peak rate of heat release for the mattress shall not exceed 100 kW
 - The total heat released by the mattress during the first 10 minutes of the test shall not exceed 25 MJ




CMS 2012 LSC Adoption

- Stairway Identification
- New stairs serving 3 or more stories and existing stairs serving 5 or more stories must comply
- Existing stairway signage must be evaluated for compliance with the 2012 LSC as the requirements differ slightly




CMS 2012 LSC Adoption

- Stairway Identification (existing 5 story stair)
 - Stairs must have signage at each floor landing
 - Must indicate the floor landing
 - Indicate the terminus of the top and bottom
 - Identification of stair enclosure
 - Floor level and direction to exit discharge
 - Signage approximately 60 inches above the floor and visible when stair door closed or open
 - Illuminated under normal and emergency power
 - Floor level designation shall be tactile




CMS 2012 LSC Adoption

- Stairway Identification (existing 5 story stair) Continued
 - Painted or stenciled on wall or securely attached sign
 - Stairway identification must be at top of sign in 1 inch lettering
 - NO ROOF ACCESS signage in 1 inch lettering for stairs without roof access
 - Floor level number must be located in the middle of the sign in minimum 5 inch lettering
 - Lower and upper terminus must be located at the bottom in minimum 1 inch lettering




CMS 2012 LSC Adoption

- Stairway Identification (existing 5 story stair) Continued
- This is an item that will be reviewed starting November 1st
- Note that the elevator signage detailed in 2012 LSC is for elevators used for egress – not an option for health care occupancies




CMS 2012 LSC Adoption

- Section 19.7.9.2 – The means of egress in any area undergoing construction, repair or improvements shall be inspected daily and comply with NFPA 241, *Standard for Safeguarding Construction, Alteration, and Demolition Operations*
- NFPA 241 was also required in the 2000 LSC but the newer edition of 241 has additional requirements




CMS 2012 LSC Adoption

- Construction barriers must be provided between an occupied portion of the structure and the portion undergoing alterations, construction or demolition operations
- Walls must be 1 hour fire-rated with 45 minute openings



CMS 2012 LSC Adoption

- Non-rated walls and openings are permitted where protected by an automatic sprinkler system, but construction tarps are not considered meeting this standard
- Sprinkler systems that are out of service in the space being renovated means that the space is **not** protected and rated walls are required




CMS 2012 LSC Adoption




NFPA 10 – Fire Extinguishers

- 2010 NFPA 10 – Inspection, Maintenance, and Recharging of Portable Fire Extinguishers
- Persons performing maintenance and recharging of extinguishers must be certified
 - The test shall at a minimum be based upon knowledge of NFPA 10
 - Persons passing the test must be issued a document or certificate made available to the AHJ stating that the person was certified based upon NFPA 10 principles
 - This does **not** apply to individuals performing the monthly inspections




NFPA 10 – Fire Extinguishers

- Formal Interpretations (FI) to Sections 5.5.5 and 6.6.1
 - Fire extinguishers provided for the protection of cooking appliances that use combustible cooking media shall be listed and labeled for Class K fires
 - FI No. 10-02-2:
 - Class K extinguishers are also required to be installed to protect cooking via a griddle or stove top frying pan
 - All cooking kitchen locations, where either a griddle or stove top frying pan is used, must have a Class K extinguisher. This extends from the main kitchen to satellite cooking kitchens




NFPA 10 – Fire Extinguishers

- Electronic Monitoring Systems
- New technology is permitted that monitors the removal of an extinguisher, when it falls out of pressure range and when it is continuously blocked. The devices may be substituted for monthly inspections completed manually.



NFPA 10 – Fire Extinguishers

- The electronic monitoring systems must meet the following:
 - Used in conjunction with the required fire alarm system and maintained in accordance with NFPA 72
 - The components must be tested and maintained annually per manufacturer’s instructions:
 - Power supply inspection/battery change
 - Obstruction sensor inspection
 - Pressure indication inspection
 - Connection continuity inspection
 - 100% of all units tested upon initial installation or reacceptance with verification of receipt of signal at the control panel
 - 20% of units to be tested annually on a rotating basis so that all units are tested within a 5-year period



NFPA 10 – Fire Extinguishers



NFPA 13 – Sprinkler Installation

- Key change from the 1999 edition to the 2010 edition of NFPA 13 with regard to privacy curtains
- Section 8.6.5.2.2.1 – Privacy curtains shall not be considered obstructions where:
 - The curtains are supported by fabric mesh of ceiling track
 - Openings in the mesh are equal to 70 percent or greater
 - The mesh extends to a minimum of **22** inches down from the ceiling




NFPA 13 – Sprinkler Installation


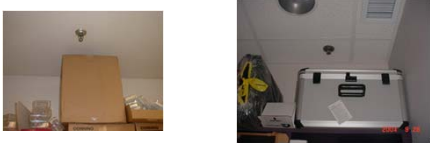


NFPA 13 – Sprinkler Installation

- Note that a minimum ½ diagonal mesh opening is considered meeting 70% or greater
- Section 19.3.5.11 of 2012 LSC states:
 - Newly introduced cubicle curtains in sprinklered areas shall be installed in accordance with NFPA 13
- Is the 18 inch rule now the 22 inch rule?
- No, the 18 inch rule still applies to other obstructions





NFPA 13 – Sprinkler Installation




NFPA 25 – Sprinkler Maintenance

- Internal inspection of piping added to the 2011 edition of NFPA 25
- Inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material




NFPA 25 – Sprinkler Maintenance

- Alternative nondestructive examination methods shall be permitted – must be approved by the AHJ
- Tubercules or slime, if found, must be tested for indications of microbiologically influenced corrosion
- If the presence of sufficient foreign material is found to obstruct pipe or sprinklers, obstruction investigation must be conducted – note that most piping systems may contain some material or evidence of corrosion but not sufficient to trigger obstruction investigation




NFPA 25 – Sprinkler Maintenance

- In dry pipe systems and pre-action systems, the sprinkler removed for inspection shall be from the most remote branch line from the source of water that is not equipped with the inspector's test valve
- Inspection of a cross main is not required where the system does not have a means for inspection – inaccessible location




NFPA 99 – HCFC

- Medical Gas System Verification
 - Testing shall be conducted by a party technically competent
 - Must meet the requirements of ASSE 6030, *Professional Qualifications Standard for Medical Gas Systems Verifiers*




NFPA 99 – HCFC

- System Maintenance
 - Persons maintaining the medical gas systems shall be qualified through one of the following:
 - Training and certification through the health care facility on the specific equipment installed in the facility
 - ASSE 6040, *Professional Qualifications Standard for Medical Gas Maintenance Personnel*
 - ASSE 6030, *Professional Qualifications Standard for Medical Gas Systems Verifiers*




NFPA 99 – HCFC

- System Maintenance Continued
 - Training and certification through the health care facility on the specific equipment installed in the facility
 - Training program/policy/procedure and certification documentation would be required to demonstrate compliance




Building Rehabilitation

- Key item to remember when working within an existing building:
 - Sections 4.6.7.4 and 4.6.12.2 of the 2012 edition of NFPA 101, Life Safety Code permit existing life safety features to be decreased only to those required for new buildings




Building Rehabilitation

- Example – A building was constructed in 2009 and was built under 2000 LSC New requirements
 - The building was constructed with 10 ft corridors, which exceeded the 8 ft requirement
 - Beginning November 1, 2016, the building will be surveyed as 2012 LSC Existing
 - Can the facility build closets in the corridors to reduce corridor width to 4 ft, which is the minimum corridor width in 2012 LSC Existing?






Building Rehabilitation

- **No**
- The facility may only reduce the existing corridor width to 8 ft wide, which is the requirement for new construction
- The same applies to building construction type and all other requirements
- It is not the intent of the LSC for facilities to decrease the level of safety within the building to that which is lower than when it was built, with the exception of when it exceeds the requirements for new




CMS Emergency Preparedness Rule

– <https://www.youtube.com/watch?v=ZhmK8IEDSrs>




CMS Emergency Preparedness Rule

- CMS Survey & Certification Letter 16-38-All
- Final Rule posted on September 8, 2016 in the Federal Register
- Health care providers must comply and implement all regulations one year after the effective date, on November 16, 2017
- 42 CFR § 483.73 – Emergency Preparedness
- LTC facility must establish and maintain an emergency preparedness plan
- Must be reviewed and updated annually




CMS Emergency Preparedness Rule

- The plan must do the following:
 - Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents
 - Include strategies for addressing emergency events identified by the risk assessment
 - Address resident population, including, but not limited to, persons at-risk, the types of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans




CMS Emergency Preparedness Rule

- The plan must do the following:
 - Include a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when it applies, of its participation in collaborative planning efforts




CMS Emergency Preparedness Rule

- The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan
- The policies and procedures must be reviewed and updated at least annually




CMS Emergency Preparedness Rule

- The policies and procedures must address the following:
 - Provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, to include:
 - Food, water, medical and pharmaceutical supplies
 - Alternate sources of energy to maintain:
 - Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions
 - Emergency lighting
 - Fire detection, extinguishing and alarm systems
 - Sewage and waste disposal
 - A system to track the location of on-duty staff and sheltered residents in the LTC facility's care during an emergency
 - If on-duty staff or sheltered patients are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location.




CMS Emergency Preparedness Rule

- The policies and procedures must address the following:
 - Safe evacuation from the LTC facility, to include:
 - Consideration of care and treatment of needs of evacuees
 - Staff responsibilities
 - Transportation
 - Identification of evacuation location(s)
 - Primary and alternate means of communication with external sources of assistance




CMS Emergency Preparedness Rule

- The policies and procedures must address the following:
 - A means to shelter in place for residents, staff, and volunteers who remain in the LTC facility
 - A system of medical documentation that does the following:
 - Preserves resident information
 - Protects confidentiality of resident information
 - Secures and maintains the availability of records




CMS Emergency Preparedness Rule

- The policies and procedures must address the following:
 - The use of volunteers in an emergency and other staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency
 - Development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain continuity of services
 - The role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials




CMS Emergency Preparedness Rule

- The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually




CMS Emergency Preparedness Rule

- The emergency preparedness communication plan must include:
 - Names and contact information for the following:
 - Staff
 - Entities providing services under arrangement
 - Residents' physicians
 - Other LTC facilities
 - Volunteers
 - Contact information for the following:
 - Federal, State, tribal, regional, and local emergency preparedness staff
 - Other sources of assistance




CMS Emergency Preparedness Rule

- The emergency preparedness communication plan must include:
 - Primary and alternate means for communicating with the following:
 - LTC facility's staff
 - Federal, State, tribal, regional or local emergency management agencies
 - A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care
 - A means, in the event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii)




CMS Emergency Preparedness Rule

- The emergency preparedness communication plan must include:
 - A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4)
 - A means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee
 - A method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives




CMS Emergency Preparedness Rule

- The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan and policies and procedures
- The training and testing program must be reviewed and updated at least annually




CMS Emergency Preparedness Rule

- Training Program – The LTC facility must do all of the following:
 - Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles
 - Provide emergency preparedness training at least annually
 - Maintain documentation of all emergency preparedness training
 - Demonstrate staff knowledge of emergency procedures




CMS Emergency Preparedness Rule

- Testing – The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills of all of the following:
 - Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event




CMS Emergency Preparedness Rule

- Testing continued:
 - Conduct an additional exercise that may include, but is not limited to the following:
 - A second full-scale exercise that is individual, facility-based
 - A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan
 - Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the facility's emergency plan as needed




CMS Emergency Preparedness Rule

- Emergency and standby power systems – The LTC facility must implement emergency and standby power systems based on the emergency plan, to include:
 - Generator location per HCFC (2012 edition of NFPA 99)
 - Emergency power system inspection, testing and maintenance requirements of the HCFC
 - Onsite fuel source to power emergency generators and plan for how to keep emergency power systems operational during the emergency, unless the facility evacuates




House Bill 264

- House Bill 264 – Carbon Monoxide Alarms
- Signed into law by Governor Wolf on June 23, 2016 with a 90 day effective date
- By September 24, 2016, all nursing homes must comply, and the Department of Health is to enforce compliance




House Bill 264

- Installation
- An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance
- If the approved carbon monoxide alarm cannot be heard by the staff on duty on a specific floor or wing of the facility, a single approved carbon monoxide alarm shall be installed where it can be heard by the staff on duty in addition to the alarm installed




House Bill 264

- Installation
- If there are resident living units or bedrooms located between a fossil fuel burning appliance and any additional approved carbon monoxide alarm required, a single additional approved carbon monoxide alarm shall be installed in a central location on the same level as the resident living units or bedrooms




House Bill 264

- Testing and replacement
- Carbon monoxide detectors and alarm systems installed at a care facility shall be tested and cleaned as indicated in the manufacturer's guidelines
- If the unit operates by a battery, the battery may not be removed for any length of time beyond that necessary to change the battery
- The battery shall be labeled with the date of installation and replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner




House Bill 264

- Evacuation and alarm protocols
- In the event that an alarm sounds, the care facility staff shall:
 - Take immediate action to introduce fresh outside air into the care facility by opening available windows and doors, where not an additional risk to residents
 - Contact emergency services in accordance with the care facility's written policies and procedures relating to carbon monoxide alarms and evacuations




House Bill 264

- Evacuation and alarm protocols continued
 - Move residents to the nearest source of fresh outside air, account for all residents and remain with the residents until first responders arrive and assess the need for evacuation
 - Evacuate residents when first responders consider an evacuation necessary





House Bill 264

- Nothing in this act shall be construed to require care facilities to conduct drills specific to carbon monoxide
- Note: If alarms are installed as a detection system, it must comply with NFPA 72 and NFPA 720
- Note: If the facility must contact emergency services per facility policy, then it must have a policy in place



Questions?



Resources

- DNCF 717-787-1816
- DSI 717-787-1911
- Message Board
 - <https://sais.health.pa.gov/commonpoc/Login/Login.aspx>
- CMS Website
 - www.cms.hhs.gov
- State Operations Manual
 - http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_tcf.pdf

