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CMS PROPOSES TO ADOPT UPDATED LIFE SAFETY CODE STANDARDS

Recently, the Centers for Medicare & Medicaid Services ("CMS") published a proposed rule to update fire safety standards for certain types of facilities ("Proposed Rule"). In the Proposed Rule, CMS proposes to adopt the 2012 Life Safety Code ("LSC"), with certain exceptions discussed below, to replace the 2000 version currently required by the Conditions of Participation and Conditions for Coverage.

Even though CMS has stated that the updated LSC standards will reduce the burden on facilities and will increase safety for patients, family and staff, some think that the Proposed Rule does not create clear standards regarding occupancy and have concerns regarding possible interpretive issues. We have summarized some of these issues in this article. However, because the changes in the Proposed Rule could require time and expense for providers to update their facilities, providers should take the time now to carefully review the guidance and standards in the Proposed Rule since providers have an opportunity to provide their input by commenting.

BACKGROUND

The LSC is issued by the National Fire Protection Association and sets out building standards for new and existing buildings. Currently, CMS generally applies the 2000 edition of the LSC to facilities, but CMS has proposed to adopt the most recent edition released in 2012. Because state and local agencies often utilize more recent versions as they become available, newer buildings are typically built to comply with newer versions of the LSC, so the Proposed Rule should bring CMS's standards in line with those agencies.

The adoption of the 2012 LSC will affect most type of health care facilities including: hospitals, critical access hospitals ("CAHs"), long-term care facilities, Programs for All Inclusive Care for the Elderly, religious non-medical health care institutions, hospice inpatient facilities, ambulatory surgical centers ("ASCs") and intermediate care facilities for individuals with intellectual disabilities. Buildings constructed before the effective date of the final rule implementing these changes will be required to meet the existing occupancy requirements of the LSC. The Proposed Rule also states that buildings that have not received all pre-construction government approvals and those that begin construction after the effective date of the final rule would be required to meet the new occupancy requirements. Although not expressly stated, this seems to imply that a building that has received all pre-construction government approvals and those that have begun construction before the effective date of the final rule would be required to meet the existing occupancy requirements.

The LSC breaks down occupancy standards that a facility must meet based on the types of services the facility offers and the types of patients the facility serves and are often tied to a minimum number of patients served by the facility. The most relevant occupancy types for health care facilities are health care occupancy, ambulatory health care occupancy, residential board and care occupancy and business occupancy. For example, the LSC provides that health care occupancy applies to facilities providing medical care or other treatment to four or more patients at the same time on an inpatient basis and such patients are mostly incapable of self-preservation, and the ambulatory health care occupancy standard applies when a facility simultaneously treats four or more patients on an outpatient basis and the treatment, the application of anesthesia or the nature of the patient's condition renders the patient incapable of taking action for self-preservation.

As further described below, CMS addresses the occupancy standards, in part, because it previously released a memo to State Survey Agency Directors (originally released on December 17, 2010 and revised on February 18, 2011) ("Memo") that provided guidance on occupancy requirements for hospitals and CAHs. Similar to the Proposed Rule, CMS indicated that the guidance in the Memo was intended to provide flexibility to hospitals and CAHs and that the occupancy classifications must be determined regardless of the number of patients served at a hospital or CAH. In addition, the Memo provided a list of criteria for the various occupancy classifications, some of which were not contained in the LSC. State regulators and industry groups interpreted the guidance in the Memo as being more onerous than prior guidance. Subsequent correspondence with CMS representatives created further confusion. As a result, CMS did not incorporate the Memo into the Medicare State Operations Manual as originally intended. Therefore, CMS is attempting to clarify the application of the LSC standards to heath care facilities in this Proposed Rule.

OCCUPANCY REQUIREMENTS

Even though the LSC applies the different standards to facilities based on the number of patients being treated, in the Proposed Rule, CMS stated that it will apply occupancy requirements regardless of the number of patients served by a facility. CMS proposes:

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1. Facility must meet the health care occupancy standards in the 2012 LSC (the highest standards for facilities) if it treats a single inpatient. We understand that this standard is intended to be limited to inpatient bed areas/towers, but it is not clear in the Proposed Rule.

2. ASCs and outpatient surgery centers must satisfy the ambulatory health care occupancy standard if even one patient is incapable of self-preservation.

CMS's explanations in the Proposed Rule are confusing because of the use of the terms such as "health care occupancy" and "facility." In some cases it is not clear if "health care occupancy" refers to the specific standard (*i.e.,* the highest LSC standard that applies to health care facilities) or the standards for health care occupancy in general. Additionally, the term "facility" could refer to a portion of a hospital building or the entire building. For example, in the Proposed Rule, CMS states that all ASCs and hospital outpatient surgical departments must meet the ambulatory health care occupancy requirements. It is unclear from the language of the Proposed Rule whether hospital outpatient surgical departments or other hospital outpatient space would be required to meet the health care occupancy requirements if even one inpatient is treated in that space. This creates confusion as to which occupancy requirements apply to hospital space that is not used primarily for inpatient services.

NOTABLE CHANGES FROM THE 2000 LSC

The Proposed Rule and the 2012 LSC make the following important changes from the current LSC standards:

- Allows for increased suite sizes;
- Requires all facilities over 75 feet in height to be sprinklered within 12 years;
- Allows controlled access doors to protect wandering patients;
- Allows for more types of alcohol based hand rub dispensers;
- Requires a fire watch or building evacuation if a sprinkler system is not working for 4 hours in a 24-hour period; and
- Requires smoke control in anesthetizing rooms.

NOTABLE EXCEPTIONS FROM THE 2012 LSC

In the Proposed Rule, CMS is generally adopting the 2012 LSC. However, CMS has incorporated certain exceptions to the 2012 LSC in the Proposed Rule, including the following:

- As described above, CMS will apply the occupancy requirements regardless of the number of patients served by a facility.
- Facilities must comply with the Americans with Disabilities Act requirement for non-continuous projections to be no more than four inches from the corridor wall, as opposed to six inches under the 2012 LSC.
- The Proposed Rule prohibits roller latches for all facilities except ASCs even though they are allowed under the 2012 LSC.
- The Proposed Rule would require the evacuation of a building or instituting of a fire watch if a sprinkler system is out for more than 4 hours in a 24 hour period in comparison to 10 hours in the 2012 LSC.
- The 2012 LSC does not have a requirement for outside windows or doors in every sleeping room in a health care occupancy setting. Under the Proposed Rule, CMS would require all sleeping rooms, except newborn nurseries and rooms intended for occupancy for less than 24 hours, to have an outside window or door with a sill height of 36 inches or less from the floor or 60 inches for special nursing care areas.
- CMS would require hospitals, CAHs and ASCs to have supply and exhaust systems in windowless anesthetizing locations. There is no such requirement in the 2012 LSC.

PRACTICAL TAKEAWAYS

1. If CMS implements the Proposed Rule as currently written, facilities would be required to meet the applicable requirements of the 2012 LSC, except as outlined in the Proposed Rule. Facilities should review the Proposed Rule to assess the impact on its locations and proposed construction projects. Hospitals should remember that provider-based locations are also required to satisfy the appropriate

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provisions of the LSC.

2. The American Hospital Association and other industry groups are soliciting feedback regarding the Proposed Rule. Facilities should carefully review the Proposed Rule and consider providing feedback to these groups or submitting their own comments to CMS. Comments are due by June 16.

The Proposed Rule is available here.

If you have any questions or would like additional information about this topic, please contact:

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