Questions and Answers from Nursing Homes Educational Seminars February 2008

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Fire Safety Q&A:

1. If you lock the front doors with a key lock but have other exit doors in a single story facility that are accessible, is this still a deficiency, if staff are not present on the floor with a key?

Answer: Yes, unless special approval is granted for a special locking device on the front door. (19.2.2.2.4 NFPA 101)

2. When can exit door be locked, even when all staff has a key?

Answer: Chapter 7 of NFPA 101 speaks to means of egress. It does give the allowance for doors to be locked, provided all staff, every shift have a key on their person. The facility would have to write a letter and have approval from the Engineering Department to do this. The letter would have to explain what type of locking system is in use. All staff would have to be in serviced on this and have monitoring by the facility that keys are maintained on their person while at work. This would be checked on survey.

Survey Process:

3. If a "deficiency" is found by staff and corrective measure took place then a survey ensues and surveyors "find the deficiency" and the facility is able to show a PoC that has been in place and working will a "tag" still ensue?

Answer: If the problem was egregious and resulted in either serious harm or death or the potential for serious harm or death to the resident(s), but there was sufficient evidence that the facility corrected the non-compliance and is in substantial compliance at the time of the current survey, the facility will be cited at an immediate jeopardy level for past non-compliance. The Civil Monetary Penalty would be assessed as a per-incidence and a plan of correction would not be required since the facility was already in substantial compliance.

4. Why do some surveyors drill you to say there is a problem and then cite you for saying you have a problem? Just cite problem!

Answer: Survey protocols require that essential interviews be conducted to ascertain this information: did the facility know or should the facility have known about a particular incident or situation (culpability)? This is part of the fact finding required by federal protocols.

5. Are revisits required on deficiencies cited with scope and severity levels of D, E, and F when no G and IJ scope and severities are involved?

Answer: Revisits can occur on any deficiencies cited at a "D" level scope and severity or above. Revisits are required for Substandard Care, Harm and Immediate Jeopardy level deficiencies. The definition of substandard care is:

"A deficiency cited in following the federal regulations that is a pattern or widespread for harm or above or that is widespread for no more than minimal harm at 42 CFR 483.13, 42 CFR 483.15 or 42 CFR 483.25." This means that a deficiency in any of these three areas even at an "F" scope and severity constitutes substandard care and would require an onsite revisit to verify compliance.

6. The "698" past noncompliance is no longer cited. How far back can the surveyor review and cite an IJ tag – can the surveyor go beyond the facility's previous recertification survey?

Answer: Past non-compliance is still cited but infrequently. Tag "698" is no longer used; the past non-compliance would be cited at the appropriate F tag number. The surveyor can go beyond the facility's last recertification date if investigating a complaint.

7. Please clarify the department's follow-up survey policy.

Answer: The following is the department's policy and is reflective of the federal requirements:

No follow-ups are required for "A", "B" and "C" scope and severity level deficiencies. Follow-up revisits can occur on any deficiencies cited at a "D" scope and severity level or above. Follow-up revisits are required for Substandard Quality of Care, Harm and Immediate Jeopardy level deficiencies. The follow-up would not occur until after the facility's alleged compliance date.

8. In what time frame will the extended or expanded survey be completed?

Answer: If surveyors suspect Substandard Quality of Care (SQC), they expand the survey sample as necessary to determine if "SQC" exists and at what scope. If surveyors determine a situation constitutes an Immediate Jeopardy, the survey team will complete the entire survey then conduct an extended survey. The extended survey normally occurs on the last consecutive day of the survey. If the survey team is unable to conduct the extended survey concurrent with the standard survey or complaint survey, it can be completed no later than 2 weeks after the survey ended.

9. The surveyor goes into facilities all over the state of TN. They see problems, they review the PoC's and approve them (or CMS does). Why is it they cannot tell you how to correct it or even give acceptable solutions? Why can they not give you suggestions?

Answer: The role of the State Survey Agency is that of regulators and as such this precludes any surveyor from being a consultant. If you wish guidance, CMS has provided to you, free of charge, a CMS contractor who is in that role. For Tennessee that contractor is Q-Source. Please refer to the website below to contact Q-Source.

http://www.qsource.org/

10. How is the facility supposed to respond to each individual deficiency when the surveyors' findings are cut and pasted from another deficiency?

Answer: Some areas of the findings may be the same for more than one deficiency, but each deficiency is cited due to noncompliance with the particular, individual regulation. For example, a deficiency may be cited at F314 Pressure sores with findings on several resident identifiers. The residents identified may not have been assessed for pressure sores nor were those residents care planned for pressure sores with identified approaches. The findings pertaining to these residents not assessed would be in the assessment deficiency. The findings for not care planning would also be in the care plan deficiency. Each of these three deficiencies are inter-related by some of the same deficient practices and may be cross referenced in the writing of the Statement of Deficiencies as directed by CMS and found in The Principles of Documentation. When the facility responds to each deficiency, each plan of correction must show in detail how each deficient practice will be corrected. A cross reference is not allowed since it would not be specific to each correction. When reviewing the form CMS 2567, the first statement after the regulatory requirement is the deficient practice statement and is a summary of the deficient practice for that individual deficiency. The requirement for facilities when formulating either a PoC or AoC requires that the facility address how the deficient practice for each individual deficiency is corrected and no cross reference is allowed by CMS.

11. When do you anticipate TN moving toward QIS surveys?

Answer: Tennessee will conduct QIS surveys when implemented by CMS. CMS is in the process of implementation of this new survey process to selected states and will implement all states following federal budget allocations.

12. What is the difference between a "certified" surveyor and a non-certified surveyor?

Answer: A non-certified surveyor has not completed or passed the Surveyor Minimum Qualifying Test (SMQT).

13. What is the time frame for TDH to get a facility the SOD?

Answer: In cases of enforcement, the state's time-frames are relative to compliance with CMS time-frames that revolve around specific guidance from CMS. For cases that do not involve enforcement the State Survey Agency has 10 business days to send the SOD to a facility. All time-frames are monitored by CMS. Please refer to: SOM 7307, 7308, 7304B, 7313, and 7305.

14. If we get an F tag with S/S of D, we cannot IDR this, but if we disagree with

portions of the citation, what recourse do we have on our PoC?

Answer: You may request a desk review from your Regional office. All deficiencies written are subject to an appeal process either by Direct IDRs (High level deficiencies) and Indirect IDRs (lower level deficiencies). Please contact your Regional Office if you have a question as to which type of IDR you may request for a particular deficiency.

15. Do you send our PoC acceptance on all surveys?

Answer: Yes except Level I (Scope and severities of A, B, and C which do not require a PoC.

16. Survey teams used to exit with staff and give the deficiencies & we were able to start working on PoC. Now they do not give any information and the clock is ticking.

Answer: Since the survey team interacts with all staff during the survey process, the facility should always be aware of what is being reviewed at any given time by the survey team. Your staff should immediately inform management of all interactions they have with the survey teams. The survey process does not require the surveyors to give specific tags on exit but to only give the global concerns identified. You will be informed of the specific problems identified with IJ on exit so that you may start to work on your AoC/PoC but you will no longer be given specific tag numbers since they are subject to change as well as additional IJ citations after the QA process.

17. Does the survey focus require perfection?

Answer: No. The survey focus is only on the minimum standards applicable to facilities, as determined by state and federal regulations.

Immediate Jeopardy:

18. What are examples of findings that would be considered evidence of immediate jeopardy under F-250 Social Services?

Answer: An example is when residents with decreased mental capacities are not provided with appropriate medically related social service interventions such as behavior management with protection for the resident and/or other residents and related psychiatric services. This lack of intervention would be reviewed by surveyors through observations, record reviews, and interviews to determine the noncompliance, and if the behaviors of the residents were found to meet the definition of Immediate Jeopardy and social services had not provided or had delayed in providing services, then social services would be cited at Immediate Jeopardy along with any other deficiency tags associated with this lack of or delay of services.

19. When jeopardy is cited retroactive 2 to 4 months during the 2-4 month period there were only isolated incidents <5 other residents.

    a. Why does jeopardy go retroactive 6-120 days or more?

    b. Jeopardy (from day 1 of survey) for 1 day creates the same urgency – AoC & PoC and corrective action, why retroactive?

Answer:

a. IJ begins when the deficient practice started that caused the Immediate Jeopardy.

b. Although the surveyor may identify IJ during the survey the non-compliance issue will go back to the date the issue started.

20. When jeopardy is cited –

    a. Center has been trying to discharge non-compliant-sexually active-or behavior pt. and documents this – no placement can be located – even though still trying.

    b. Survey comes in – finds same problem – reason why we have been trying to DC pt.

    c. Patient and family have appealed discharge.

    d. Where is rationale for citing jeopardy in this situation?

Answer: If a facility did not provide all behavioral and medically necessary interventions possible for a non-compliant sexually active/behavior resident, and did not provide supervision as needed to protect this resident and other residents from harm, and the facility proceeded immediately to discharge the resident, the facility could be cited at a jeopardy level.

21. A statement was made that the State Operations Manual for CMS states that IJ would be situations that would **likely be** harm, injury or death. The term potential, then, high potential is used in Appendix Q and in IJ deficiencies. There is a big difference in likely to be and high potential. An example is that, if I bought a lottery ticket, I would have the potential to win the lottery, but I would not be likely to win. I request this be brought to the attention of the Department and CMS.

Answer: Immediate Jeopardy is defined as “A situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.” This definition in the Appendix Q is used since it directly refers to the CFR language which is the law and not an interpretation of the law. Please see: 42

CFR Part 489.3 We also would like to refer you to the triggers found in Appendix Q which require the surveyors to review for immediate jeopardy situations should any of these non all inclusive triggers be found in a facility. You will also find situations described in Appendix Q which illustrate some situations, if found, may or may not be IJ and the reasons the particular situation may or may not be IJ. These situations are part of surveyor training and would be well use by facilities as part of their staff training on Immediate Jeopardy Situations. Please go to this website to download the entire appendix Q:

http://cms.hhs.gov/manuals/Downloads/som107ap_q_immedjeopardy.pdf

22. Please explain how the facility scope and severity increases from D level to J after the surveyors on site leave the building. This does not give the facility "due process" to try to alleviate a "crisis" situation and should be stated before exit.

Answer: There is a supervisory review process with the State Survey Agency and CMS that occurs after the Statement of Deficiencies is written. If during or upon this review, it is determined that we need further clarification and review in order to determine that the appropriate deficiency/deficiencies and scopes and severities have been cited, we may extend and expand our survey. In order to make that determination, we must re-enter the facility and extend the survey. We can re-enter a facility up to 10 days from the original exit date.

23. Please explain the differences in scope and severity for the same situations. One will be cited at a D and another at a J.

Answer: In the determination of immediate jeopardy there are strict guidelines that must be met before a survey team can call IJ. One of the criteria is Culpability. The survey team must be able to prove that the facility either knew or should have known about this situation prior them calling IJ. This is only one of the criteria. Please refer to Appendix Q for further guidance. It can be found at:

http://cms.hhs.gov/manuals/Downloads/som107ap_q_immedjeopardy.pdf

24. Complaint is filed about improper feeding of individual. Survey indicates the evidence of improper feeding for several days but facility "caught it" and implemented new procedures to correct. No more evidence of problems. Is that an IJ?

Answer: That would depend. Did the resident have any choking episodes or have a diagnosis of Aspiration Pneumonia? Are there any other residents in the facility with the potential for this to occur? If none what process has the facility put into place to prevent this from occurring in the future? Who is monitoring the actions and what training has been implemented to current staff, pool staff, part time staff etc.? The survey team would follow the process

and continue their investigation until it is either confirmed or ruled out if an Immediate Jeopardy.

Allegations of Compliance/Plans of Correction:

25. It was mentioned that facilities don't have to do an AoC, can just due a PoC instead – what is the advantage of doing only a PoC – why not do an AoC?

Answer: When an Immediate Jeopardy (IJ) is cited, the facility is placed on a fast track to termination. This time-frame can be as short as 2 business days and only as long 23 calendar days but no longer. The reason for the fast time frame for termination is to get the facility to correct the immediacy of the situation that led to the citation of immediate jeopardy. The facility must make a decision on which to submit to correct the immediacy of the IJ deficiencies. Here is the information needed to make an educated decision as to which to submit:

Allegation of Compliance (AoC)	Plan of Correction (PoC)
Only applies to Immediate Jeopardy Tags	**Applies to either IJ or Non-IJ Tags**
1. If the AoC plan is acceptable by both CMS and the State Survey Agency 2. Only IJ tags are reviewed. 3. The State Survey Agency must find on revisit within the time-frame imposed by CMS that the facility has removed the immediacy or has corrected the deficiency, the facility then goes into the standard 6 month termination track. 4. The CMP will be lowered but will continue until all deficiencies are corrected. 5. The revisit for the AoC constitutes the first revisit of two that the State Agency is authorized to conduct. 6. A PoC would then have to be submitted by the facility to correct all other deficiencies which would be reviewed only by the State Agency and a revisit conducted on the PoC. This would constitute the second revisit. 7. If any of the deficiencies were not corrected a third revisit could not be conducted until a comprehensive review by CMS as to why a third revisit should be allowed. If CMS were not to allow this third revisit, the facility would terminate at the end of the 6 month termination track.	1. Must be submitted during same time-frame as the requirement for the AoC. 2. More prone to not having all plans for each individual deficiency accepted by CMS and the State Agency since all deficiencies must be reviewed by both CMS and the State Agency. 3. Requires much more time for facility to write due to number of deficiencies that must be covered. 4. If the PoC for all deficiencies is accepted by CMS and the State Survey Agency, a revisit will be conducted that will review both IJ and lower level deficiencies. If the IJ is either corrected or the immediacy removed but all the deficiencies are not corrected the facility will go back to the 6 month termination track and the CMP will be lowered but will continue until the facility is found to be in substantial compliance. This would constitute the first revisit. 5. This allows the facility to have one more revisit (the second revisit) that the State Agency is authorized to conduct. 6. During the second revisit should the facility not be in substantial compliance, it would then be in a third revisit status as addressed in item 7.

26. If a facility sends in AoC and its approved by all parties and reduced to a lower level, should the facility wait to send in the PoC after the follow-up for

AoC or at least after the facility has received a revised PoC from the state reflecting a reduction of IJ?

Answer: The facility should wait to submit its plan of correction until the SA sends a revised Form CMS-2567 (statement of deficiencies) citing the Jeopardy tags at the lower scope and severity. The Form CMS-2567 would also include all non-jeopardy tags cited on the survey and not addressed on the facility's AoC.

27. Why are survey PoC acceptance letters taking so long to return? I'm referring to surveys that have no harm or IJ. It leaves surveys open too long. Is there a time limit that the state is required to return?

Answer: The RO attempts to return PoC acceptance letters within 2-4 weeks of an on-site follow-up or an administrative review.

28. If jeopardy is identified on day 1 or 2 of a 3 day survey can an AoC be submitted and jeopardy removed before survey team leaves on day 2?

Answer: If the facility is able to immediately implement corrective measures that include the prevention of repeat Jeopardy situations of this deficient practice, the facility could correct the Immediate Jeopardy before the survey team leaves the facility. The facility should provide evidence of its implementation of corrective measures which will be sent to CMS for its review and acceptance. If accepted, prior to the exit of the survey the survey team will confirm by comprehensive review just like a revisit that the IJ has been removed. If the facility was successful in removing the IJ, the Surveyors must still cite the IJ deficient practice(s) on the Form CMS 2567 and document evidence of the facility's actions, including dates that indicate that the facility has removed the Immediate Jeopardy and corrected the deficient practice.

29. Where can we get more information on AoC?

Answer: Copy/paste the following to your web browser:

http://cms.hhs.gov/manuals/Downloads/som107ap_q_immedjeopardy.pdf

30. F490 is usually cited because of multiple other tags. If you don't want to cut and paste, how would you suggest that the Administrator answer since each part of those individual deficiencies is what was done to correct?

Answer: The F490 deficiency is cited for failure of the facility to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Administrator would have to respond to the deficiency and to each of any referred deficiency, to ensure the facility is in compliance. Not all the entire PoC/AoC from each deficiency would have to be documented in the F490 tag, or cut and pasted. The Administrator

would need to respond how he/she is providing oversight, monitoring, participating in, for example, daily stand up rounds, weekly or monthly committee meetings, reviewing monitoring reports of other staff assigned, etc., to ensure compliance with the other tags referred.

31. Is it okay to state on the PoC that a specific tag is undergoing or requesting IDR review?

Answer: No. To request an IDR according to Health Care Facility Policy 0210: "Request must be made within the same 10 calendar day period that the provider has for submitting an acceptable plan of correction and must contain additional justification as to why the deficiency(s) should not have been written for harm level deficiencies or other deficiencies that are not substandard or immediate jeopardy. Evidence to dispute the scope and severity levels may only be submitted for substandard or immediate jeopardy deficiencies. If the facility is requesting a desk review in addition to a face to face IDR, the facility must submit two separate requests with their plan of correction. The additional justification to support either a desk review or face to face IDR must be submitted with the plan of correction and shall consist of no more than five (5) typed pages with a font size of not less than ten (10)." It is not acceptable to place your request for an IDR in the 2567 or cover letter sent with the PoC. They are two separate survey processes with the same time frame for submission and must be kept separate.

32. Once IDT team member or QA members are mentioned by title, is it necessary to report that same information time after time when using IDT QA, CQI, etc?

Answer: Each deficiency must stand on its own. Therefore, you will need to state the disciplines for each committee, team, etc. that you note on your PoC.

33. Is there any particular format required for an AoC? Is there a specific time in which an AoC is required?

Answer: The AoC time frame is the same 10 day period as a PoC; however, it is to the facility's advantage to present its AoC to the State and CMS as soon as possible, for there may need to be clarification and revisions. The facility must also realize that 23 days is the maximum time given by CMS prior to termination. The time-frame can be as short as 2 days or any number between 2 and 23 days. If you should wait until 2 days prior to termination and the revisit finds anything in your AoC not corrected, it is not enough time for another AoC and revisit. In that instance, CMS will terminate your facility. You also need to keep in mind your completion dates on your AoC. It is possible to have your AoC submitted and accepted with ample time for a revisit but the State Agency cannot go back in because your completion date is listed 2 days before your termination.

34. Once a PoC is written and accepted and the facility begins working the PoC

what should be done if the facility determines that the PoC is not working and needs to be changed. Does the State need to be contacted, or is an internal QA process adequate?

Answer: If you decide that the PoC that you have presented is not practical or you decide to augment it, then YES, you need to contact the State and/or CMS (if enforcement is involved). You will be surveyed on what you have documented in your PoC and if you are not following your PoC, this may become problematic in achieving a successful re-visit.

35. PoC/AoC. Can nursing personnel monitor IJ nursing issues? Or any other department for that matter monitor themselves?

Answer: There still needs to be someone else to monitor oversight. For example, if the Administrator tag is cited, who will monitor the corrections that are being made? This monitor cannot be the Administrator. Direct care staff can collect data but cannot effectively monitor themselves. Another source will have to evaluate and monitor the data that is collected.

36. Will CMS consider an AoC before they receive the SOD?

Answer: Yes, especially when the facility wants to expedite the removal of its Immediate Jeopardy.

Unusual Incident Reporting System (UIRS):

37. If a facility does a self-report to SA and surveyor comes to investigate after the facility has had an annual survey and found to be in compliance; why would a deficiency be cited regarding a self-report that occurred in the past before the survey was done; but the facility got cited a Fed. Tag when they thought everything had been corrected?

Answer: If a self-report (UIRS) rises to the level of a potential violation of any Condition of Participation (COP) it must be entered into the Federal Complaint/Incident Tracking System as a self-reported incident and then be investigated using federal protocols. If a violation of a COP has occurred a deficiency must be cited. Just as complaints, self reported incidents, under federal protocols, must be investigated even if they go beyond the last standard (annual) survey.

38. Why are unusual events submitted not being closed? Have one from July 2007 and one from August 2007, but have not been notified of any problem with CAPS. I called state and was told no one has had a chance to look at it

Answer: All corrective actions plans are reviewed and closed by the Regional Offices as time and staffing permits. For any “CAPS” older than four months,

that have not been accepted and closed, please call the RO and ask for a supervisor to assist in getting the "CAPS" closed.

ETRO Supervisors	MTRO Supervisors	WTRO Supervisors
Mary Ann Dyke	**Diane Carter**	**Jan Priddy**
Vicky Frazier	**Leonard Robinson**	**Celia Skelley**
Karen Kirby	**Philipa Reed-Wilkins**	**Hope Forderhase**

39. If a resident hits another resident, but does not cause any injury, are we required to report an unusual incident and do an investigative analysis on this resident? What types of resident to resident contact is reportable as unusual incidents?

Answer: For state licensure, the Interpretive Guidelines for Reporting Unusual Events, revised January 2005, for occurrence code 964, notes the inclusion for reporting purposes of, "Resident/Patient to Resident/Patient altercations (nursing homes, Homes for the Aged, ACLF, A&D facilities would only report those that required physician intervention)." It excludes from reporting, "Non-physician interventions and appropriate facility interventions." The occurrence code for 968 is Physical Abuse, for 969 is Sexual Abuse, for 970 is Verbal Abuse, for 971 is Neglect or Self-Neglect and for 972 is Misappropriation of Funds. Definitions of abuse, neglect and misappropriation are included. The definition of Abuse is, "The willful infliction of injury, unreasonable confinement, and intimidation, punishment with resulting physical harm, pain, or mental anguish."

It should be noted that the federal regulations are more stringent than the state regulations. The regulation at F223 – Abuse states, "the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." The intent is that, "…Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, **other residents**, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals."

At F224, the regulation states, "The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property". The intent "…includes the facility's identification of residents whose personal histories render them at risk for abusing other residents, and development of intervention strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior and reassessment of the interventions on a regular basis."

At F226, the intent of the regulation is that, "The facility must develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property…." The facility must have, "procedures to: Report all **alleged** violations and all substantiated incidents to the state agency and to all other agencies as

required, and take all necessary corrective actions depending on the results of the investigation…."

At F225, the regulation states at CFR 483.13(c) (2), "The facility …must ensure that all **alleged violations** involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)."

CFR 483.13 (c) (3) states that, "The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress." It further states, "…States may not eliminate the obligation for any of the alleged violations (i.e., mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property) to be reported, not [nor] can the State extablish [establish] longer time frames for reporting than mandated in the regulations at 483.13 (c) (2) and (4). No state can override the obligation of the nursing home to fulfill the requirements under 483.13 (c), so long as the Medicare/Medicaid certification is in place."

40. Will you have a seminar on URIS [UIRS]? I think this would be beneficial to us.

Answer: The Department of Health intends to hold frequent training sessions to facilities throughout the year. This will be one of the topics discussed in upcoming sessions.

41. Do we report all alleged abuse, i.e. resident to resident altercation with dementia diagnosis?

Answer: Yes.

Miscellaneous/Other:

42. Could we get a list of nursing homes with secured units?

Answer: Please call your Regional Office for a list.

43. Interventions for falls: After <u>all</u> interventions have been tried and the resident continues to fall what should be done to try to prevent them?

Answer: The facility must continue to re-assess the resident after all falls and put interventions in place. An intervention that did not work in the past might be appropriate now. There are always different interventions to try.

44. If one situation affects only one resident and no other resident has the potential from being affected, why can't we start training for that one resident at the time of the incident to prevent an on-going fine?

Answer: At the time of the incident, the facility has not fully investigated the situation to determine how many residents have the potential to be affected. The scope of the problem must be determined by investigation and assessment of all other residents with the potential to be at risk. You must remember that a situation may only affect one resident in your facility, but this situation may still have the potential to affect other residents in a similar situation that might be admitted to your facility in the future. You must also address how you will keep similar situations from affecting any other residents in the future. Since you may have to write or change policies or procedures you may not be able to correct immediately. An example would be that you have a behavior resident who is in harm to them self or others. You send the resident out of the facility. You still have not corrected the deficiency since you have not addressed future such situations.

45. Does having osteopenia exclude facilities from reporting fractures as well as osteoporosis?

Answer: If you are referring to UIRS reporting please go to the Department of Health Website and then drill down to Health Care Facilities then to Unusual Event Reporting Requirements where you may down load and print an Unusual Event Manual to guide you in state reporting requirements. If you are referring to federal requirements then all unusual events are required to be reported to the state survey agency. You may contact our centralized complaint hot line and request to speak to the hotline supervisor for more guidance on the federal and state guidelines. If the supervisor is not available please ask for the manager of the Unit. The toll free number is: 1-877-287-0010.

46. Please address if any citations that could be passed for lack of use of restraints on a resident with multiple failed interventions -- increased falls.

Answer: Whenever a resident fall occurs, an assessment must be conducted and new interventions implemented. Documentation of such interventions, including the use of any restraint device, should be evident of this being the least restrictive intervention for that particular resident according to the latest assessment.

47. Our facility is on CMS watch list for high risk pressure ulcers (presently 7 admitted with and 0 acquired). Do we need to stop admitting resident with PU?

Answer: No, if you are capable of caring for this type of resident then you should not deny admission. Please refer to the answer to question number 28 for your answer to what you refer to "watch list".

48. There is an increase in number of behavioral resident referrals from other facilities usually after a resident to resident altercations and a brief psych stay. We do have a behavioral unit (Alzheimer's unit) and typically do very well with these residents. Are we placing ourselves and our residents in jeopardy by admitting them? Being in a small town with excess of NH beds, we usually have beds available—yet Linton Law ties our hands on admission "1st com 1st served". We've had really good surveys and want to keep having good surveys.

Answer: First, do you have a behavioral unit or an Alzheimer's unit? There is a difference. Prior to admitting a resident, it would behoove you to perform an onsite visit at their home or other facility. You should observe and interview (if possible) the potential resident, interview family members and caretakers, do a thorough medical record review. This all, is in an effort to determine if they are an appropriate placement for your unit. If placement is still questionable, involve your Psych. Services and/or Social Worker.

49. What do we do if we have an aggressive resident that no other facility will accept D/T their behaviors?

Answer: If the resident is deemed by their physician or your Medical Director that they are danger to themselves or others, then you have a responsibility to find other placement. Until that placement is found, you may have to implement interventions that will protect that resident or others and that will ensure their safety, including the possibility of one to one supervision.

50. On Sliding Scale Formulas: Can we use the formulas and make up a grid that is accurate so nurses do not need to calculate i.e. Bs = 310 use formula then use amount of units indicated? Each MD uses a different formula.

Answer: You must ensure that the physician's orders are followed and that the calculations are correct. If you need a grid to do so, there should not be a problem as long as there is monitoring, staff is appropriately trained, and correct doses and physician notifications are ensured.

51. Are feeder tables allowed by the State of TN? Will TN ever go to the restraint free policy, i.e. including side rails?

Answer: Feeder Tables are allowed. CMS has not issued any requirements for a restraint free policy.

52. What are alternatives to Mobile Crisis if we have combative resident that we are unable to control but Mobile Crisis won't come?

Answer: In situations where the resident is considered dangerous to him- or herself or others, there is an immediate need for response. The facility may

have to contact law enforcement to ensure safety if Mobile Crisis is not available.

Top 10 & Lists:

53. Please give us again a list of the top 10 cited tags for East Tennessee.

Answer:
F-490 Administration
F-323 Accidents/Supervision (F-323 and F-324 combined)
F-309 Necessary Care and Services in Accordance with Assessment and POC
F-157 Notification of Physician and/or Family
F-520 Quality Assessment and Assurance (QA)
F-353 Nursing Services – Sufficient Staffing
F-501 Medical Director
F-333 Medication Errors
F-281 Services Provided Must Meet Professional Standards of Quality
F-314 Pressure Sores

54. The new CMS list of 101 nursing homes had a posting of high risk pressure ulcers and restraints. Where does this derive from? How does a facility get off the list? Stay off the list?

Answer: This list of 101 nursing homes was not a list published or posted by the CMS Division of Survey and Certification but was a list posted by the Quality Unit of CMS. This list was not designed to point fingers or create a "poor performing" list of nursing homes. The CMS Quality Unit, a separate unit of CMS, in following the federal guidelines for opening bids for a federal contract, had to supply a list of potential nursing homes that could be selected for the next scope of practice for a contract that was being opened for Quality Improvement Programs such as the QIO Organizations. CMS Quality Division had to open this to all Quality Organizations in the nation thus a list had to be published so that bids for all quality organizations could formulate costs in order to accurately bid for the contract. CMS had a Nationwide Telecast with facilities to explain this list and its purpose. The Tennessee Provider Organizations as well as many facilities were on this call. This is a similar process that State Governments have to use when opening bids for contracts. Again this list was not a Survey and Certification Process and should not be confused with the Special Focus Facilities of which Tennessee has three special focus facilities. The Special Focus Facilities are a Survey and Survey Process.

55. Can you give examples of the top 10 deficiencies (maybe 2 or 3 for each one, presentations pg. 19?

Answer: As stated in the oral presentation, the majority of the deficiencies cited, relate to behavior issues (including resident to resident altercations) these usually have not been addressed by the facility and the facility has no

evidence that interventions or appropriate interventions after each incident/accident involving a resident. The Social Services Director not addressing the behavioral issues. Lack of assessments after altercations or incidents is one example. The facility not notifying the physicians, Power of Attorneys when there is a change in condition in the resident's health. Not addressing these issues in the Care Planning process and basic care and services that should have been rendered to the residents.

ATTACHMENTS

A. EXIT INTERVIEW HANDOUT

B. CMS LIFE SAFETY QUESTIONS AND ANSWERS

C. RELATED WEB PRESENTATION LINKS

ATTACHMENT A

Task 7 Exit Conference

- Objective of Exit Conference: to inform the facility of the survey team's observations and preliminary findings.

- The following persons will be invited to the exit conference: Ombudsman, an officer of an organized resident group (if one exists), one or two residents, and staff as invited by the facility administrator.

- An explanation of the preliminary findings will be given in an understandable manner with no identity of any individual resident given.

- Information provided will be given such as: the team found problems that relate to the development of pressure sores. We will not say Tag F-314 has been cited at a specific scope and severity.

- The team will let the facility know that they will receive a report of the survey which will contain any deficiencies that have been cited (Form CMS 2567). The team will provide the facility with a list of residents included in the standard survey sample with the 2567.

- If an extended survey is required and the survey team cannot complete all or part of the extended survey prior to the exit conference, the team will notify the Administrator that concerns identified in the exit conference may be amended upon completion of the extended survey. The facility will be given an opportunity to discuss and supply additional information that they believe is pertinent to the identified findings throughout the survey process.

- There should be few instances where the facility is not aware of surveyor concerns or has not had an opportunity to present additional information prior the exit conference. On these rare instances the facility will be allowed to present the additional information at the exit conference.

ATTACHMENT B

CMS Life Safety Questions and Answers

Since there were numerous Life Safety Questions, the following CMS Question and Answers document is included with the other questions so that an understanding for most Life Safety Questions not only in Tennessee but from the entire US can be answered. If you find that you are unable to find specific Life Safety questions please call your regional office and speak to the Life Safety Supervisor for that Office.

Centers for Medicare & Medicaid Services
Life Safety Code 2000 Edition
Questions and Answers

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Note from the Editor: The information contained in the following Qs and As should be considered final, but may be updated to include additional technical information.

Three year phase-in guidance, roller latches, emergency lighting

Question #1: We would like guidance on how CMS would expect us to document and track three year phase in citations (i.e., emergency lighting). We have already cited these violations and facilities are requesting more than the normal allotted 90 days before penalties are imposed. How will we document these citations when a facility requests the full three years for correction?

Answer #1: Cite the deficiency on each survey. Facilities should then submit an acceptable plan of correction. These deficiencies in LTC facilities should be assigned a scope and severity of A, B, or C. Monitor the progress (or lack of progress) at each Recertification Survey until the work is complete. You should also use this process for roller latches. However, the doors must be positive latching and emergency lighting must be provided and operable.

Waiver correction

Question #2: We were previously advised us that, instead of deleting previously approved waivers, write on the CMS 2567, "Previous waiver now meets 2000 LSC." Questions have come up. Is this notation made in the general comments section of the 2567, or would a surveyor actually cite it by tag number, and then write under the tag number the above statement? If it is done by notation in the general comments, that seems to make sense. However, if it is done under a tag number, does this get data entered, and how? We're not sure why we should be noting it at all. This would appear that there is a deficiency when in actuality, it meets code. Our engineers tell me that we "drop" waivers all of the time with no specific notation of them.

Answer #2: The Surveyor should record this fact in the general comments data tag, 0000, on the CMS-2567 and in the Building/Wings section of the Survey Booklet for the first survey of each facility using the 2000 Code.

ICF/MR's – Waivers

Question #3: The state agency no longer has authority to grant waivers for ICF/MR facilities. The state will recommend waivers to CMS and CMS will grant waivers. How should the process work with waivers that have already been granted by the state agency? Should these now be written as initial waivers and we will process them through CMS for approval/denial based on our recommendation?

Answer #3: All requests for waivers of ICF/MR's surveyed under Healthcare should be submitted to the Regional Office for approval after each survey. (Waivers are not allowed per statute in ICF/MR's surveyed under the Board and Care regulations.)

However, there is no need to submit all outstanding ICF/MR LSC waivers now. Waiver requests from these facilities should be submitted following the State's first survey of these facilities under the 2000 Life Safety Code.

LSC Conditions – hospital

Question #4: When LSC deficiencies are cited in a non-accredited hospital, can the state exercise more discretion in determining if a Condition is not met? In contrast, in an accredited hospital, with respect to Weekly Note #72, there may be only 1 deficiency that adversely affects the health and safety of residents and we will put the Condition out, however, in a non-accredited hospital, there may be several deficiencies not met and the state agency may decide that the Condition is still met since the provider can pass, for example, the Fire Safety Evaluation System (FSES). We are asking for CMS clarification if this inconsistency is intended and accurate. Should we be treating nonaccredited differently than accredited when it comes to citing these LSC deficiencies?

Answer #4: Due to the difference in the certification requirements for accredited versus non-accredited hospitals, you do have more flexibility in marking the LSC Standard and, as a result, the PE COP "not met" in non-accredited hospitals. For accredited, you cannot mark "Meets based upon…Acceptance of a Plan of Correction" until you get a POC. You can't get/require a POC until you remove their deemed status, which can only be done when you have marked the standard not met/PE COP not met.

Alcohol gel

Question #5: If we see alcohol sanitizer dispensers in the exit corridors during survey, are we to cite this?

Answer #5: Yes. Alcohol sanitizer dispensers are not allowed in exit corridors and are to be cited as a deficiency at either K73, K135 or K029 as appropriate. These sanitizers should be located within the resident room. See attached for additional information (prepared by Katharine Achor of RO VII).

Alcohol gel

Question #6: Earlier this year CMS provided direction/references for mounting of dispensers containing alcohol gel products in long term care facilities. The direction indicated while these dispensers were not permitted in egress corridors, they could be mounted in the room.

Last month, a Quality Measure update contained a note indicating that the executive committee of the Hospital Fire Marshals' Association (HFMA) has unanimously voted to support the installation of alcohol-based hand washing gels in corridors. HFMA

said the committee compared the fire risk versus the risk of infection, and concluded the likelihood of a fire was minimal by comparison to the risk of spreading a life threatening infection. The organization said it looked at the history of fires in health care facilitiesand did not find an incident where the corridor was the area of fire origin. It also considered studies indicating hand gels are used more often when access to the gel is convenient to caregivers, and a study commissioned by the AHA's American Society of Healthcare Engineering that found dispensers of the gel not exceeding 1 liter could be safely installed in corridors as long as they were spaced intermittently and not in carpeted areas. The HFMA recommended that the fire code community revisit the applicable codes and change them to clear the way for acceptance by all of the authorities having jurisdiction. It also recommended facilities using the gels have automatic sprinklers."

I would like to know:

1) Has the CMS position issued previously changed? If so, when, and is the statement from the Quarterly Measure update the current CMS position?
2) Are long term care facilities located in hospitals allowed to have the dispensers located on corridor walls?

Answer #6: 1) No, our position has not changed. 2) No. In September 2003, the CDC issued instructions on the placement of these materials and they recommended placing these gels in patient/resident rooms near the entrance and not in egress corridors where they could be considered a fire hazard. CMS fully supports the recommendation that alcohol gels not be placed in egress corridors.

I am attaching CDC recommendations on this issue that are dated September 12, 2003. I hope you find this helpful. Let me know if you have questions.

Liquid Oxygen

Question #7: May liquid oxygen tanks be refilled in a resident's room?

Answer #7: As stated during the FY 2000 Life Safety Code Satellite Broadcast on October 9, 2003, the transferring/transfilling of oxygen containers in resident bedrooms is prohibited by NFPA 99 and is to be cited as a deficiency at K143.

According to the NFPA 99, 1999 edition:

Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:

a) Separated from any portion of a facility where patients are housed, examined or treated, by a separation of a **fire-barrier of 1-hour fire resistive construction;** and

b) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete

flooring; and
c) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.

NFPA 99 continues to state that transferring shall be in accordance with CGA Pamphlet P 2.6 and comply with pamphlet P2-7 . It has been alleged that these pamphlets permit filling in patient rooms. This is not correct. The pamphlets state how to fill, but not where to fill.

NFPA staff has advised us that filling must be done in accordance with the 3 criteria listed in section 8-6.2.5.2. As the Authority Having Jurisdiction, we concur with their opinion.

Oxygen is not to be transferred from one container to another in patient sleeping rooms, and such transferring must take place only in rooms protected in accordance with section 8-6.2.5.2 as listed above.

Alcohol gel

Question #8: Must there be secondary “No Smoking” signs in the vicinity of Oxygen tanks in “Smoke free” facilities?

Answer #8: Under the 2000 LSC, in health care occupancies where smoking is prohibited –and strictly enforced - and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking are not required in areas of administration. Signage is still required in areas where transfilling is allowed.

Single station smoke detectors

Question #9: What are the maintenance and testing requirements for single station smoke detectors placed in resident rooms with unrated furnishings brought from home?

Answer #9: The 1999 edition of NFPA 72 at 7-3.3 indicates in part "Single station detectors installed in other than one-and-two family dwelling units shall be tested and maintained in accordance with Chapter 7. Section 7-4.1 indicates that "fire alarm system equipment shall be maintained in accordance with manufacturer's instructions." Most single station detectors have a test button which says "test weekly."

Range hood – fire alarm connection

Question #10: Is it correct that the range hood needs to be interconnected to the fire alarm system? If so, do you have any tips on how surveyors can verify the connection? Most commercial range hood inspection forms I have seen make no note about an interconnection and short of taking a facility's work for it we are not sure how

to go about verifying.

Answer #10: Yes. NFPA 1998 edition of NFPA 96, 7-6 System Annunciation 7-6.1.

Upon activation of an automatic fire-extinguishing system, an audible alarm or visual indicator shall be provided to show that the system has activated.

7-6.2
Where a fire alarm signaling system is serving the occupancy where the extinguishing system is located, the activation of the automatic fire-extinguishing system shall activate the fire alarm signaling system.

Every initiation device or special hazard device (the range hood could be either) should be listed on the annual fire alarm paperwork. If it is not listed, then you could use this as your evidence. The fire alarm testing and maintenance paperwork is a legal document and should be complete with every item checked with a yes, no, not applicable or a line drawn through a section. Citations could be made at K52. This tag would cover both the failure to install the system in accordance with NFPA 72 (1999) as well as the maintenance, inspection, testing and records requirements at 7-5.2, which requires that all devices are listed.

Corridor width - obstructions

Question #11a) Under the 2000 LSC, 19.2.3.2 states exit corridors shall not have less than four feet clear width. Can we allow portable equipment placement in corridors if they meet the following criteria? Non-hazardous/nonflammable items, wheeled, mobile items (i.e. resident lifts), not including trash/soiled linen containers of a greater size or density as required by the code and all items are stored on the same side of the corridor. Staff is trained to include recognition and manner of removal in an emergency, and the clear width is never less than four feet.

Question #11b) We are running into facilities that are putting crash carts and isolation carts in the corridors. These corridors are 8 foot and have no alcoves to place the carts in. The most prominent situation is with the isolation carts that they need at each residence room. They advise that they need to have them directly available and cannot have them in the resident room.

Answer #11: You cannot shrink the corridor width if the facility was required to be constructed to a greater width. If the facility was constructed when the width was required to be 8 feet, the facility must maintain that 8-foot width even with the 2000 edition of the LSC being adopted. The exception is that you can have things in use in the corridor and that does not constitute a narrowing of the corridor. The storage of things in the corridor does narrow the corridor width and prohibits residents from being able to use handrails.

The appendix note talks about "storage" vs. "not in use." CMS interpretation says that storage is something not in attendance or not in use for over 30 minutes. If the appropriate staff is around (not on break) and using something every 30 minutes in the hall it is acceptable.

There is an exception that allows crash carts in the hall and small, wheeled isolation carts are acceptable for temporary use with items such as gowns and gloves while the particular room is under universal precautions. “Temporary” in this instance is that the unit is not dedicated to the care of individuals under isolation. Facility staff should trained in the identification and method of removing these items in the event of an emergency and should also be addressed in the fire plan.

We understand the issues involved as they are common to many facilities but it is also a function of the proper design of a facility to include storage areas for these purposes.

Sprinkler head recall

Question #12: Survey and certification memoranda 02-16 and 02-24 dealt with the sprinkler head recall and implied this would be completed within a year or two. We’re still hearing that providers have difficulty getting replacements from the suppliers. Any new advice on this, or do we simply look for evidence that the provider is making good faith attempts to correct, has contacted the supplier, and is awaiting delivery/installation?

Answer #12: Replacing recalled sprinkler heads has been a problem in some areas, where the contractor cannot get to the facility within a year (or even longer). If the provider is making good faith attempts to correct, then that is enough. For example, if, in a certain area, ten providers had their sprinkler heads replaced and one did not, that one provider was likely NOT making a good faith attempt to have the heads replaced.

Range hood

Question #13: Should a facility replace the hood system, if it is out of date but has not discharged? Are you allowing them until 2006?

Answer #13: No, the only things that are allowed until 2006 are the emergency lights and roller latches – unless you have an emergency light or roller latch that does not function and then the facility must correct the violation within the enforcement guidelines.

A dry-chemical suppression system must be changed to meet UL-300 when the hydrostatic testing is due or if the system is dumped. A UL-300 system must also meet requirements in NFPA 96 and NFPA 17A – such as hood requirements, fan controls, shut off valves, and emergency notification requirements.

It should also be noted that if a facility changes out kitchen appliances, the new installation of these appliances under an existing hood should also meet the current code standards of UL-300. Here are some things to look for that are unacceptable practices and should be reported to your Fire Marshal's office:

- We have found some service companies that have removed the dry chemical, completed the hydrostatic test and then replaced the dry-chemical back into the system.

- Some companies have also required the purchase and placement of a K extinguisher to meet UL-300 requirements. The K class extinguisher should not be used with a dry-chemical system.

Anesthetizing locations – battery-powered lights

Question # 14: We were wondering if a ruling was ever made regarding the anesthetizing locations and the battery powered back up lights. The code states "in INHALATION therapy" only. It does not state "IV drip." Are the battery-powered lights required in ALL anesthetizing locations or just those that use inhalation therapy?

Answer #14: Yes, it is CMS's position that all anesthetizing locations have battery powered lights.

Electronic locks

Question #15: Recently there was talk that electronic door locking mechanisms did not have to be tied to the fire alarm. Reviewing the NFPA codes, it appears to me that nothing has changed regarding the requirement that electronic door locks must be tied to the Fire Alarm. Comments?

Answer #15: This is often misunderstood. Yes, if you have door locking it must be hooked to the fire alarm. However, the part that is misunderstood is the part that says delayed egress shall be **permitted.** Not required, but permitted. You do NOT have to use delayed egress, but if you do so, the requirements in the Code must be met.

Fire alarm transmission/FSES

Question #16: One of the new healthcare requirements in the 2000 LSC has to do with the fire alarm sending a signal to a central station. Can a facility use the FSES to "get out" of this requirement?

Answer #16: Off-site fire alarm transmission has been required in healthcare occupancies by each edition of the Life Safety Code, (LSC) NFPA 101 since the 1973 edition and is a routine part of fire alarm and fire protection systems CMS in adopting the 2000 edition of the Life Safety Code which requires that existing health care

facilities fire alarm systems to transmit off-site was discussed in the adoption of the 2000 LSC. CMS concluded that it was a necessary requirement to protect the health and safety of the residents and that healthcare facilities are expected to meet this requirement. This was reiterated in a letter S&C 03-23 dated May 8, 2003.

Although, one way of reaching equivalency to the provisions of the LSC is by using the Fire Safety Evaluation System (FSES), NFPA 101A, and *Guide on Alternative Approaches to Life Safety,* 2001 edition. This would not be an appropriate use of the FSES in this case.

The FSES was developed by the National Bureau of Standards at the request of the Department of Health and Human Services (DHHS) as an alternative method of determining compliance with the LSC. Facilities that pass the FSES may be certified for participation in the Medicare/Medicaid program even though they have repeat deficiencies reflected on the CMS-2786. The following guidelines should be observed when using the FSES:

- Only structural deficiencies that would be difficult or impossible to correct should be considered for FSES.

- Waivers and FSES processes should not be combined.

- The FSES may be applied only to buildings that conform with the LSC Worksheet 4.7.10, Facility Fire Safety Requirements Worksheet, items A through L, or Worksheet 7.7.6, items A through E, if applicable, or when a Plan of Correction (POC) for nonconforming items is accepted by the fire authority.

- The FSES can be used in facilities with many deficiencies or with a few costly deficiencies.

To use the FSES to “get out” of fire alarm transmission would not conform to the requirements for use and would also be a time consuming survey for a deficiency that is not structural and that is not impossible to correct. To allow this would be a misuse of the original intent of the FSES process.

(Q&As #17 – #30 pertain to Liquid Oxygen - LTC-Chapters 4 and 8)

Question #17: Is the intent to include the quantity of liquid oxygen storage containers in use as part of the sum total of liquid oxygen in storage in the facility?

Answer #17: No, only as it pertains to containers being stored.

Question #18: Is the intent to prohibit bulk supply storage of liquid oxygen in the

amount of 20, 000cf per smoke compartment or per floor or per wing or per facility?

Answer #18: If a facility has bulk storage in excess of 3000 ft3 or 20,000 cubic feet within the facility, then the facility is required by NFPA 99, 4.3.1.1.2 to meet NFPA 50 Standard for Bulk Oxygen Systems. This requires that the oxygen be stored outside or in a building used only for the purpose of oxygen storage.

Question #19: Is the intent to define storage as personal use containers throughout the facility not connected to a patient for a period of time greater than one (1) hour?

Answer #19: In use is defined as anything that is in the process of being used or that which is used every 30 minutes.

Question #20: Is the intent to not require posting of oxygen signage when a containers is part of the nursing home emergency response cart?

Answer #20: Secondary signage or the posting of "No smoking – oxygen in use" is required if facility allows smoking. All other signage requirements still apply, such as posting locations of oxygen storage or transfilling areas, regardless if smoking is prohibited or not.

Question #21: Is the intent to limit the number of liquid oxygen containers in use in a single sleeping room?

Answer #21: Yes, to the extent that the facility meets the requirements at chapters 4 and 8 of NFPA 99.

Question #22: Is the intent to limit the number of persons in a single sleeping room requiring use of liquid oxygen containers?

Answer #22: No, it is not intended to limit the number of persons using liquid oxygen.

Question #23: Is the intent that all persons of a sleeping room are educated in oxygen use and safety?

Answer #23: Yes, if capable of being trained and educated.

Question #24: Is the intent that documentation of patient education for oxygen use And safety is maintained?

Answer #24: It would be in the best interest of the facility to keep this documentation, however it is not required by NFPA.

Question #25: Is the intent that liquid oxygen containers in use becomes liquid oxygen in storage once the connection to the user/resident is discontinued?

Answer #25: Yes, if oxygen is no longer being used by resident at least every 30 minutes. Additional consideration should be given as long as the oxygen is supervised/attended, for instance in a physical therapy room.

Question #26: Is the intent to limit the size of the liquid oxygen containers in a resident sleeping room?

Answer #26: Yes, to the extent that the facility/room can meet the safety precaution requirements at Chapters 4 and 8 of NFPA 99.

Question #27: Is the intent to limit the number of liquid oxygen containers maintained at bedside per bed in a sleeping room?

Answer #27: Yes, to the extent that the safety precautions at chapters 4 and 8 of NFPA 99 are met.

Question #28: Is the intent to require securing (stand, chain rope or other device) of liquid oxygen containers in use in a sleeping room?

Answer #28: Yes, all oxygen containers, in use or in storage shall be secured in accordance with NFPA 99, Chapter 4 and the Basic LSC training manual SM M4L-19.6.

Question #29: Is the intent to require securing of liquid oxygen containers in oxygen storage rooms?

Answer #29: Yes, all oxygen containers, in use or in storage shall be secured in accordance with NFPA 99, Chapter 4 and the Basic LSC training manual SM M4L-19.6.

Question #30: Is the intent to require physical separation of the full liquid oxygen containers from the partial or empty liquid oxygen containers in the oxygen storage room?
Answer #30: Yes, all empty and full oxygen cylinders shall be stored physically separated. Refer to NFPA 99, Chapter 4 and the Basic LSC training manual SM M4L19.6.

K146 – generator fuel source

Question #31: K-146 Surveyors were advised that the CMS policy is that natural gas is not a reliable source of fuel for a required generator. The exception would be if the utility company will provide in writing a guarantee that their service would never be interrupted. If this is the case, this will cause a major uproar in Michigan as many generators have over the years been switched over to natural gas. I do not see a utility guaranteeing that their service will never be interrupted.

Answer #31: This is not a policy of CMS, but a requirement of the 1999 edition of NFPA 110, chapter 3-1 for for a Level 1 generator.

3-1 Energy Sources. 3-
1.1

The following energy sources shall be permitted for use for the emergency power supply (EPS):

(a) * Liquid petroleum products at atmospheric pressure
(b) Liquefied petroleum gas (liquid or vapor withdrawal)
(c) Natural or synthetic gas

Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage, or a demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source.

Clearance for sprinkler heads

Question #32: I would like to have clarification on perimeter stacking and the 18-inch clearance required for sprinkler heads. I have encountered open shelves along the wall with notebooks or items stored on the shelves. The shelves are not built-ins with doors, just boards attached to the wall with stuff kept on them. Is this ok or should the 18-inch plain across the room be maintained?

Answer #32: Yes, the 18-inch clearance from the bottom of the sprinkler head should be maintained across the entire room/closet.

Exception:
NFPA 13 A-5-6.6

The 18-in. (457-mm) dimension is not intended to limit the height of shelving on a wall or shelving against a wall in accordance with 5-6.6. Where shelving is installed on a wall and is not directly below sprinklers, the shelves, including storage thereon, can extend above the level of a plane located 18 in. (457 mm) below ceiling sprinkler deflectors. Shelving, and any storage thereon, directly below the sprinklers cannot extend above a plane located 18 in. (457 mm) below the ceiling sprinkler deflectors.

Scope and Severity/Downgrading

Question #33a: When you give a S/S level for ISOLATED "D" and the facility shows that they are working on the deficiency, are you are permitted to drop the S/S?

Question #33b: We have a facility that was cited in mid February for not having the range hood system connected to the fire alarm. Our revisit will be around mid April.

This facility is in process of completely upgrading the fire alarm system with work beginning the first of April and completed by the end of April. Facility said they have and can/will produce documents from their fire alarm contractor showing that connection of the range hood system to the fire alarm is part of the upgrade.

In this situation, do you feel it inappropriate to lower the citation to the substantial compliance level? Pushing the revisit back would not work because we would run into problems with the 70th day. What would we accomplish by leaving them out of compliance? The denial date (90th day) would not occur until after the upgrade to the fire alarm system was completed.

Answer #33: It is not appropriate to downgrade the S/S of any tag based upon a plan of correction, unless substantial compliance has been achieved and verified, or on revisit, it is determined that the s/s has actually changed. This has been misused in the past, as a way to extend to a facility additional time to complete corrections. From a fire inspector's liability point of view, it would be unwise to report that a facility is in substantial compliance, when in fact the facility is not – in the event of tragedy, I would not want to be in that position.

A possible example of when it may be appropriate - a facility has 10 doors that are not positive latching and they are cited a deficiency at an F. At the time of the revisit they have replaced 6 doors. They provide you documentation that 2 more are on backorder. It would not be appropriate to say the facility is in substantial compliance,

but it would then be appropriate to rewrite the deficiency, because substantial compliance has not been achieved, but change the S/S from an F to a D.

If a facility has to correct a deficiency that will obviously take longer than the allowed time, then a temporary waiver should be requested. Some examples of deficiencies that may take longer to fix – upgrading, installing or repairing a fire alarm, sprinkler system, or range hood; sidewalks cited in December in northern climates, and construction type deficiencies. From a customer service standpoint, it would be advisable to mention to a facility that they could ask for a waiver in the POC. They should explain in detail what would be accomplished in a given timeframe and they should keep the SA apprised of progress and delays. In some cases the facility may also need to implement additional safety measures while they work on the deficiencies. CMS is willing to grant 'construction' waivers, and the norm seems to be between 6 months to 1 year, depending on the situation.

The other option is to impose sanctions if the facility does not complete corrections within the timeframe they gave in the POC, just as you would a healthcare deficiency. The facility is to be in compliance with all regulations at all times, including LSC.

We teach the Basic LSC class to review the definitions of the harm levels and choose the scope based on the numbers of occupants who are affected.

Level 1 or S/S of A-C: A poor practice that the facility has with regard to paperwork – when we have investigated the issue and know that a maintenance practice is done, but is not documented correctly. An example might be that a facility is completing monthly fire extinguisher checks, records the inspection in a maintenance manual, but fails to document the checks on the fire extinguisher tag. This is not to say that all paperwork deficiencies belong at level 1 or that only paperwork deficiencies are assigned level 1 severity.

Level 2 or a S/S of D-F: Most deficient practices with regard to fire safety fall in this category as most issues do not harm the residents, but have the potential to do so.

Level 3 or S/S of H-I: Rarely used in LSC deficiencies because if a practice has caused harm in the fire safety arena, then it is most likely immediate jeopardy.

Level 4 or S/S of J-L: These issues are the ones that the threat to life is imminent or have the potential to cause egregious harm or death to the occupants of the building – fire alarm or sprinkler system not working, boilers in such poor repair as to cause an explosion hazard, blocked exits, or emergency generator malfunction and the facility accepts residents on life support. See Appendix Q of the State Operation's Manual.

These are only potential examples and every deficient practice needs to be evaluated on its own merits, on a case-by-case basis. No two deficiencies are ever

the same. If you have questions about scope and severity, please contact your RO.

Door Swing

Question #34: Does the lack of addressing existing same swing smoke doors that do not swing in the direction of egress mean the 2000 Edition of 101 in Health Care occupancies no longer allows this condition? If so, would this be a waiver item, or does it in some way meet the code? I have not as yet found any direction or position indicated in the code.

Some of our surveyors are now writing this condition as a K32 cite, because it can create a dead end corridor with no acceptable access to exit. Please advise.

Answer #34: Section 19.3.7.6, page 165 says, *"Such doors in smoke barriers shall not be required to swing with egress travel."*

Section 18.3.7.5 indicates cross-corridor openings in smoke barriers shall be protected by a pair of swinging doors or a horizontal sliding door complying with 7.2.1.14. *Swinging doors shall be arranged so that each door swings in a direction opposite from the other.*

Therefore, existing doors do not need to swing with exit travel and new ones do.

3-Bin Trash/Soiled Linen Containers

Question #35: We have a three-bin laundry container. Each bin has a hanging container with a plastic flip top. Each container is less than 32 gallons, but combined the total capacity would be over 32 gallons. They are separate containers with separate lids but have a three-bin rack that the bags hang in Is this considered to be a container over 32 gallons? May this be stored in the corridor? May we restrict the use to only two of the three bins to avoid having to store in a hazardous area?

Answer #35: Yes, this is considered to be over 32 gallons. Per K75, this container would have to be located in a room protected as a hazardous area, according to 18/19.7.5.5

However, if the bin is 'in use', or it is attended and used no less than every 30 minutes, then this scenario would be acceptable. So, if you have containers larger than the 32gallons and they are in use when staff make rounds, then this would be okay. As soon as they are done the container must be placed in a room protected as a hazardous area.

For storage in a non-hazardous area:
If there are three 15-gallon drums connected, and staff only use two of the drums, that would equal 30 gallons. Then the facility would need to remove one of the containers, as there would be a potential to fill all of them.

Waivers – Not Permanent

Question #36: Are all waivers issued as time-limited and subject to re-cite and re-review each year?

Answer #36: That is correct. There is no such thing as a permanent waiver. A facility is cited every time there is a survey, until the deficiency is corrected. Facilities who have received a waiver or an FSES equivalency are NOT in compliance - they are still noncompliant with the prescriptive requirements until the deficiency is corrected.

Posting of Survey Results F167

Question #37: Where can the requirements be found for posting life safety code surveys?

Answer #37: F167 states:

"A resident has the right to--

1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents and must post a notice of their availability; and…"

The Guidelines for F167 state:

Guidelines: §483.10(g)(1)-(2)
"Results of the most recent survey" means the Statement of Deficiencies (HCFA-2567) and the Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent extended surveys, and any deficiencies resulting from any subsequent complaint investigation(s).

"Made available for examination" means that survey results and approved plan of correction, if applicable, are available in a readable form, such as a binder, large print, or are provided with a magnifying glass, have not been altered by the facility unless authorized by the State agency, and are available to residents without having to ask a staff person.

"Place readily accessible to residents" is a place (such as a lobby or other area frequented by most residents) where individuals wishing to examine survey results do not have to ask to see them.

Facilities are required to have both a health and a life safety survey to enter/remain in the program. In order for this requirement to be met, both the health and the fire safety surveys should be posted.

Fire Extinguisher Signage

Question #38: Are you aware of any requirements for fire extinguisher cabinets to be labeled? Obviously, you want building occupants to be able to find/easily identify extinguishers but does the cabinet have to have any type of "signage." I can't find anything in NFPA 10 covering this.

Answer #38: NFPA 10 1.6.12 does say that fire extinguishers have to be conspicuously marked. CMS considers the very nature of an extinguisher hanging openly on a wall to be conspicuous. Recessed fire extinguisher cabinets according to the NFPA can be labeled in any manner – and does not need to be visible from the ends of a corridor. We are aware of OSHA requiring the signs to be visible from both directions, however this is not an NFPA requirement. Life Safety Surveyors are not responsible for the enforcement of OSHA requirements, but this is a good practice to inform facilities about.

Sprinklers in Closets

Question #39: What are the requirements for sprinklers in closets?

Answer #39: NFPA 13, Section 4-1.1, states that a building with sprinklers installed throughout is considered fully sprinklered. CMS policy classifies freestanding wardrobes as furniture and does not require them to be sprinklered. However, closets and wardrobes that are permanently affixed to the wall must be protected by sprinklers; the sprinkler heads need not necessarily be inside the closet. The closet may be covered by a sprinkler head that is located outside of the closet if: the top is removed off the wardrobe or if the closet doors have louvers or screen doors. Two or three sprinkler heads may also be provided outside the closet as a water curtain. In your survey, you should determine whether the closet/wardrobe has a small enough fuel load that a fully developed fire that cannot be controlled by the heads outside the closet/wardrobe is unlikely to occur.

K38 Hard path to a public way **11/29/04**

Question #40: Do walk ways to the public way have to be an all weather surface? Correct me if I'm wrong, but I believe this has changed with the new code as not being required under 7.7.1. A7.7.1 specifically says that grass or similar surfaces are acceptable as long as there being enough space to accommodate all occupants. Any clarifications on this would be greatly appreciated.

Answer #40: Regarding the citation involving the lack of a suitable exit path to a public way, Section 7.7 of the 2000 LSC Handbook does indicate that a path as simple as grass may be allowable in some cases. This application could be construed as acceptable for normally mobile individuals; however, residents in health care settings required to rely on assistive support or wheeled devices during evacuation may need a more substantial walking surface. In a health care setting, the terrain outside of a

facility, the safe distance to get away from a building to a public way and extreme weather conditions must be taken into consideration. The paramount consideration (especially in the mid-west) is whether the exit path of travel can be easily maintainable and usable under all weather conditions.

The interpretive letter referenced for this deficiency, as previously stated, is still applicable (although the tag has changed from K32 to K38 with the adoption of the 2000 code) even though it is more than ten years old and agreeably somewhat inconsistent with the current 2000 LSC language. Surveyors may have to reconsider their view on the appropriateness of exit paths when visiting facilities to determine if all exits are fully available and adequate under all weather conditions. This does not mean, in all cases, formal concrete or blacktop materials may be necessary or required. Other alternative materials may suffice if the path can be easily maintained and safely traversed throughout the year.

Waivers and the FSES:

Question #41: We were told at the last Fire Safety Evaluation System (FSES) training that a facility may receive a waiver of a requirement on Table 8 of the FSES evaluation form and still pass the FSES. Is this true?

Answer #41: CMS has come to the agreement that a facility **MUST** meet all of the requirements on Table 8 of the FSES form, without any waivers of those items, in order to pass the FSES. If a facility does not meet all the requirements of Table 8, then they may request a waiver of that requirement but they **CANNOT** be deemed in substantial compliance based on the FSES. In summary, a facility can only be surveyed under the FSES if they meet all Table 8 requirements without the use of a life safety code waiver.

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ATTACHMENT C

RELATED WEB PRESENTATION LINKS

Click link below for the Immediate Jeopardy presentation —>
http://health.state.tn.us/HCF/index.htm It's the Educational Training for Nursing Homes... at the right, under Featured Topic.

Click link below for the fire safety video —>
http://www.ircfiresprinkler.org/resources.htm See bottom of list of resources.

Note: You need a MP4 compatible media player on your computer to be able to play this fire safety video. A free Windows Essentials Codec Pack download that will enable Windows Media Player to play the video can be downloaded at: http://www.mediacodec.org/