

PUBLICATION

New CMS Final Fire Safety Regulations [Ober|Kaler]

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The Centers for Medicare and Medicaid Services (CMS) has updated its fire safety regulations [PDF] governing certain Medicare and Medicaid participating health care providers.

These include hospitals, critical access hospitals (CAHs), long-term care (LTC) facilities (such as Medicare skilled nursing facilities and Medicaid nursing facilities), intermediate care facilities for individuals with intellectual disabilities (ICF-IID), ambulatory surgery centers (ASCs), hospices which provide inpatient services, religious non-medical health care institutions (RNHCIs), and programs of all-inclusive care for the elderly (PACE) facilities. The regulation is effective July 5, 2016.

CMS's updated fire safety regulations incorporate the 2012 edition of NFPA 101, the *Life Safety Code* (LSC) fire safety requirements published by the National Fire Protection Association (NFPA),¹ with some specific qualifications. Not only is a LTC facility subject to the incorporated LSC edition, but certain Tentative Interim Amendments also apply, including TIA 12-1, 12-2, 12-3 and 12-4. Also, CMS made clear that, because the 2012 edition of the NFPA LSC references the 2010 edition of NFPA 101A, *Guide on Alternative Approaches to Life Safety*, the 2013 edition of NFPA 101A is not adopted at this point.

CMS may accept a state's fire and safety code if it is considered equivalent to or stricter than the LSC in the federal regulations. Providers in states with existing fire and safety codes that have been used as equivalent to the federal regulations can confirm with their applicable state survey agencies whether the agency in that state will continue to use its state code even after the new federal regulations go into effect.

The updated fire safety regulations also adopt the 2012 edition of the *Health Care Facilities Code* (NFPA 99) and Tentative Interim Amendments TIA 12-3, 12-4, 12-5 and 12-6, with some qualifications. CMS excludes Chapters 7 (information technology and communication systems), 8 (plumbing), 12 (emergency management) and 13 (security management), stating that CMS does not have authority to regulate those specific systems in health care facilities. CMS notes that facilities wishing to address individual needs may reference those chapters. Neither the International Code nor the International Fire Code are incorporated.

CMS notes that LSC compliance does not assure compliance with Americans with Disabilities Act (ADA) requirements. These need to be reconciled in certain situations. For example, CMS points out that the ADA's 2010 Standards for Accessible Design have stricter requirements for the protrusion of wall-mounted objects into corridors than the LSC. In the event of a difference between the LSC and ADA the stricter standard applies. CMS intends to provide technical assistance on strategies for avoiding ADA noncompliance and modifying noncompliant protruding objects.

The updated LSC regulation includes language permitting waivers if application of the regulation would result in unreasonable hardship for the facility and if such waiver would not compromise the health and safety of patients. There are two types of waivers: categorical waivers and waivers that may be requested if a deficiency is cited. Categorical waivers, which exist under the current CMS LSC regulation, may be requested without the citation of a deficiency, based on multiple CMS transmittals explaining the process for seeking confirmation of the categorical waiver at the commencement of a LSC survey. Three such transmittals were issued in 2013

and 2014. Categorical waivers need not be accompanied by a recommendation of the state survey agency or accrediting organization. Additional waivers may be requested based on the deficiency cited.

Prior to requesting a waiver, many facilities use the NFPA's Fire Safety Evaluation System (FSES), which is an equivalency system that provides facilities with an alternate way to meet LSC provisions and thereby demonstrate a level of fire protection that is equivalent to the LSC. Facilities that have used the FSES to demonstrate compliance and avoid a waiver request should reach out to their fire safety engineers to inquire about how CMS's new regulations using the updated NFPA LSC may or may not affect a passing FSES score with or without additional improvements to the facility. CMS notes that the FSES may offer flexibility in demonstrating compliance while mitigating potential unnecessary burdens of applying the LSC requirements. Older facilities with various buildings or wings may wish to consider which are considered used for health occupancies.

The incorporated 2012 NFPA LSC contains chapters addressing New Occupancies versus Existing Occupancies. Under the updated fire safety rule, buildings that have not received all pre-construction governmental approvals prior to the rule's effective date or buildings that begin construction after the effective date are required to comply with the New Occupancy chapters.

In contrast, the 2012 edition of the Health Care Facilities Code, NFPA 99, does not divide its chapters and requirements into new versus existing requirements. CMS clarified this distinction in response to a comment expressing concern about existing facilities and their ability to comply with NFPA 99's requirements on ductwork, HVAC system designs, electrical and medical gas systems, ground fault protection, piped medical gas systems and receptacles. CMS notes, however, that section 1.3.2 of NFPA 99 states that construction and equipment requirements shall be applied only to new construction and new equipment, except as modified in individual chapters, and points out that there are no modified requirements in the areas questioned.

Buildings constructed prior to the fire safety rule's effective date must comply with the 2012 LSC's Existing Occupancy chapters. However, a new Building Rehabilitation chapter in the 2012 LSC distinguishes between repairs, renovations, modifications, change of use, change of occupancy and additions, and identifies when new or existing occupancy chapters apply. CMS points out some instances in which the 2012 LSC does not apply, however.

First, CMS notes that its updated fire safety rule does not follow the 2012 LSC with respect to window sill height requirements. The 2012 LSC eliminated a previously existing requirement that window sills in newly constructed facilities not exceed a height of 36 inches above the floor. In its proposed update to the fire safety rule, CMS proposed not only to retain this requirement, but to extend it to *all* facilities – both new and existing. In response to commenters' concerns regarding the undue burden of retrofitting existing window structures, however, CMS revised the regulation to apply the 36-inch window sill requirement only to facilities built after the rule's effective date. Therefore, the requirement will apply under the updated fire safety rule even though it has been removed from the 2012 LSC.

Next, CMS emphasizes that the more stringent ADA requirements to remove barriers to accessibility take precedence over LSC standards. Therefore, facilities must comply with the ADA's limitation of corridor projections to 4 inches from the wall (four and one-half inches for handrails), rather than the LSC's more lenient 6-inch limitation.

CMS focused particular attention on certain requirements of its updated fire safety regulation, as follows:

- Roller latches on corridor doors are prohibited even in existing health occupancies. CMS states that roller latches in auxiliary spaces such as doors to toilet rooms, bathrooms, shower rooms, sink

closets and similar spaces that do not contain flammable or combustible materials present a danger to patients and staff. This is a departure from the 2012 LSC requirement on door latching.

- The updated rule maintains the requirement for annual inspection and maintenance of fire door assemblies with required documentation.
- The size of containers for recycling clean waste is limited to a maximum of 96 gallons unless the containers are in a protected hazardous area. The rule provides a phase-in period to enable affected facilities to establish separate hazardous areas.
- Certain types of interior door locks are permitted under specific conditions in areas requiring specialized protective measures for safety and security, such as psychiatric units or memory units, for example. Such interior doors may be locked provided (1) all staff have keys; (2) smoke detection is in place; (3) the facility is fully sprinklered; (4) the locks are electrical locks that release upon loss of power; and (5) the locks release by independent activation of the smoke detection system and water flow in the automatic sprinkler system.
- Alcohol-based hand rubs are permitted in certain types of dispenser.
- To avoid evacuation when a sprinkler system is out of service for more than 10 hours in a 24-hour period, a fire watch may be implemented until the system is returned to service. CMS indicates in the preamble that any such fire watch would be conducted by dedicated staff with no other duties, who constantly circulate throughout the facility or area affected by the sprinkler impairment to look for a fire, fire hazard or other hazardous fire safety conditions. Documentation of the fire watch rounds is advisable but not required.
- To allow for more timely patient care, certain types of wheeled equipment in use, medical emergency equipment not in use, and patient lift and transportation equipment may be kept in a corridor. In addition, fixed furniture may be in a corridor without obstructing accessible routes required by the ADA. Note that CMS refers to low risks because the LSC has shifted to a “defend in place” approach that does not rely upon evacuation as the primary means of fire safety.
- Cooking facilities may be open to a corridor under specific circumstances.
- Combustible furnishings and decorations are permitted subject to certain requirements and limits.
- Newly constructed facilities must have smoke alarms installed in every sleeping room and certain other areas.
- The 2012 NFPA LSC provisions apply to inpatient hospice units, not to hospice care provided in a patient's home.
- Swing beds are considered hospital or CAH beds, not LTC beds. Thus, they are not subject to LTC sprinkler requirements, but note that hospital requirements would apply.

It is advisable that each provider type review this rule closely for applicable provisions. The changes will have varying effects on different provider types, depending on which standards may have already been applicable to such providers. For example, the updated fire safety rule contains a new sprinkler requirement for high-rise buildings, i.e., those over 75 feet tall (generally seven or eight stories). The impact of such new requirement will be felt by all provider types except LTC facilities, the only provider type that already is required to be sprinklered.

CMS has projected, based on survey but also some estimates since not all states responded to the survey, that a number of hospitals are in high-rise buildings that are only partially sprinklered or are not sprinklered at all. Such hospitals must take steps to be fully sprinklered in 12 years. Moreover, all outpatient surgical departments must meet the applicable provisions in the Ambulatory Health Care occupancy chapter, regardless of the number of patients served.

CMS has removed the requirement that hospitals, CAHs and ASCs install a dedicated air supply and exhaust system in windowless anesthetizing locations. The requirement that doors to hazardous areas be self-closing or automatic-closing is applicable to ambulatory health care.

Ober|Kaler's Comments

Providers subject to the updated fire safety regulation should evaluate their compliance with the related NFPA LSC and Health Care Facilities requirements. It is advisable that each provider type review this rule closely for applicable provisions for that provider type. This entails knowledge of which areas are considered a health care occupancy and whether the facility is considered new or existing. An existing facility that is undergoing renovations, in particular, should evaluate the NFPA's requirements to determine if new or existing facility standards apply. If necessary, the provider should consider whether an FSES report would demonstrate compliance in a more flexible way, without the need for a waiver. If compliance cannot be demonstrated, the provider should determine if a categorical waiver would address the issue or if a waiver request based on citation of a deficiency is likely to be needed. The granting of a continuing waiver should not be taken for granted and the provider should be able to demonstrate how the standard for a waiver is met.

¹ While the NFPA LSC updated and published every three years, CMS incorporates particular editions of the requirements.