



Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C-11-05-LSC
REVISED 02.18.2011

DATE: December 17, 2010

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Hospital and Critical Access Hospital (CAH) Facility Life Safety Code (LSC)
Occupancy Classification Update

*******Language is added in the memo and guidance (blue font and italics) clarifying that a facility may qualify as a business occupancy if, among other criteria, *most* [not all] of its current and potential patients are capable of self-preservation. *******

Memorandum Summary

- ***Hospital/ CAH LSC Occupancy Classification:*** Hospital and CAH component facilities may be classified as new or existing Health Care, Ambulatory Health Care, Business, or other occupancies, as allowed by provisions of the LSC.
- ***Hospitals/CAHs with multiple component facilities may have various occupancy classifications.***
- ***State Operations Manual (SOM) Appendices A, I & W*** are being updated accordingly.

Discussion

We are updating guidance for hospitals and CAHs to assure alignment with the LSC occupancy classification provisions. In particular, we are providing clarification on determining the appropriate occupancy classifications for separated, non-contiguous or off-site facilities that are part of a certified Hospital or CAH. In accordance with 42 CFR 482.41(b) and §485.623(d), Medicare-participating hospitals and CAHs must meet the applicable provisions of the 2000 Edition of the National Fire Protection Association (NFPA) 101: LSC. The LSC permits certain hospital and CAH component facilities to be classified as occupancy types other than Health Care Occupancy, including Ambulatory Health Care, Business, and others. These other occupancy types have less stringent requirements. Accordingly, we are updating the interpretive guidance currently found in SOM Appendices A, I and W to ensure that it appropriately reflects the LSC requirements concerning occupancy classification. An advance copy of the updated Appendices is attached and may differ slightly from the final versions that will be released at a later date.

The LSC has a methodology for determining the appropriate occupancy classification that is required at a facility to ensure an adequate level of fire protection is present to protect patients and other building occupants. Allowing component facilities of a hospital or CAH to be surveyed as occupancy classifications other than Health Care, in accordance with the LSC, will

ensure both that an adequate level of fire protection is afforded and unreasonable hardship or burden is not imposed upon a hospital or CAH.

The following sections provide an explanation of the LSC occupancy classification determination for hospital and CAH facilities.

Mixed Occupancy Classifications

Hospital or CAH component facilities located in a building with more than one occupancy classification must be adequately separated from the other building occupancies, as required by the LSC, in order to be eligible for their own occupancy classification. If a hospital or CAH component facility is not adequately separated from other building occupancies, the most stringent occupancy classification must apply to the entire building.

In summary:

For Mixed Occupancy:

- Building houses mixed occupancies; and
- Hospital or CAH component facility is adequately separated from other building occupancies;
 - If adequately separated, occupancy classification is determined as explained below,
 - If not adequately separated, the most stringent occupancy classification of all the building occupants applies.

Health Care Occupancy (LSC Chapters 18 & 19)

A hospital or CAH component facility, regardless of whether it is located in a separate building on the main provider's campus or is located off the main provider's campus, ("campus" and "main provider" are defined in 42 CFR 413.65(a)(2)), must initially be considered as a new or existing Health Care Occupancy.

Section 3.3.134.7 of the LSC defines a Health Care Occupancy as, "[a]n occupancy used for the purpose of medical or other treatment or care of four or more persons where such occupants are mostly incapable of self-preservation because of age, because of physical or mental disability, or because of security measures not under the occupants' control." According to sections 18/19.1.1.1.3, "health care facilities regulated by these chapters provide sleeping accommodations for their occupants." Further, sections 18/19.1.1.1.7 provide that, "[f]acilities that do not provide housing on a 24-hour basis for their occupants shall be classified as other occupancies and shall be covered by other chapters of this Code." Therefore, hospital or CAH component facilities that provide sleeping accommodations and medical treatment or services on a 24-hour basis for patients *mostly* incapable of self-preservation must be classified as a Health Care Occupancy.

Section 1861(e) of the Social Security Act (the Act) defines "hospital" as being primarily engaged in providing care to inpatients and is not based upon a minimum number patients receiving treatment, care or services. CMS does not consider the number of patients in determining if a provider is a hospital or a CAH; therefore, a CMS-certified hospital or CAH does not need to have four or more inpatients at all times in order to be classified as a Health

Care Occupancy. Occupancy classification must be determined regardless of the number of patients served at a hospital's or CAH's component facility.

In summary:

For Health Care Occupancy:

- Facility provides sleeping accommodations;
- Facility provides medical treatment or services on a 24-hour basis; and
- Patients are *mostly* incapable of self-preservation.

Ambulatory Health Care Occupancy (LSC Chapters 20 & 21)

Section 3.3.134.1 of the LSC defines a Ambulatory Health Care (AHC) Occupancy as “[a] building or portion thereof used to provide services or treatment simultaneously for four or more patients that: (1) provides on an outpatient basis, treatment for patients that renders the patients incapable of taking action without the assistance of others; or (2) provides, on an outpatient basis, anesthesia that renders the patients incapable of taking action for self-preservation under emergency conditions without the assistance of others.” Considering the definition of an AHC provided in section 3.3.134.1 and the occupancy classification exemption provided in sections 18/19.1.1.1.7, a hospital or CAH component facility initially considered to be a Health Care Occupancy but which does not provide either sleeping accommodations or medical treatment or services on a 24-hour basis, may be classified as another occupancy type. For example, if it provides treatment or services to patients who are *mostly* incapable or rendered incapable by treatment or anesthesia provided by the facility, it must be classified as a new or existing AHC Occupancy.

CMS does not consider the number of patients treated when determining an AHC occupancy classification. Furthermore, CMS does not consider whether or not a patient has been “rendered” incapable of taking action for self-preservation by the facility; rather, the only consideration is whether the patient is capable or incapable of self-preservation. Therefore, occupancy classification must be determined regardless of the number of patients being served or whether or not a patient has been rendered incapable of self-preservation by a hospital or CAH component facility.

In summary:

For Ambulatory Health Care Occupancy:

- Facility does not provide sleeping accommodations;
- Facility does not provide medical treatment or services on a 24-hour basis;
- Facility provides anesthesia services; and
- Patients are *mostly* incapable of self-preservation.

Business Occupancy (LSC Chapters 38 & 39)

According to the Ambulatory Health Care section 20/21.1.1.1.4 of the LSC, “[b]uildings, or sections of buildings, that primarily house patients who, in the opinion of the governing body of the facility and the governmental agency having jurisdiction, are capable of judgment and appropriate physical action for self-preservation under emergency conditions shall be permitted

to comply with chapters of this code other than Chapter 20/21.” Therefore, a hospital or CAH component facility previously considered an AHC Occupancy, but which does not provide anesthesia services or serve patients who are *mostly* incapable of judgment and appropriate physical action for self preservation under emergency conditions, could be classified as a new or existing Business Occupancy.

A patient may be incapable of self-preservation due to many factors, including, but not limited to, age, physical or mental disability, medical or therapeutic interventions, medication reactions, etc. In addition, when determining the ability for self-preservation, consideration *should* be given to *both* the characteristics of current patients *and the characteristics of patients the facility is likely to provide medical treatment or services to in the future, as evidenced by the provider’s own advertisement and clientele to which the provider holds itself out to serve.*

In summary:

For Business Occupancy:

- Facility does not provide sleeping accommodations;
- Facility does not provide medical treatment or services on a 24-hour basis;
- Facility does not provide anesthesia; and
- Patients are *mostly* capable of self-preservation.

Other Occupancy Classifications

Hospital and CAH component facilities to which patients are not expected to have access (i.e., patients have no “customary access”), which are non-contiguous or adequately separated from other hospital or CAH occupancies, as determined by the LSC, could be classified as other occupancies. Other occupancy classifications may include, but are not limited to, Assembly, Day Care, Mercantile, and Storage Occupancies.

In summary:

For Other Occupancy Types:

- Patients are not expected to access the facility for medical treatment or services; and
- Facility is non-contiguous or adequately separated from other occupancies.

Questions: If you have questions about hospital and CAH occupancy classification determinations, please contact LCDR Martin Casey via e-mail at Martin.Casey@cms.hhs.gov.

Effective Date: This guidance is effective immediately. Please ensure that all certification personnel are appropriately informed as to using this guidance within 30 days of this memorandum.

Training: The information contained in this letter should be shared with all survey and certification staff, their managers, and the State/RO training coordinators.

/s/

Thomas E. Hamilton

Page 5 – State Survey Directors

Attachment: (1)

cc: Survey and Certification Regional Office Management

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal

(Advance Copy)

Date:

SUBJECT: Revised State Operations Manual (SOM) Appendices A, I, and W

I. SUMMARY OF CHANGES: Clarification is provided in the SOM appendices pertaining to the appropriate occupancy classification of component facilities of hospitals and critical access hospitals, in order to determine compliance with the applicable portions of the Life Safety Code.

NEW/REVISED MATERIAL - **EFFECTIVE DATE*:** Upon Issuance
IMPLEMENTATION DATE: Upon Issuance

The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)
(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix A/§482.41(b) Standard: Physical Environment/Life Safety Code
R	Appendix I, Life Safety Code Interpretive Guidance & Survey Procedures
R	Appendix W/§485.623(d) Standard: Life Safety from Fire

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2011 operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

State Operations Manual

Appendix A - Survey Protocol,

Regulations and Interpretive Guidelines for Hospitals

A-0710

(Rev. XX, Issued: XX-XX-XX, Effective/Implementation: XX-XX-XX)

§482.41(b)

(1) Except as otherwise provided in this section—

(i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101[®] 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to:

http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals.

(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.

(3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals.

Interpretive Guidelines §482.41(b)(1) –(3)

Medicare-participating hospitals, *including all component parts or facilities of the hospital*, must comply with the applicable Life Safety Code (LSC) requirements. *All hospital component facilities, including those located in a separate building on the main provider's campus, as well as those located off the main provider's campus, (see 42 CFR 413.65(a)(2) for the definitions of "main provider" and "campus"), may be classified as new or existing "Health Care," "Ambulatory Health Care," "Business," or other occupancy classifications, based upon their usage, as permitted under the provisions of the LSC. LSC requirements differ depending upon the component facility's occupancy classification. In addition, a hospital, including all of its component parts or facilities, must be in compliance with all other applicable NFPA codes cross-referenced in the LSC, such as, NFPA-99: Health Care Facilities.*

The following criteria summarize the LSC requirements for determining the occupancy classification for the various separate component facilities that may comprise the hospital:

- If patients receiving medical treatment or services are mostly incapable of self-preservation during an emergency, and are provided with sleeping accommodations or treatment and services on a 24-hour basis, the facility must be classified as a Health Care Occupancy.*
- If patients receiving medical treatment or services are mostly incapable of self-preservation during an emergency or receive anesthesia services, but are not provided with sleeping accommodations or treatment and services on a 24-hour basis, the component facility must be classified as a Ambulatory Health Care Occupancy.*
- If patients receiving medical treatment or services are mostly capable of self-preservation during an emergency, are not provided with sleeping accommodations or treatment and services on a 24-hour basis, and do not receive anesthesia, the facility must be classified as a Business Occupancy.*
- Hospital facilities to which patients are not expected to have access (i.e., "customary access") and are non-contiguous or adequately separated from other occupancies, as required by the LSC, may be surveyed as other occupancy classifications, as determined by the LSC.*
- If more than one occupancy classification exists within a hospital building and there is not adequate separation between them, as determined by the LSC, the most stringent occupancy classification must apply to the entire building.*

When determining whether or not a facility provides treatment or services to patients incapable of self-preservation, surveyors should consider:

- *Patients may be incapable of self-preservation due to many factors, including, but not limited to, age, physical or mental disability, medical or therapeutic interventions, medication reactions, etc.*
- *The characteristics of patients the facility is likely to provide medical treatment or services to in the future, as evidenced by the provider's own advertisement and clientele to which the provider holds itself out to serve.*

The aforementioned requirements for determining hospital facility occupancy classifications apply regardless of:

- *The location of the component facility (e.g., in a separate or adjoining building on the main campus, or in an off-campus location).*
- *The number of patients receiving medical treatment or service.*
 - *CMS does not consider the number of patients receiving treatment or services in the determination of occupancy classification.*
- *Whether or not a facility has "rendered" a patient incapable of self-preservation without the assistance of others under emergency conditions.*
 - *CMS does not consider whether a patient has been "rendered" incapable of taking action for self-preservation by the facility, only whether the patient is capable or incapable of self-preservation.*

A hospital that has been cited for LSC deficiencies may request a waiver from a provision of the LSC if the hospital can adequately justify that the application of a LSC requirement will result in unreasonable hardship and the waiver will not adversely affect the health and safety of the patients. The facility must submit a written request for a waiver (with supporting documentation) to the State survey agency or Medicare-approved national accreditation organization, in the case of a deemed, accredited hospital, as part of the hospital's plan of correction. The State Survey Agency or Medicare-approved national accreditation organization, as applicable, must forward the waiver request and supporting documentation to the CMS Regional Office, along with a recommendation whether to approve or deny the request. CMS Regional Offices will make the determination to approve or deny the waiver request.

Additional interpretive guidelines on LSC waivers can be found in the SOM, Chapter 2, Section 2480 – LSC Waivers.

A State's Fire Code may be utilized in lieu of the LSC if the State has made such a request to CMS and CMS has determined that the State has in effect a fire and safety code imposed by law that adequately protects patients in health care facilities. The State must submit a request to utilize its Fire Code in lieu of the LSC, and CMS Central Office will make the final determination as whether or not to accept the State Fire Code.

Additional interpretive guidelines on the substitution of State Fire Code for the LSC can be found in the SOM, Chapter 2, 2470E – Substitution of State Fire Code for the Life Safety Code (LSC).

Survey Procedures §482.41(b)(1) – (3)

- *Identify all hospital facilities, including separate component facilities that may be on-campus or off-campus, and determine the occupancy classification for each facility. A facility may assign an occupancy classification to its component facilities, but the surveyor is responsible for confirming the occupancy classification through document reviews, interviews, site visits, etc., as necessary.*
- *Survey all facilities in which inpatient or surgical services, including same-day surgery, are provided. The definition of “surgery” is broad and includes not only surgical procedures, but other invasive and diagnostic procedures. See the hospital guidelines A-0940 for a definition of what constitutes “surgery. Survey a sample (minimum of one component facility) of the remaining facilities, as well as any component facilities for which there are questions about the accuracy of the occupancy classification or concerns about the physical environment. The selected facilities and sample size above one should be determined on a case-by-case basis at the surveyor’s discretion. Factors to consider in determining sample size and selecting facilities may include, but are not limited to, results of previous surveys, number of similar hospital component facility occupancies, facility appearance, and customary access by patients.*

The hospital component facilities should be surveyed according to the most stringent occupancy classification of all the building occupancy(ies), unless the component facilities are adequately separated from other building occupancy(ies) by construction having a fire resistance rating, as required by the LSC.

The SOM, Appendix I – Life Safety Code, provides procedures for LSC surveys, including determining facility occupancy classification, applicability of LSC chapters, and determining which buildings to survey.

Survey form, (Form CMS-2786) *is* used by **CMS** surveyors to *assist in* evaluating compliance with the Life Safety Code.

- *In preparation for a survey, surveyors must review the facility file for existing waivers. In addition, the existence of any waivers should be confirmed by the surveyors when onsite. Assess existing waivers to determine if they are still applicable or if the related deficiency requires correction. Some instances that would render a waiver as being no longer applicable may include: the approved time-limit for the waiver has expired; the condition of “unreasonable hardship,” which was the basis of waiver approval, is no longer present; the waiver is adversely affecting the health and safety of the patients; or the facility has had the opportunity but has not corrected a waived deficiency.*

Survey procedures on LSC waivers can be found in the SOM, Appendix I – Life Safety Code, including waiver requirements, limitations, time-limits, recommendations, and applicability. In addition, SOM, Chapter 2, Sections 2472A and 2480, provide additional survey procedures, including the authority to grant waivers, meeting the intent of the LSC, and elements considered in determination of unreasonable hardship.

- *Determine if an approved State Fire Code is applicable in lieu of the LSC in advance of performing a survey. In instances when a CMS- approved State Fire Code is utilized in lieu of the LSC, the State Fire Code must be applied in its entirety.*

SOM Section 2470E – Substitution of State Fire Code for the LSC, provides additional survey procedures, including guidance regarding State Fire Code requirements, CMS approval process, and excluded facilities. In addition, the process by which CMS reviews a State’s request to use its State Code in lieu of the LSC is further addressed in Survey and Certification policy memorandum S&C-08-34, dated September 5, 2008.

Appendix I – Survey Procedures and Interpretive Guidelines for Life Safety Code Surveys

(Rev. XX, Issued: XX-XX-XX, Effective/Implementation: XX-XX-XX)

II. The Survey Tasks

Task 1 – Offsite Survey Preparation

The surveyor or survey team will review the facility file for:

- Recent licensure and/or certification surveys, including any deficiencies from the previous, bed capacity, change in ownership, facility waivers;
- Corrective action status (if applicable);
- Complaint investigations;
- Facility floor plans, including the location of individual rooms, exits and commons areas; and
- Correspondence to or from the SA and the facility.

If more than one surveyor is participating in the survey designate a team coordinator. The team coordinator will conduct a brief presurvey meeting with team members, such as the State Agency or State Fire Authority, to: review previous findings, make specific assignments, and discuss efficient approaches to surveying the facility.

Determine the occupancy or use of the facility such as a hospital, nursing home, ambulatory surgical center, etc. Then determine which chapters of the Life Safety Code (LSC) should be used in the survey process based on the occupancy or use of the building. The basic fire safety requirement for participating facilities at this time is compliance with the National Fire Protection Association (NFPA) 101, Life Safety Code, 2000 edition. *Interpretive Guidelines and survey procedures for determining the occupancy classification of hospital and Critical Access Hospital (CAH) facilities, including those components which are separated, non-contiguous or off-site, can be found in SOM Appendices A and W, respectively.*

Review the date the facility first applied for admission into the program. The use of the EXISTING or NEW chapters of the LSC depends on the date of plan approval or the date of construction (if there is no plan approval process) for the facility's building(s). If the facility's building plans were approved or a building permit was issued or construction

started after the effective date, (March 13, 2003), of the final regulation, the building or addition must be surveyed under 2000 NEW LSC.

If the facility's building plans were approved by a State Agency or building permit issued or construction started prior to the effective date, (March 13, 2003), of the final regulation, the building must be surveyed under 2000 EXISTING LSC.

CMS has defined the terms "major" or "minor" for alterations, modernization or renovation of buildings as follows: If the building has undergone a modification (usually more than 50 percent or more than 4,500 square feet, of the smoke compartment involved) it is considered "major," if the building has undergone a modification (usually less than 50 percent or less than 4,500 square feet, of the smoke compartment involved) it is considered "minor." If a building undergoes a "major" modification after March 13, 2003 then the building would be surveyed under 2000 NEW LSC. The replacement of a system such as a fire alarm system would be considered "major" for that system only. Thus, that system only would have to meet the LSC requirements for 2000 NEW, not the entire building.

Cosmetic changes such as painting and wallpapering by themselves would not constitute a "major" modification regardless of the size of the area involved.

A building, which is a conversion from an occupancy other than Health Care such as a hotel or apartment house, but NOT a hospital *or CAH*, must also meet NEW requirements. Changes within Health Care such as a hospital to a nursing home are not considered conversions.

If the building is a hospital *or CAH* and has a SNF located within or attached to it, then a determination has to be made as to whether the SNF is considered a "distinct part." If there is two-hour fire wall between the hospital and the SNF, then a LSC survey of the SNF section alone is allowed. A floor-ceiling assembly does not meet the separation requirements of a two-hour fire wall. If there is no fire wall, then a LSC survey of the complete building, hospital and SNF, is to be conducted. When there is no two-hour separation, then the complete building must be surveyed regardless of whether the hospital *or CAH* is accredited by *a CMS-approved hospital or CAH accreditation program*. All deficiencies found will be reported whether they were found in the *deemed* hospital portion or in the distinct part SNF.

Validation surveys of *deemed* hospitals *or CAHs* must use the appropriate chapters, NEW or EXISTING, of the 2000 LSC.

CMS, in its regulations adopting the 2000 edition of the LSC, did not adopt the paragraph 19.3.6.3.2 exception No.2 dealing with existing roller latches. The use of roller latches is no longer acceptable as a corridor door-latching device in existing health care facilities. This includes facilities that are both non-sprinklered and sprinklered. Facilities have until March 13, 2006 to remove roller latches from use. Emergency lighting lasting at least 1-1/2 hours is required by the LSC; facilities have until March 13, 2006 to meet this

requirement. CMS also adopted by regulation the requirement that any facility certified as an ASC is to meet the requirements of the LSC for ambulatory health care, without regard to the number of patients served by the ASC at any one time.

Determine whether or not a Fire Safety Evaluation Survey (FSES), has previously been conducted at the facility. The use of the FSES may be applicable when a facility has multiple deficiencies that may be cost prohibitive to correct. The facility should be informed that the use of the FSES is a certification option at the exit conference. It is up to the facility to decide if the FSES is to be used to achieve certification.

The State Agency, at its option, may complete the FSES for the facility or may act as a reviewer of an FSES submitted by the facility as part of the facility's Plan of Correction (POC).

NFPA 101A, Guide on Alternative Approaches to Life Safety, 2001 Edition, is to be used to complete all FSES's. An FSES evaluation is to be done in conjunction with the completion of the regular Fire Safety Survey form (CMS Form 2786). If the building is certified in compliance with the LSC on the basis of an FSES evaluation, an FSES evaluation must be completed each time a LSC survey is completed. To recertify the building using the FSES, a regular Fire Safety Survey form is completed before completing the FSES, this evaluation will take into account any changes in the facilities life safety features.

The FSES is only available for buildings surveyed using the Health Care Occupancies and Residential Board and Care Occupancies chapters. There is no FSES available for use when surveying ASCs, which are surveyed using the prescriptive requirements of the Ambulatory Health Care Occupancies chapter (20/21) of the LSC.

State Operations Manual

Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access CAHs (CAHs) and Swing-Beds in CAHs

C-0231

(Rev. XX, Issued: XX-XX-XX, Effective/Implementation: XX-XX-XX)

§485.623(d) Standard: Life Safety *f*rom Fire

(1) Except as otherwise provided in this section, the CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capital Street NW, Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the Life Safety Code does not apply to a CAH.

Interpretive Guidelines §485.623(d)(1)

Medicare-participating CAHs, *including all component parts or facilities of the CAH*, must comply with the applicable Life Safety Code (LSC) requirements. *All CAH component facilities, including those located in a separate building on the main provider's campus, as well as those located off the main provider's campus, (see 42 CFR 413.65(a)(2) for the definitions of "main provider" and "campus"), may be classified as new or existing "Health Care," "Ambulatory Health Care," "Business," or other occupancy classifications, based upon their usage, as permitted under the provisions of the LSC. LSC requirements differ depending upon the component facility's occupancy classification. In addition, a CAH, including any of its component parts or facilities,* must be in compliance with all *other* applicable *NFPA* codes *cross*-referenced in the *LSC*, such as, NFPA-99: Health Care Facilities.

The following criteria summarize the LSC requirements for determining the occupancy classification for the various separate component facilities that may comprise the CAH:

- *If patients receiving medical treatment or services are mostly incapable of self-preservation during an emergency, and are provided with sleeping*

accommodations or treatment and services on a 24-hour basis, the facility must be classified as a Health Care Occupancy.

- *If patients receiving medical treatment or services are mostly incapable of self-preservation during an emergency or receive anesthesia services, but are not provided with sleeping accommodations or treatment and services on a 24-hour basis, the component facility must be classified as a Ambulatory Health Care Occupancy.*
- *If patients receiving medical treatment or services are mostly capable of self-preservation during an emergency, are not provided with sleeping accommodations or treatment and services on a 24-hour basis, and do not receive anesthesia, the facility must be classified as a Business Occupancy.*
- *CAH facilities to which patients are not expected to have access (i.e., “customary access”) and are non-contiguous or adequately separated from other occupancies, as required by the LSC, may be surveyed as other occupancy classifications, as determined by the LSC.*
- *If more than one occupancy classification exists within a CAH building and there is not adequate separation between them, as determined by the LSC, the most stringent occupancy classification must apply to the entire building.*

When determining whether or not a facility provides treatment or services to patients incapable of self-preservation, surveyors must consider:

- *A patient may be incapable of self-preservation due to many factors, including, but not limited to, age, physical or mental disability, medical or therapeutic interventions, medication reactions, etc.*
- *The characteristics of patients the facility is likely to provide medical treatment or services to in the future, as evidenced by the provider’s own advertisement and clientele to which the provider holds itself out to serve.*

The aforementioned requirements for determining CAH facility occupancy classifications apply regardless of:

- *The location of the component facility (e.g., in a separate or adjoining building on the main campus, or in an off-campus location).*
- *The number of patients receiving medical treatment or service.*
 - *CMS does not consider the number of patients receiving treatment or services in the determination of occupancy classification.*
- *Whether or not a facility has “rendered” a patient incapable of self-preservation without the assistance of others under emergency conditions.*

- *CMS does not consider whether a patient has been “rendered” incapable of taking action for self-preservation by the facility, only that the patient is capable or incapable of self-preservation.*

Survey Procedures §482.41(b)(1)

- *Identify all CAH facilities, including separate component facilities that may be on-campus or off-campus, and determine the occupancy classification for each facility. A facility may assign an occupancy classification to its component facilities, but the surveyor is responsible for confirming the occupancy classification through document reviews, interviews, site visits, etc., as necessary.*
- *Survey all facilities in which inpatient or surgical services, including same-day surgery, are provided. The definition of “surgery” is broad and includes not only surgical procedures, but other invasive and diagnostic procedures. See the hospital guidelines A-0940 for a definition of what constitutes “surgery. Survey a sample (minimum of one component facility) of the remaining facilities, as well as any component facilities for which there are questions about the accuracy of the occupancy classification or concerns about the physical environment. The selected facilities and sample size above one should be determined on a case-by-case basis at the surveyor’s discretion. Factors to consider in determining sample size and selecting facilities may include, but are not limited to, results of previous surveys, number of similar hospital component facility occupancies, facility appearance, and customary access by patients.*

The CAH component facilities should be surveyed according to the most stringent occupancy classification of all the building occupancy(ies), unless the component facilities are adequately separated from other building occupancy(ies) by construction having a fire resistance rating, as required by the LSC

The SOM, Appendix I – Life Safety Code, provides procedures for LSC surveys, including determining facility occupancy classification, applicability of LSC chapters, and determining which buildings to survey.

Survey form, (Form CMS-2786) *is* used by **CMS** surveyors to *assist in* evaluating compliance with the Life Safety Code.

C-0232

(Rev. XX, Issued: XX-XX-XX, Effective/Implementation: XX-XX-XX)

§485.623(d)(2) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects patients, CMS may allow the State survey agency to apply the State’s fire and safety code instead of the LSC.

Interpretive Guidelines §485.623(d)(2)

A State's Fire Code may be utilized in lieu of the LSC if the State has requested this and CMS has determined that the State has in effect a fire and safety code imposed by law that adequately protects patients in health care facilities. The State must submit a request to utilize its Fire Code in lieu of the LSC, and CMS Central Office will make the final determination whether or not to accept the State Fire Code.

Additional interpretive guidelines on the substitution of State Fire Code for the LSC can be found in the SOM, Chapter 2, 2470E – Substitution of State Fire Code for the Life Safety Code (LSC).

Survey Procedures §482.41(b)(2)

Determine if an approved State Fire Code is applicable in lieu of the LSC in advance of performing a survey. In instances when a CMS- approved State Fire Code is utilized in lieu of the LSC, the State Fire Code must be applied in its entirety.

SOM Section 2470E – Substitution of State Fire Code for the LSC, provides additional survey procedures, including guidance regarding State Fire Code requirements, CMS approval process, and excluded facilities. In addition, the process by which CMS reviews a State's request to use its State Code in lieu of the LSC is further addressed in Survey and Certification policy memorandum S&C-08-34, dated September 5, 2008.

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§485.623(d)(3) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the CAH, but only if the waiver does not adversely affect the health and safety of patients.

Interpretive Guidelines §485.623(d)(3)

A CAH that has been cited for LSC deficiencies may request a waiver from a provision of the LSC if the CAH can adequately justify that the application of a LSC requirement will result in unreasonable hardship and the waiver will not adversely affect the health and safety of the patients. The facility must submit a written request for a waiver (with supporting documentation) to the State survey agency or Medicare-approved national accreditation organization, in the case of a deemed, accredited CAH, as part of the CAH's plan of correction. The State Survey Agency or Medicare-approved national accreditation organization, as applicable, must forward the waiver request and supporting documentation to the CMS Regional Office, along with a recommendation of whether to approve or deny the request. CMS Regional Offices will make the determination to approve or deny the waiver request.

Additional interpretive guidelines on LSC waivers can be found in the SOM, Chapter 2, Section 2480 – LSC Waivers.

Survey Procedures §485.623(d)(3)

In preparation for a survey, surveyors must review the facility file for existing waivers. In addition, the existence of any waivers should be confirmed by the surveyors when onsite. Assess existing waivers to determine if they are still applicable or if not, whether the related deficiency requires correction. Some instances that would render a waiver as being no longer applicable may include: the approved time-limit for the waiver has expired; the condition of “unreasonable hardship,” which was the basis of waiver approval, is no longer present; the waiver is adversely affecting the health and safety of the patients; or the facility has had the opportunity, but has not corrected, a waived deficiency.

Survey procedures on LSC waivers can be found in the SOM, Appendix I – Life Safety Code, including waiver requirements, limitations, time-limits, recommendations, and applicability. In addition, SOM, Chapter 2, Section 2472A and 2480, provide additional survey procedures, including the authority to grant waivers, meeting the intent of the LSC, and elements considered in determination of unreasonable hardship.