2024 Compliance Update

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JLL SEE A BRIGHTER WAY

Agenda

- Joint Commission & Congressional Oversight
- Joint Commission Workplace Violence
- Survey Process Issues
- Often Cited Survey Findings
  - *Top 7 Environment of Care*
  - *Top 7 Life Safety Chapter*

Congressional Oversight: House Committee Probes all Accrediting Organizations (AO) & CMS

Republican members of the House Energy & Commerce (Greg Warden, R-Ore; Greg Harper, R-Miss; and Michael Burgess, R- TX) launched an investigation into the hospital accreditation process following a Wall Street Journal (WSJ) article (*9/8/2017 by Stephanie Armour*)

- The Committee sent letters to CMS and 4 AO's requesting detailed information about accreditation process for hospitals and other facilities
  - The Committee wrote that they were "concerned about the adequacy of the CMS oversight of accreditation organizations" and the rigor of their survey process
    - The Committee cited a 2015 report that showed missing 39% of CLD findings during validation surveys
    - The Committee also cited from the WSJ article that "The Joint Commission revoked the accreditation of less than 1% of the hospitals that were out of Medicare compliance in 2014."
- The Joint Commission responded that this probe "is an opportunity to share more on the work we do to improve healthcare quality and patient safety by facilitating high reliability" said Kim McCullough, TJC.

Wall Street Journal (Sept. 8, 2017), Excerpt:

The Joint Commission revoked the accreditation of less than 1% of the hospitals that were out of Medicare compliance in 2014, the Journal found. In more than 30 instances, hospitals retained their full accreditation although their violations were deemed by CMS so significant they caused, or were likely to cause, a risk of serious injury or death to patients.

A result is that hundreds of hospitals with safety problems could continue to display a "Gold Seal of Approval" and promote their accredited status. The Joint Commission provides hospitals with an accreditation publicity kit, and a consulting arm of the organization sells "We Are Accredited!" pins and stickers. A brochure it prepared for patients reads, "Whenever and wherever you receive health care, look for The Joint Commission Gold Seal of Approval."

CMS Validations Have Resumed, But…

The Joint Commission and the CMS Validation process has resumed

- Previously CMS contracted with State Agencies to perform “look back” Validation surveys of Accrediting Organizations (AO)
  - Full survey within 60 days of survey ending
  - State agency results compared to AO survey results
- CMS now contracts with two national organizations to conduct *Direct Observation Validation Surveys* (DOVS)
  - Intent is to directly observe and evaluate the ability of the AO surveyor's ability to assess compliance with Medicare conditions
    - Eliminates the need for a second full survey
- The DOVS will be performed on a random sample of selected surveys, sent to the contractor by CMS
- The DOVS Survey Observers will be assigned on a 1:1 basis, matching the experience of the AO surveyor where possible

CMS Validations Resume, but…

- The DOVS Survey Observers will enter and leave the facility at the same time as the AO and will remain present while the AO surveyors perform their survey
  - The DOVS Survey Observers will present identification and a CMS authorization letter
- The DOVS Survey Observers *ARE NOT* performing a separate survey of the facility
  - The AO will lead and run the survey
    - The DOVS Survey Observers *ARE NOT* surveying the facility or assessing compliance with the Medicare requirements
    - The DOVS Survey Observers *ARE* directly observing and evaluating the AO ability to assess for Medicare conditions
    - The DOVS Survey Observers will use a CMS-developed Direct Observation Scoring Worksheet (DOSW) to evaluate the AO surveyor
    - Completed DOSW are submitted to CMS Baltimore after survey exit

- *Applies to HAP, CAH, ASCs, Hospice, BHC*

CMS QSO: https://www.cms.gov/files/document/admin-info-23-14-nltc.pdf

Joint Commission Focus: Health Equity

Health Equity

a. Standard LD.04.03.08 (Elevated to NPSG 16.01.01 effective 7/1/2023)
   - EP 1: Leadership
   - EP 2: Assess health related social needs of the patient
   - EP 3: Data analysis
   - EP 4: Action plan
   - EP 5: Improve the process
   - EP 6: Inform stakeholders

b. Universal Design
   - Equitable Use
   - Flexibility in Use
   - Simple & Intuitive Use
   - Perceptible Information
   - Tolerance for Error
   - Low Physical Effort
   - Size & Space for Approach and Use

Universal Design:
First introduced by Ron Mace in 1985, Universal Design is defined by the AIA as:

"The design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design."

Environmental Sustainability: De-Carbonizing Healthcare
Categorizing Business Emission Scopes (1 – 3)

- *Scope 1, 2* and *3* emissions is a classification system used to bucket greenhouse gas emissions (GHGs) exerted by an organization to help measure, manage, and reduce business emissions
- This Scope system first appeared in the 2001 Greenhouse Gas Protocol
  - *Scope 1:* Direct emissions form sources that are owned or controlled by the organization *[Within Our Control]*
    - includes on-site fuel combustion and fleet fuel consumption
  - *Scope 2:* indirect emissions from sources that are owned or controlled by the organization *[What we Consume]*
    - includes emissions that result from the generation of electricity, heat or steam purchased by the organization from a utility provider
  - *Scope 3:* from sources not owned or directly controlled by EPA but related to organization activities *[What We Purchase]*
    - Includes employee travel and commuting
    - Includes emissions associated with contracted solid waste disposal & wastewater treatment
    - Can also result from transportation and distribution losses associated with purchased electricity

Sustainable Healthcare Certification (effective 1/1/24)

- 15 CPR Standards (19 EPs)
  - General requirements for Certification
- 2 SHCLD Standards (4 EPs):
  - SHCLD 1: Environmental sustainability is a strategic priority
    - EP 1 Written strategic plan, board approved annually, includes reducing Greenhouse Gas Emissions (GhGE)
    - EP 2 Allocate resources to improve environmental footprint to reduce GhGE
  - SHCLD 2: Defines leadership responsibilities
    - EP 1 Appoints leaders(s) responsible for oversight to reduce GhGE
      - May be system or corporate level accountability
    - EP 2 Leaders develop and implement operational plans to reduce GhGE

Sustainable Healthcare Certification (effective 1/1/24)

- SHCME Standards (2 EPs)
  - SHCME 1:The organization measures its GhGE
    - EP 1 measures ≥3 GhGE sources (list provided)
    - EP 2 the organization converts its GhG measurements to metric tons of Carbon Dioxide equivalents ($MTCO_2e$) with documentation
- SHCPI 2 Standards (3 EPs)
  - SHCPI 1: Improves its environmental footprint by reducing GhGE
    - EP 1 organization develops goals to reduce GhGE in the ≥3 areas selected and implements action plans to meet those goals, documentation required
    - EP 2 Annually analyzes its GhGE data
    - EP 3 the organization determines if it is meeting its goals and revises if goals are not achieved or sustained

Workplace Violence Prevention

An act or threat occurring at the workplace that can include any of the following:

- verbal
- nonverbal
- written
- physical aggression
- threatening
- intimidating
- harassing
- humiliating words or actions
- bullying
- sabotage
- sexual harassment
- physical assaults
- or other behaviors of concern

involving staff, licensed practitioners, patients or visitor.

Workplace Violence Prevention

The Joint Commission expanded workplace violence requirements, effective January 1, 2022:

EC.02.01.01 EP 17
The hospital conducts an *annual worksite analysis* related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis.
Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.

Consider including:

- Multidisciplinary team
- Interior and Exterior
- Mitigation plan and execution

Resource:
OSHA.gov *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*

Workplace Violence Prevention

EC.04.01.01

- EP 1: the organization establishes a process(es) for continually monitoring, internally reporting, and investigating the following *[NOTE: Only the bullet point related to Workplace Violence included here]*
  - Safety and security incidents involving patients, staff, or others within its facilities*, including those related to workplace violence.*
- EP 6: Based on its process(es), the organization reports and investigates the following *[NOTE: Only the bullet point related to Workplace Violence included here]* :
  - Safety and security incidents involving patients, staff or others within its facilities*, including those related to workplace violence.*

Workplace Violence Prevention

HR.01.05.03 EP 29

As part of its workplace violence prevention program, the hospital provides training, education, and resources (at time of hire, *annually*, and whenever changes occur regarding the workplace violence prevention program) to leadership, staff, and licensed practitioners. The hospital determines what aspects of training are appropriate for individuals based on their roles and responsibilities. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows:

- What constitutes workplace violence
- Education on the roles and responsibilities of leadership, clinical staff, security personnel, and external law enforcement
- Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents
- The reporting process for workplace violence incidents

Workplace Violence Prevention

LD.03.01.01 EP 9

The hospital has a workplace violence prevention program *led by a designated individual* and *developed by a multidisciplinary team* that includes the following:

- Policies and procedures to prevent and respond to workplace violence
- A process to report incidents in order to analyze incidents and trends
- A process for follow up and support to victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary
- Reporting of workplace violence incidents to the governing body

Additional Joint Commission Information:
https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/

Revisions to the Environment of Care & Life Safety Chapters

EC.02.05.01 EP 23

Power strips in a patient care vicinity are only used for components of movable electrical equipment assemblies used for patient care. These power strips meet UL 1363A or UL 60601-1. Power strips used outside of a patient care vicinity, but within the patient care room, meet UL 1363. In non–patient care rooms, power strips meet other UL standards. (For full text, refer to NFPA 99-2012: 10.2.3.6; 10.2.4; NFPA 70-2011: 400-8; 590.3(D); Tentative Interim Amendment [TIA] 12-5)

- Note 1: The mounting of power strips to medical equipment assemblies or the reconfiguration of equipment powered by power strips in a medical equipment assembly must be performed by personnel who are qualified to make certain that this is done in accordance with NFPA 99-2012: 10.2.3.6(1 – 4) *[not 5, see S&C TIA 12-5].*

EC.02.05.01 EP 23

- Note 2: Per NFPA 99-2012: 3.3.138, patient care room is defined as any room of a health care facility wherein patients are intended to be examined or treated. Per NFPA 99-2012: 3.3.139, patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 1.8 meters (6 feet) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment and extending vertically to 2.3 meters (7 feet, 6 inches) above the floor.

- Note 3: In new facilities, the number of receptacles shall be in accordance with NFPA 99-2012: 6.3.2.2.6.2. If patient bed locations in existing health care facilities undergo renovation or a change in occupancy, the number of receptacles must be increased to meet the requirements of NFPA 99-2012: 6.3.2.2.6.2 to eliminate the need for power strips.

EC.02.05.01 EP 23

This is not deemed compliant because the thumb screw makes it not a fixed assembly, and the equipment it would support is not attached.

This is deemed compliant because the power strip is a permanently attached assembly, and the equipment it supports is attached.

NFPA 70-2011, Article 400: Extension cords are only for temporary use.

Alternative Equipment Maintenance (AEM)

Moved to Appendix

- Still allowed by both Joint Commission and CMS
- Rarely scored, so identified as significant standards reduction casualty

Survey & Process Issues

Joint Commission Survey Status

- Joint Commission is still working through the surveys that were delayed by COVID travel restrictions
  - The goal was to be caught up by mid-2023
- Corporate Lead Surveyor has resumed
- Many organizations still have late surveys, but there has been a noticeable increase in survey activity this year
- Blackout dates will not be allowed, as per CMS
- Once the survey team arrives (between 7:30 and 8am) and is acknowledged by the organization, their bio's are posted
- LSCS occasionally are after the main team leaves

Survey Process Issues

- Document review: see the Survey Activity Guide, which includes the *"Life Safety and Environment of Care—Document List and Review Tool"*
  - Resource located at the Joint Commission website:

https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/physical-enviroment/hosp_critaccesshosp_life_safety_ec_documentlist_reviewtool.pdf

Legend: C=Compliant; NC=Not compliant; NA=Not applicable; IOU=Surveyor awaiting documentation

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Yes	No	
LS.01.01.01					**Buildings serving patients comply w/ NFPA 101 (2012)**			
EP 1					Individual assigned to assess Life Safety Code® compliance			
EP 2					Building Assessment to determine compliance with Life Safety (LS) chapter *(frequency of assessment is defined by the hospital)*			
EP 3					Current and accurate drawings w/ fire safety features & related square footage a. Areas of building fully sprinklered (if building only partially sprinklered) b. Locations of all hazardous storage areas c. Locations of all fire-rated barriers d. Locations of all smoke-rated barriers e. Sleeping and non-sleeping suite boundaries, including size of identified suites f. Locations of designated smoke compartments g. Locations of chutes and shafts h. Any approved equivalencies or waivers	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
EP 5					Deemed Hospitals: Documentation of inspections and approvals made by state or local AHJs			
EP 7					The hospital maintains current Basic Building Information (BBI) within the Statement of Conditions (SOC).			
COMMENTS:								

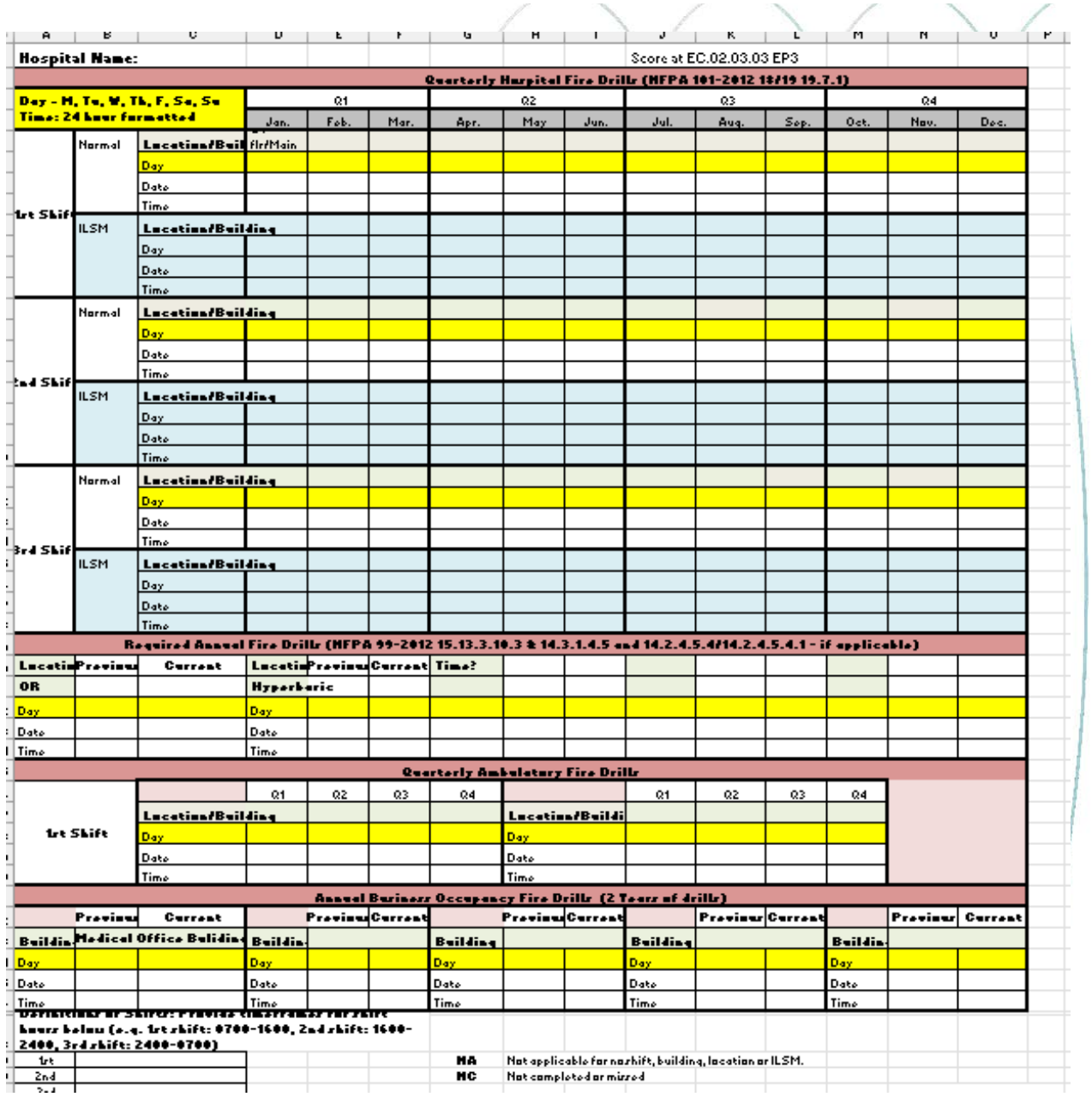
Survey Process Issues: Documentation

- Document review is ‘limited’ to 4 hours
  - Generally, takes between 90 and 120 minutes
- Electronic records are acceptable
  - Ensure the CMMS or other data source works as expected
  - Ensure the CMMS or other data source can sort high risk vs non-high risk
- Documents required for Surveyor review during Survey include:
  - Life Safety Drawings
  - Written Fire Response Plan
  - Documentation and Evaluations of Fire Drills for previous 12 months
  - EC Data
  - EC Management Plans and Annual Evaluations
  - Previous 12 months EC Meeting Minutes
  - ILSM Policy
- Cover Sheet may not be acceptable if it is not integrated into the test results

Survey Process Issues

Fire Drill Matrix

https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/



See it . . .

. . . Cite it

EC.02.05.01 OR Temp. Ranges Outside Established Ranges

- The Joint Commission references NFPA 99-2012 Ch 9, which requires the use of ASHRAE 170-2008 Ventilation Table 7-1
  - NOTE: the Joint Commission uses the edition of the FGI Guidelines the space was designed & built to, unless renovated (see NFPA 101-2012 Ch 42)
- The ASHRAE document provides allowances to exceed minimum temperature ranges.
  - To use this exception it must be done *by following established organization policy.*
  - This must be on a case by case basis, and restored to normal ranges following the procedures.
    - Based on either surgeon, patient or procedure
  - IT IS NOT ACCEPTABLE TO APPLY THIS EXCEPTION CONSISTENTLY
    - **“THIS IS NOT A BLANKET WAIVER”**
- *Expectation is the Operating Room RH range is ≤60%*
  - *Operating Room Temperature range is 68°F – 75°F*

EC.02.05.01 OR Temp. Ranges Outside Established Ranges

For critical spaces, to include operating rooms, standard EC.02.05.01 EP 15 uses the 2008 ASHRAE 170, Ventilation Table 7-1.

- Note "l" has an allowance to deviate from the prescribed temperature ranges. It states, *"lower or higher temperature shall be permitted when patients' comfort and/or medical conditions required those conditions."*
- Note "o" states, *"Surgeons or surgical procedures may require room temperatures, ventilation rates, humidity ranges, and/or air distribution methods that exceed the minimum indicated ranges"*.

These notes indicate that organizations may take allowances to meeting the range requirements however these are not blanket allowances but based on specific patient, surgeon and or procedure requirements.

- This is inferred by Note "o" as the guidance begins with "Surgeons or surgical procedures…"

Accepting the 20% to 60% waiver: Joint Commission – EC 02.05.01 EP 15 / ASHRAE 170-2008 Addendum D

As an organization you can adjust the 30% to 60% waiver to 20% to 60%

Factors Involved

- As an Organization you must agree to accept the waiver and show documentation through EC/Surgical Team meetings.
- The waiver must be declared during survey.
- Recommendation is to evaluate the waiver in place annually. (i.e. Don't just accept it if you never go below 20% and it MUST be in Anesthetizing Locations Only.)

Processes that must occur as a result of the Waiver Acceptance

- A full evaluation must occur of all the clinical equipment being used during cases. Bio-Med and Surgery must have documentation on hand that indicates that the manufacturer of each piece of equipment has provided documentation that that specific piece of equipment can be utilized in those humidity ranges (This only applies to the 20% to 60% waiver.

Issues that have arisen as a result of accepting the waiver

- Certain manufacturers will not certify equipment to operate below 30% Humidity.
- Most Common Finding in Recent surveys… OR Booms/Lights have been cited under this standard since Stryker or other manufacturers will not provide documentation.

Infection Control

Joint Commission, CMS, and State AHJs are putting a lot of focus on Infection Control:

- Ice machine dirty or build up
- Dirty/dusty HVAC vents
- Non-cleanable counter and wall surfaces
- Mixed clean and soiled storage
- Dirty filters
- Dish machine temperatures

These are often scored at EC.02.05.05 EP 5

GFCI Outlets

Joint Commission has been scoring the lack of GFCIs on equipment that they haven't scored in the past:

- Soda Dispensers
- Coffee Machines
- Water/Ice Machines
- Ice Bin (Kitchen)
- Vending Machines
- Water Fountains
- Bottled Water Dispensers

Kitchen Issues

Kitchens have been identified as an issue:

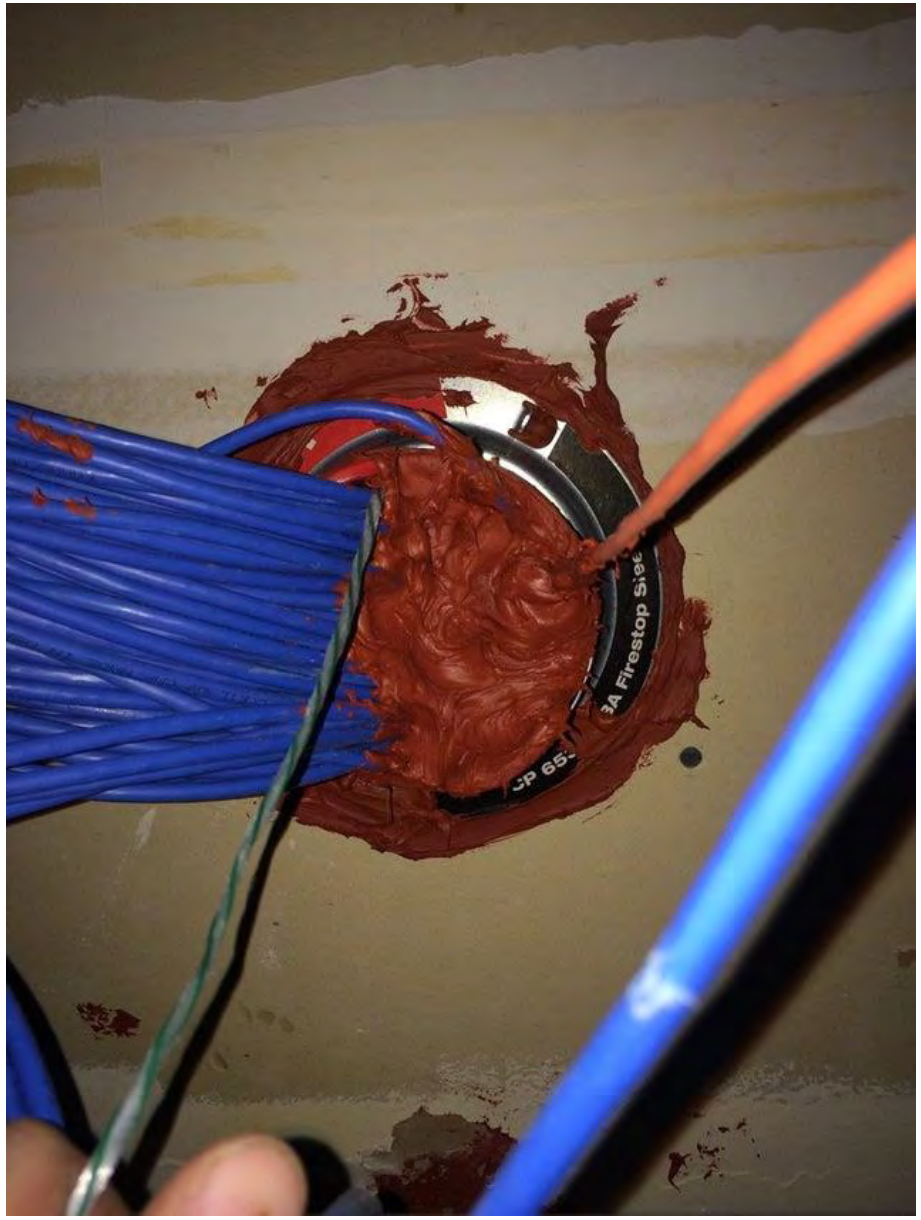
- Dish machine temps low or log incomplete
- Dirty floors, ceiling, and HVAC vents
- Rusty sprinklers and HVAC vents
- Dirty ice machines
- Dry storage room door blocked open
- Eyewash station blocked
- K-type fire extinguisher blocked or too far away
- Ansul system nozzles not lined up
- Exhaust hood filters dirty and gaps
- Expired or undated food

Rated Barriers & Penetrations

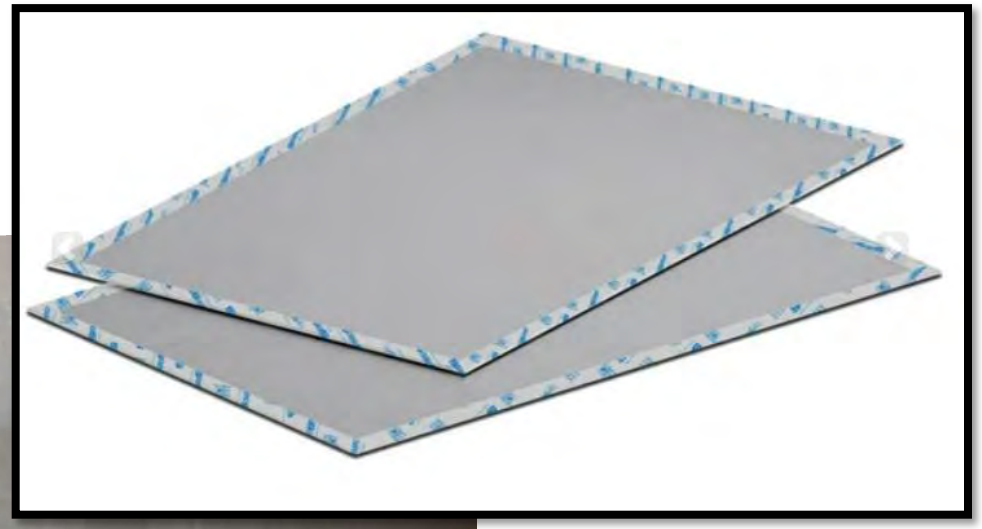
Compliance Tips

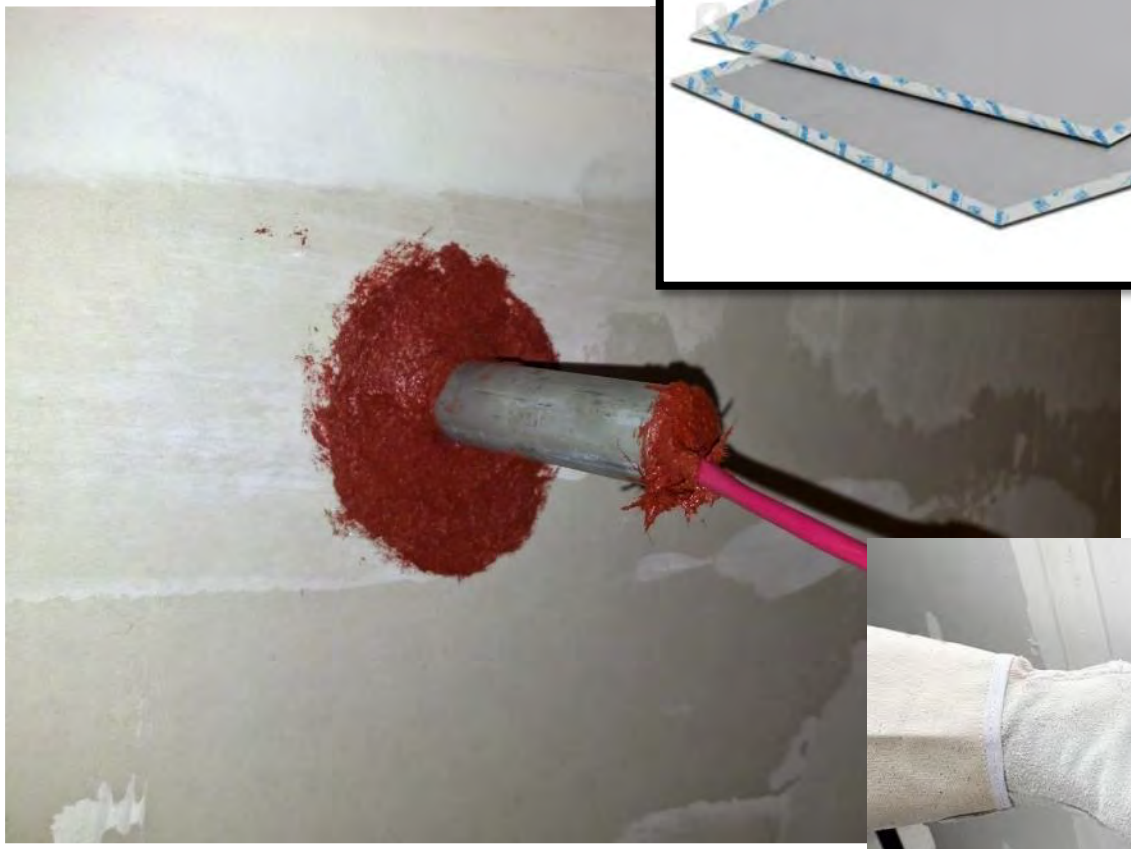
- Above Ceiling Permit Program
- During above ceiling inspections:
  - check both sides of the wall
  - open a tile on the left and the right to see all angles
- Use products and systems where the solution seems more complicated than caulk or putty
- Check your non-rated walls for old or incorrect rating stenciling
  - Surveyors can score an inconsistency between the stenciling and drawings

Fire Barriers
WRONG



Fire Barriers
RIGHT





The Joint Commission Top 10 Findings

Most Frequently Scored EC/LS EP's		
EC.02.06.01 EP 1	61.8%	Safety catch all (odors in geriatrics)
LS.02.01.35 EP 4	53.9	Items on sprinkler piping
EC.02.05.01 EP 9	54.8	Utility controls labeling (FA Circuit)
EC.02.05.05 EP 6	51.2	Non-HR Utility components ITM
LS.02.01.10 EP 14	45.4	Fire wall penetrations
LS.02.01.35 EP 14	44.3	Fire Extinguisher on Floor / Blocked
EC.02.02.01 EP 5	41.5	Haz Chem: selecting, storing, handling
LS.02.01.10 EP 11	39.8	Fire door latching, gaps, propping
EC.02.06.01 EP 26	40.1	Furnishings & Equipment condition
LS.02.01.35 EP 5	38.6	Sprinkler escutcheons, painted, dusty

17

Rough average number of EC & LS RFIs hospitals received during full surveys last year

21.3%

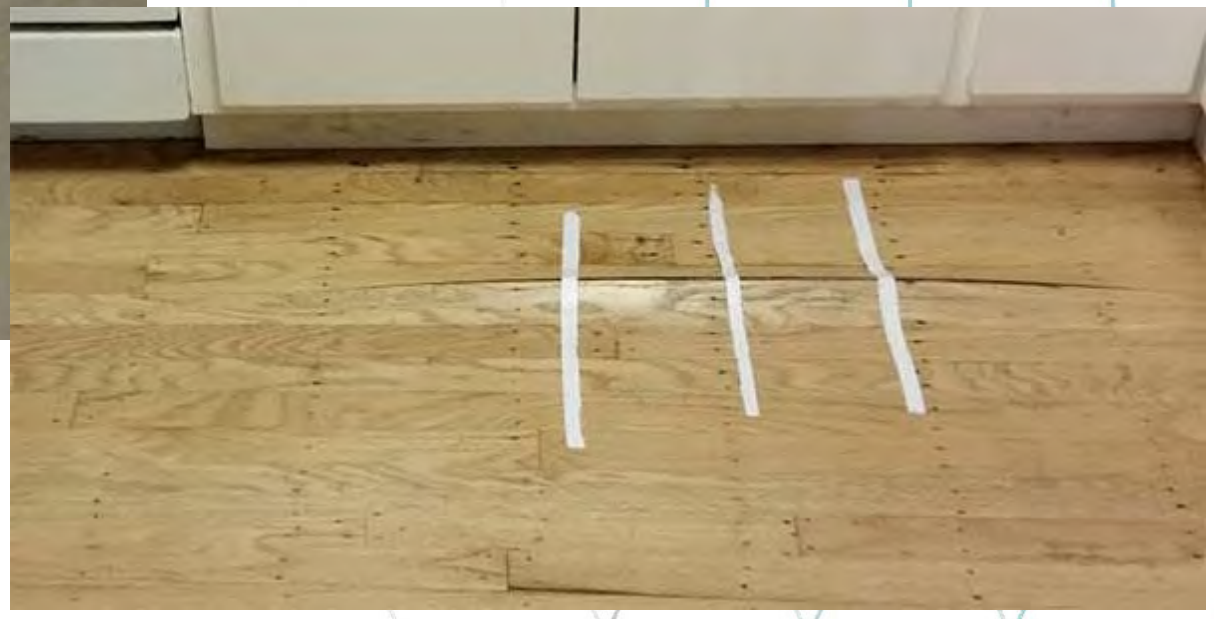
Rough percentage of hospitals with at least 1 Condition Level Deficiency (CLD) last year

Top 7 Survey Findings: EC

Rank	Standard	EP	Description	Examples	Surveys Scored
1	EC.02.06.01	1	Interior space meets the needs of the patient population	Stained ceiling tiles; defective flooring; wall stains; peeling paint	1,027
2	EC.02.05.01	9	The hospital labels utility system controls for partial or complete emergency shutdown	Identify fire alarm circuit; Spare circuit breaker in off position	923
3	EC.02.05.05	6	Hospital ITM non-high risk utility system components on the inventory, with doc. date and activity results	Open J boxes; exceeding ITM schedules	866
4	EC.02.02.01	5	Minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of haz. chem.	Eye Wash stations weekly testing (AN358.1); Manifests & DOT	720
5	EC.02.06.01	26	Furnishings and equipment are safe and in good repair	Damaged equipment/furniture	666
6	EC.02.06.01	20	Clean and free from odors	Dirty environment; Geriatric odors	597
7	EC.02.05.01	15	Critical areas ventilation (pressure relationships, temperature and humidity)	Rooms out of balance; Rooms out of range for temperature and RH	587

#1 EC.02.06.01 EP 1 61.8%

Stained Ceiling Tiles, Peeling Paint & Damaged Flooring



#2 EP.02.05.01 EP 9 Utility Labeling 54.8%

This EP covers labels on all utility system valves or controls. This is typically scored for:

- Medical gas source/main shutoff valves
- Kitchen gas shutoff valves
- Electrical breaker schedule accuracy
- Medical gas isolation valves
- Sprinkler system valves

#2 EC.02.05.01 EP 9 Utility Labeling: Fire Alarm Panel 54.8%

Fire Alarm Panel

- Identify where the fire alarm panel is being supplied power from
- At the electrical panel, clearly identify the fire alarm circuit [RED]
- Ensure the fire alarm panel is either in a protected environment that is continuously occupied or has a smoke detector
  - Protected environment: 1 hour fire rated walls with ¾ hour rated door and continuously occupied

#3 EC.02.05.05 EP 6 Inspection Testing & Maintaining (ITM) 51.2%

Incomplete maintenance

- >100% completion rates for NON-High Risk Equipment on the inventory

#4 EC.02.02.01 Haz Mat

41.4%

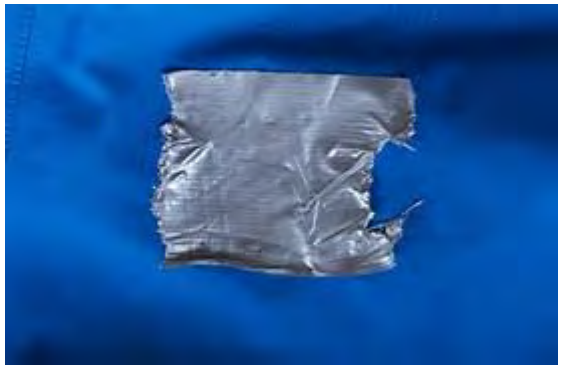
- Provide Safety Glasses, Hearing Protection for Maintenance & EVS
- Ensure Eye Wash & Showers are tested weekly as per ANSI Z358.1

Personal Protective Equipment Testing

DOSIMETRY BADGES

- Accurate inventory
- Testing frequencies (based on policy)
- Training for PPE users

#5 EC.02.01.06 EP 20 Furnishings in good repair 38.6%



#6 EC.02.06.01 EP 20 Clean and free of odors 37.6%

The Nose of A Nurse: Dealing with Bad Smells in the Hospital

In the clinical setting, nurses come across all manner of sights, sounds, and ye
the obvious ones that people complain about (which I never understand...you
were getting into, right?), certain smells can tell you a thing or two about your
this post we've compiled a list of a few disease states that come with a speci
So, while bad smells in the hospital probably aren't your favorite part of your

How to handle bad smells in the hospital

Which brings us to the next obvious question...how do you handle intense odors with grace and compassion? The first step is to recognize that one of your jobs as a nurse is to care for people who are vulnerable. [bctt tweet="By maintaining grace in an ungraceful situation, you help that patient retain his/her dignity at a very difficult time." username="StraightANurse"] NEVER let your patient know that you are affected by any unpleasant odors...if you have to leave the room for a minute, make up excuse and leave the room...but don't let it show. Please.

Below are a few tips that might help your encounter with rough odors a not-so-traumatizing experience:

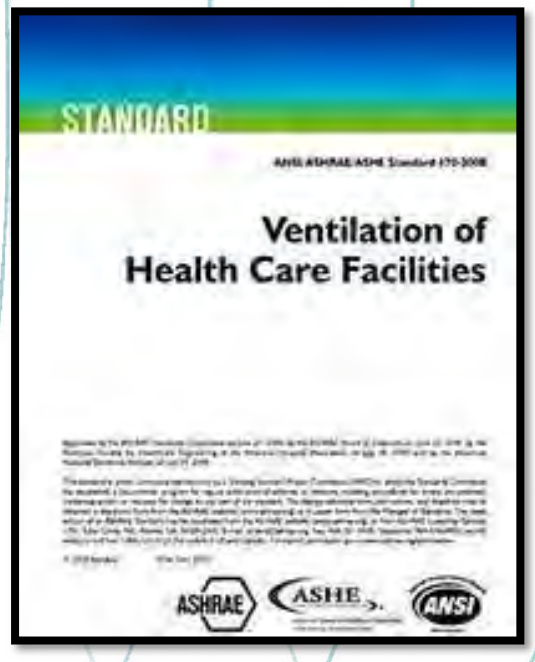
a bag inside a face mask and smell the scent of lemon or mint instead
few drops of essential oil inside a face mask (peppermint is good one!)
ttle Vicks Vapor Rub under your nose
enthol cough drop before you head into the room
all container of coffee beans in your work bag; as soon as you leave the room
whiff of the coffee beans to clear any residual unpleasant odors out of your

tying ostomy bags, immediately place a washcloth or hand towel over the
and set it aside as you finish cleaning and caring for the patient.
ning stool, coverage is the key. Immediately cover the stool on the absorbent
ither another pad (or fold the one you are using over) or a towel. Use

#7 Air Pressure Relationships

Improper air-pressure relationships in critical spaces are frequently scored at elevated risk levels and as a CLD!

- There are many ways to verify air movement, but the surveyors will all use a Vaneometer™
  - Some hospitals give vaneometers to clinical staff so they can check before cases
- Frequency of testing can vary based on each hospital's needs and equipment
  - ASHRAE 170 has many spaces defined, so focus efforts on critical spaces
  - Ensure your inventory matches ASHRAE 170



Top 7 Survey Findings: LS

Rank	Standard	EP	Description	Examples	Surveys Scored
1	LS.02.01.35	4	Piping for Approved Automatic Sprinkler Systems (AASS) is not to be used to support any item other than the AASS	Wires on piping	934
2	LS.02.01.10	14	Space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating rated walls or floors are protected with approved fire-rated material	Holes, gaps or improperly repaired barriers	797
3	LS.02.01.35	14	The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012	Stained ceiling tiles	763
4	LS.02.01.10	11	Fire door non-compliance	Fire door issues	677
5	LS.02.01.35	5	Sprinklers are not damaged and have escutcheons	Escutcheon plates missing, foreign materials on heads	608
6	LS.02.01.34	9	Ceiling membrane maintained	Gaps in ceiling tiles	525
7	LS.02.01.35	6	18” clearance below sprinkler	Compromised space	522

#1 LS.02.01.35 EP 4 Items on Sprinkler Piping 53.9%

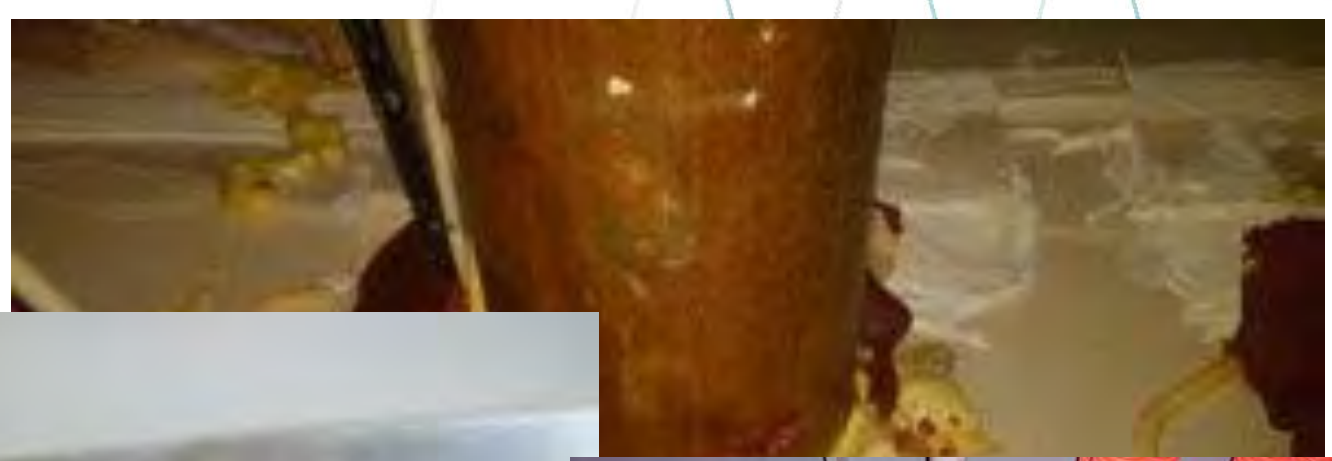
Items on Sprinkler Piping

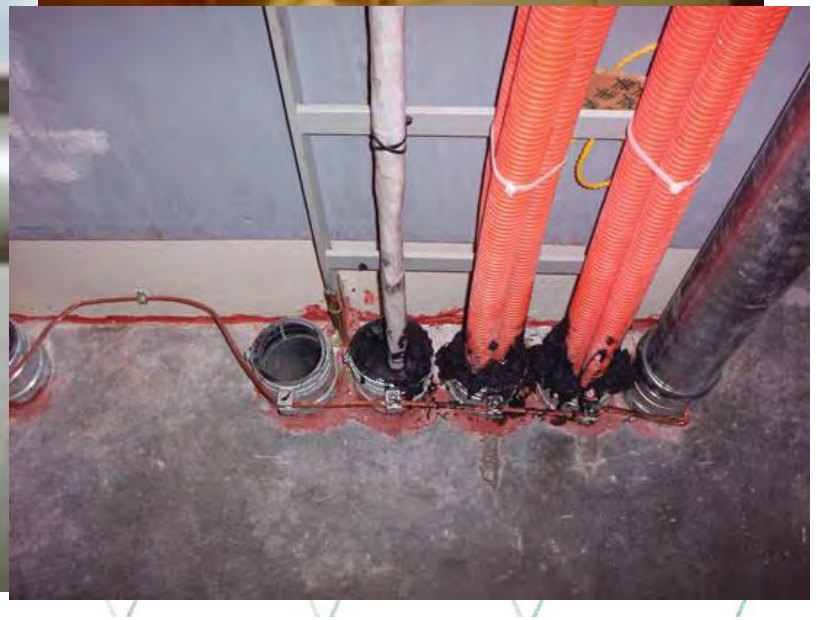
LS.02.01.35 EP 4

Observations typically scored:

- IT cables draped over sprinkler piping
- Electrical conduit on sprinkler piping
- HVAC ducting on sprinkler piping
- Cables zip-tied to piping or treaded supports
- Exterior piping has debris or bird nests
- Signs hanging from sprinkler piping
- Ceiling grid supported by sprinkler piping

#2 LS.02.01.10 EP 14 Space Around Pipes 45.4%



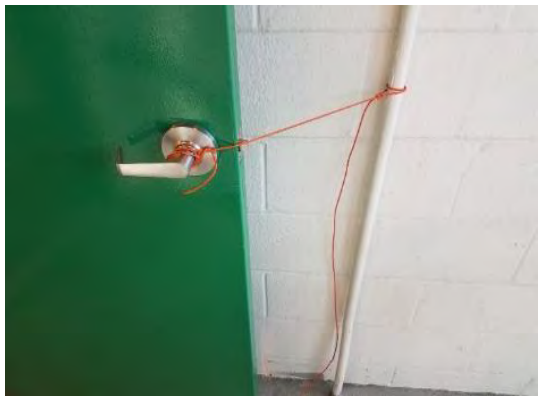


#3 LS.02.01.35 EP 14 Stained Ceiling Tiles 44.3%

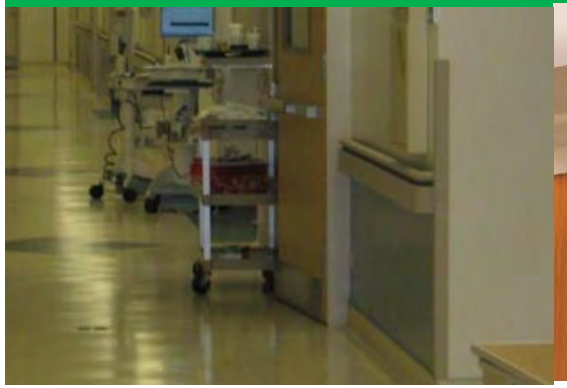
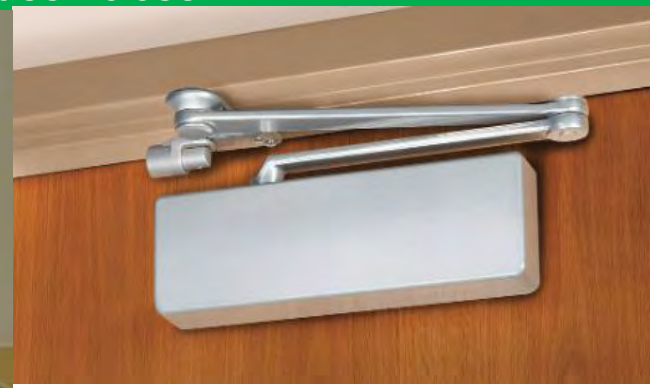
#4 LS.02.01.10 EP 11 Doors 39.8%

FIRE DOORS
Must not be blocked
Must self-close
Must self-latch

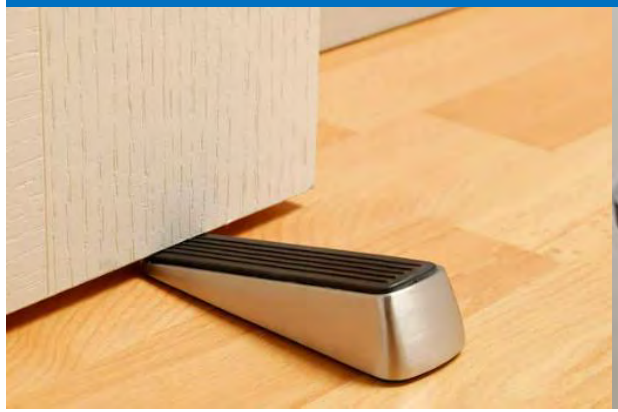
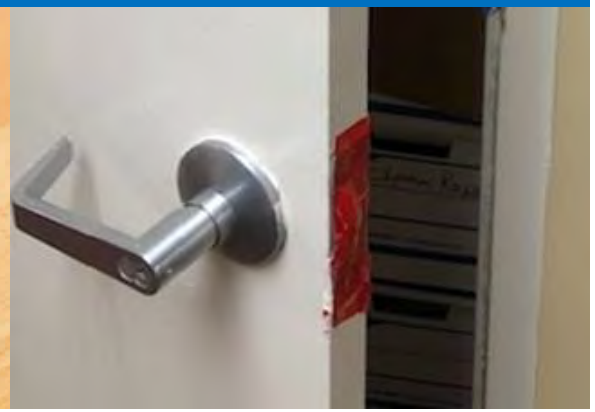





SMOKE DOORS
Must not be blocked
Must self-close

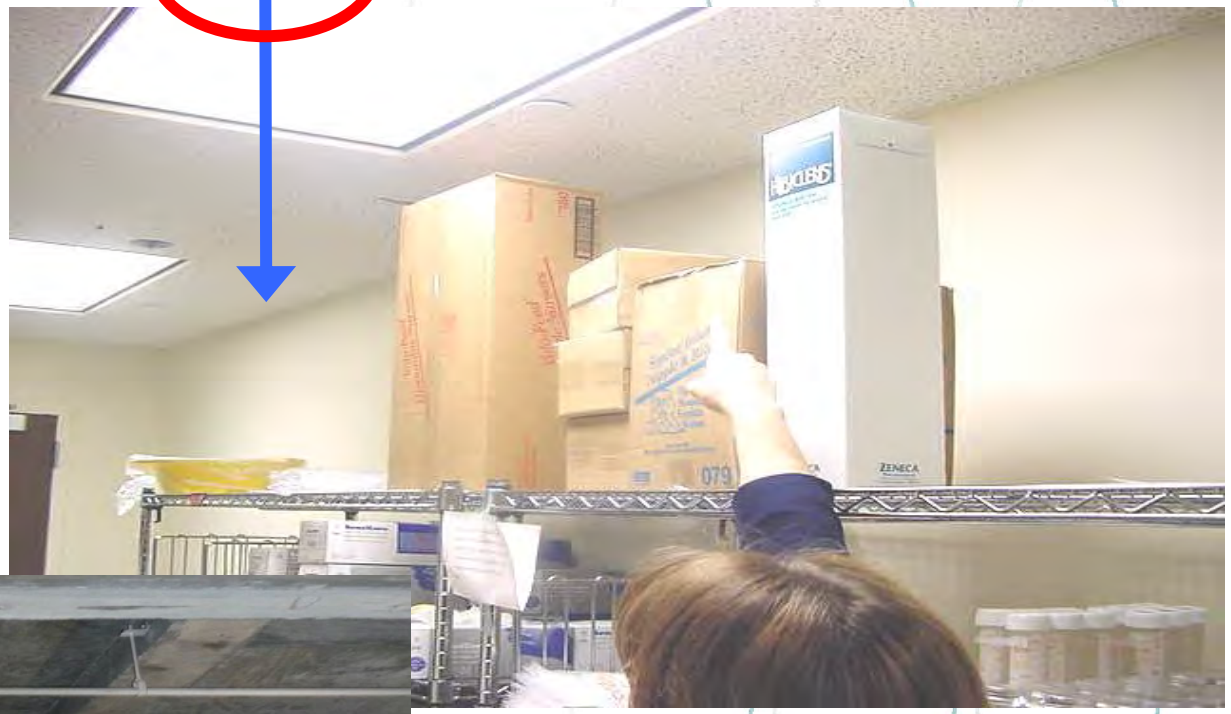
CORRIDOR DOORS
Must not be blocked
Must self-latch

#5 LS.02.01.25 EP 5 Sprinkler Damaged 36.2%

#6 LS.02.01.34 EP 9 Gaps in Ceiling Tiles 27.2%

#7 LS.02.01.35 EP 6 18” Clearance 26.4%




THANK YOU

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New Code Changes in

- *NFPA 101*
- *NFPA 99*

NOTE:

CMS must adopt a more current edition of the LSC for these changes to take effect.

Self-Latching Doors

Self-closing or automatic closing door leaves, which become self-latching upon operation of approved smoke detectors, shall be considered as meeting all the self-latching provisions.

Added #3 in NFPA 101-2021, 18.3.6.3.7

Powered doors that comply with the requirements of 7.2.1.9 shall not be required to meet the latching requirements of 18.3.6.3.5, provided that all of the following are met:

1) The door is equipped with a means of keeping the door closed that is acceptable to the AHJ
2) The device used is capable of keeping the door fully closed if a force of 5lbf is applied at the latch edge of the swinging door and applied in any direction to a sliding or folding door, whether or not power is applied
3) Where door leaves are operated by power by any automatic mechanism, the automatic opening of the doors shall cease to function upon operations of approved smoke detectors installed in accordance with the provisions of NFPA 72 for door release service.

Smoke Compartment Size Increase

Changed in 2018 & again in 2021

- Smoke compartments may be increased in size to:
  - 40,000 sf for smoke zones with all patient sleeping rooms configured for only one patient and suites in accordance with 18.2.5.7
  - 40,000 sf for smoke zones with no patient sleeping rooms
  - 22,500 sf in nursing homes and unlimited care facilities
- Looking at impacts to other code sections (i.e. ABHR)

NON-Sleeping Suite Size Increase

Changed in 2015 & again in 2018

- Currently: shall not exceed 10,000 sqft
- In 2018: Shall not exceed 12,500 sqft 101-2021 18.2.5.7(A)
  - May be increased to 15,000 sqft with automatic smoke detection 101-2021 18.2.5.7.3.2(B)

Exit Sign Inspections

Changed in 2021

- 7.10.9 sends the user to 7.9.3
- 7.9.3 provides four options for testing
- 7.9.1.3 eliminated the requirement for exit signs to have visual inspections for operation of the illumination sources every 30 days

Temporary Construction Separation

Changed in 2021 & again in 2024

- 101-2021 18.7.9.3:
  - Added that flame resistant plastic barriers used during construction on rehabilitation activities shall be permitted for not more than 30 days

- NFPA 241-2024
  - Flame resistant plastic barriers shall be permitted during rehabilitation projects

Responsible Facility Authority

NFPA 99-2021 5.1.14.1 Requirement that a “Responsible Facility Authority” is designated to oversee the medical gas and vacuum system

- Advising on the risk assessment
- Writing and upkeep of portions of the emergency plan that might affect piped gas
- Ensuring the emergency plan addresses unusual requirements necessary for patient and staff safety during design and construction
- Develop permit to work rules
- Evaluation and acceptance of test reports
- Maintenance of facility records for piped gas
- 5.1.14.1.2.2

New Chapter for Dental Medical Gas & Vacuum

- New requirements for medical gas & vacuum systems used in dental facilities added in 2015
  - NFPA 99-2015 5.3.3.6 Dental Air Supply Systems
  - NFPA 99-2015 5.3.3.6.2 Dental Air Cylinder Supply Systems
  - NFPA 99-2015 5.3.3.4 Medical-Surgical Vacuum
  - NFPA 99-2015 5.3.12.2 Category 3 Dental Vacuum Supply Systems
- Moved to new Chapter 15 in NFPA 99-2018

Fire Protection Feature: OR Solution Soaked Materials

Changed in NFPA 99-2021 16.14.3.4

- Solution-soaked materials are no longer required to be removed from the operating room prior to draping or using electro surgery, lasers, or cautery
- Now it is only required to be removed from the patient care vicinity

Fire Protection Feature: OR Extinguishers

Changed in NFPA 99-2018 16.9.1.3

- Clean Agent-type or Water Mist-type extinguishers shall be provided in operating rooms