

# Antibiotic use in long-term care facilities

## Get Smart About Antibiotics Week

November 14-20, 2011



### Did you know?

1. Antibiotic resistance is one of the world's most pressing public health threats.
2. Antibiotics are the most important tool we have to combat life-threatening bacterial diseases, but antibiotics can have side effects and complications.
3. Antibiotic overuse increases the development of drug-resistant germs.
4. Patients, healthcare providers, healthcare facility administrators, and policy makers must work together to employ effective strategies for improving antibiotic use – ultimately improving medical care and saving lives.

### Scope of the Problem

- Antibiotics are among the most commonly prescribed medications in long-term care facilities.
- Up to 70% of long-term care facilities' residents receive an antibiotic every year.
- Estimates of the cost of antibiotics in the long-term care setting range from \$38 million to \$137 million per year.

Antibiotic resistance in long-term care is associated with:

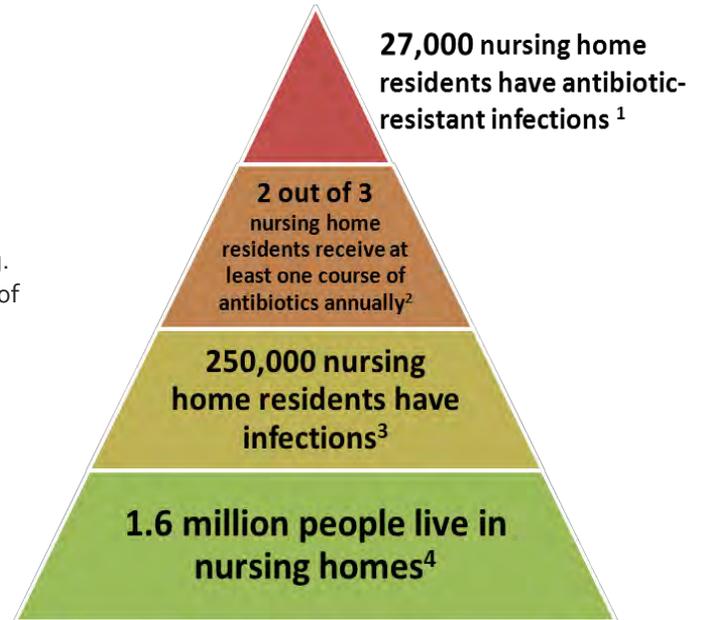
- Increased risk of hospitalization
- Increased cost of treatments
- Increased risk of death

### Why we need to act

- Among the antibiotic-resistant organisms most commonly found in long-term care populations are multidrug-resistant gram negative bacteria, methicillin-resistant *Staphylococcus aureus* (MRSA), and vancomycin-resistant enterococci (VRE).
- Antibiotic use may result in the selection of antibiotic-resistant organisms.
- Recent studies indicate that multidrug-resistant Gram-negative bacteria are becoming a more important challenge in long-term care.
- Overuse of antibiotics also increases the problems of drug side effects, allergic reactions, and diarrheal infections caused by *Clostridium difficile*.
- The way we use antibiotics today or in one patient directly impacts how effective they will be tomorrow or in another patient; they are a shared resource.
- Since it will be many years before new antibiotics are available to treat some resistant infections, we need to improve the use of antibiotics that are currently available.

## Why focus on long-term care?

1. Long-term care facilities inconsistently use criteria for diagnosing infection and/or initiating antibiotics.
2. Many long-term care residents can be “colonized” with bacteria meaning that germs can live on the skin, wound surfaces or even in the bladder without making the person sick. Challenges with separating colonization from true infection can contribute to antibiotic overuse in this setting.
  - Studies have consistently shown that about 30%-50% of frail, elderly long-term care residents can have a positive urine culture even without any symptoms of a urinary tract infection. Unfortunately, many of these patients are placed inappropriately on antibiotic therapy.
3. Poor communication about antibiotic treatment of a patient, who is transferred from a hospital to a long-term care facility, may result in prolonged or inappropriate antibiotic therapy.
4. Antibiotic-related complications like diarrhea from *C. difficile* can be more severe, difficult to treat, and lead to more hospitalizations and deaths among people over 65 years. Long-term care facility residents are particularly at risk for these complications.



<sup>1</sup> Centers for Medicare and Medicaid Services, Long Term Care Minimum Data Set, Resident profile table as of 05/02/2005. Baltimore, MD.  
<sup>2</sup> Loeb, M et. al. Antibiotic use in Ontario facilities that provide chronic care. *J Gen Intern Med* 2001; 16: 376-383.  
<sup>3</sup> Centers for Disease Control and Prevention, National Center for Health statistics, 1999 National Nursing Home Survey. Nursing Home Residents, number, percent distribution, and rate per 10,000, by age at interview, according to sex, race, and region: United States, 1999.

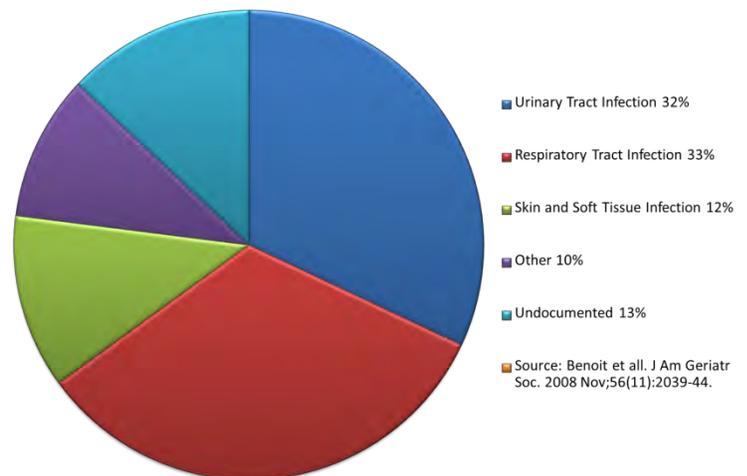
## Long-term care facilities can

- Have clear policies and practices to ensure that patients are not started on antibiotics unless they are needed.
- Review the facility’s microbiology reports and antibiogram to detect trends in antibiotic resistance.
- Implement policies that encourage prudent antimicrobial prescribing, including establishment of minimum criteria for prescribing antibiotics and review of antibiotic appropriateness and resistance patterns.
- Implement nursing protocols for monitoring patients’ status for an evolving condition if there is no specific indication for antibiotics.

## Long-term care providers can

- Obtain microbiology cultures prior to starting antibiotics when possible so antibiotics can be adjusted or stopped when appropriate.
- Remember that treatment with antibiotics is only appropriate when the practitioner determines, on the basis of an evaluation, that the most likely cause of the patient’s symptoms is a bacterial infection.
- Use antibiotics only for as long as needed to treat infections, minimize the risk of relapse, or control active risk to others. Antibiotics are generally not indicated to treat colonization.
- Avoid use of antibiotics to treat viral illnesses such as colds, influenza, and viral gastroenteritis.
- Engage residents and their family members in addressing the need to improve antibiotic use in your facility.

## Most common infections treated with antibiotics in nursing homes



Developed in partnership with the **American Medical Directors Association**



### Centers for Disease Control and Prevention

For more information please contact Centers for Disease Control and Prevention  
 1600 Clifton Road NE, Atlanta, GA 30333

Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-63548

Email: [cdcinfo@cdc.gov](mailto:cdcinfo@cdc.gov) Web: <http://www.cdc.gov/getsmart/> Web: <http://www.cdc.gov/getsmart/healthcare/>



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Department of Health Services

**DIVISION OF QUALITY ASSURANCE**

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**Date:** November 29, 2011

DQA Memo 11-031

**To:** Nursing Homes

NH 21

**From:** Juan Flores, Director  
Bureau of Nursing Home Resident Care

**Via:** Otis Woods, Administrator  
Division of Quality Assurance

**Glucose Meters and Infection Control**

The Division of Quality Assurance (DQA), Bureau of Nursing Home Resident Care (BNHRC) is an agent of the federal government and conducts nursing home surveys to ensure compliance with federal health and Life Safety Code regulations. Satisfactory performance during these surveys is required for facilities to continue their participation in the Medicare and/or Medicaid programs.

**Background**

Previously, DQA issued [DQA Memo 08-013 Glucose meters and Infection Control](#) and [DQA Memo 09-054 Cleaning and Disinfecting Glucose Meters Shared Between Residents](#). These memos addressed the standards of practice to prevent patient-to-patient transmission of bloodborne pathogens when using glucose meters and also provided information and guidance regarding the cleaning and disinfecting of glucose meters that are shared between residents in the facility. The information in these memos remains a valuable resource in order to comply with infection control requirements related to glucose meters.

Facilities continue to be cited for failing to clean and disinfect meters between residents when the meter is used by multiple residents. One new issue that has arisen is not ensuring the cleaning and disinfecting process is effective. Observations have included staff using cleaning agents that do not kill bloodborne pathogens or staff not adhering to the manufacturer's instructions for the cleaning agents to ensure effectiveness. For example, for a given disinfecting wipe, the manufacturer's instructions direct the disinfecting wipe to have contact time on the surface for 2 minutes to be effective. For this particular wipe, an observation of a violation would be staff using a wipe with a contact time of 30 seconds.

**Requirements and Resources**

Facilities should evaluate the products that are being used to clean and disinfect the glucose meters to ensure they are effective against bloodborne pathogens. Facilities should also

complete surveillance to ensure staff is following the appropriate instructions for the cleaning agent being used. Most manufacturers have specific product websites that contain instructions for product use.

Please see the following resources for more information:

[Resources for Fingerstick Device Standards](#)

[EPA Approved Cleaning Agents](#)

### **Questions**

If you have questions about this memo, please contact Doug Englebert, Pharmacist Consultant, at (608) 266-5388.

Office of Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 12-30-ALL

**DATE:** May 18, 2012  
**TO:** State Survey Agency Directors  
**FROM:** Director  
Survey and Certification Group  
**SUBJECT:** Use of Insulin Pens in Health Care Facilities

**Memorandum Summary**

**Insulin Pen devices:** The Centers for Medicare & Medicaid Services (CMS) has recently received reports of use of insulin pens for more than one patient, with at least one 2011 episode resulting in the need for post-exposure patient notification. These reports indicate that some healthcare personnel do not adhere to safe practices and may be unaware of the risks these unsafe practices pose to patients. **Insulin pens are meant for use by a single patient only.** Each patient/resident must have his/her own. Sharing of insulin pens is essentially the same as sharing needles or syringes, and must be cited, consistent with the applicable provider/supplier specific survey guidance, in the same manner as re-use of needles or syringes.

**Background**

Insulin pens are pen-shaped injector devices that contain a reservoir for insulin or an insulin cartridge. These devices are designed to permit self-injection and are intended for single-person use. In healthcare settings, these devices are often used by healthcare personnel to administer insulin to patients. Insulin pens are designed to be used multiple times by a single patient/resident, using a new needle for each injection. Insulin pens must never be used for more than one patient/resident. Regurgitation of blood into the insulin cartridge after injection will create a risk of bloodborne pathogen transmission if the pen is used for more than one patient/resident, even when the needle is changed [1]. A previous memo (10-28-NH), dated August 27, 2010, similarly identified that point of care testing devices must not be shared between residents because of the risk of bloodborne pathogen transmission.

In 2009, in response to reports of improper use of insulin pens in hospitals, the Food and Drug Administration (FDA) issued an alert for healthcare professionals reminding them that insulin pens are meant for use by a single patient only and are not to be shared between patients [2]. Despite this alert, patients continue to be placed at risk of bloodborne pathogen exposure through inappropriate use of insulin pens for more than one patient, including an incident in 2011 that required notification of more than 2,000 patients [3]. These events indicate that some healthcare personnel may be unaware of the risk this unsafe practice poses to patients/residents.

## Discussion

Any provider or supplier using insulin pens should review the following recommendations of the FDA to prevent transmission of bloodborne infections in the patients/residents under their care.

- Insulin pens containing multiple doses of insulin are meant for single patient/resident use only, and must never be used for more than one person, even when the needle is changed.
- Insulin pens must be clearly labeled with patient/resident's name or other identifiers to verify that the correct pen is used on the correct patient/resident.
- Healthcare facilities should review their policies and procedures and educate their staff regarding safe use of insulin pens.

Reuse of insulin pens is similar to reusing needles or syringes for more than one patient/resident and must direct the surveyor to focus on the overall infection control practices in the facility. The facility plan of correction should include notification of the local health department or state epidemiologist for determination of the need for post-exposure follow-up of patients and residents.

**Effective Date:** Immediately. Please ensure that state and RO surveyors are incorporating this information into their survey practices.

**Training:** The information must be shared with all survey and certification staff, surveyors, managers, and the State and CMS Regional Office training coordinators.

## Additional Resource Material

The CDC has updated their website reference material [www.cdc.gov/injectionsafety](http://www.cdc.gov/injectionsafety) and issued a clinical reminder accessible at <http://www.cdc.gov/injectionsafety/clinical-reminders/insulin-pens.html>

## References

1. Sonoki K, Yoshinari M, Iwase M, Tashiro K, Iino K, Wakisaka M, Fujishima M. Regurgitation of blood into insulin cartridges in the pen-like injectors. *Diabetes Care*. 2001;24(3):603-4.
2. Information for healthcare professionals: risk of transmission of blood-borne pathogens from shared use of insulin pens (2009). *U.S. Food and Drug Administration Postmarket Drug Safety Information for Patients and Providers*. Accessed November 14, 2011 from <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/DrugSafetyInformationforHealthcareProfessionals/ucm133352.htm>
3. Important Patient Safety Notification (2011). *Dean Clinic*. Accessed November 14, 2011 from <http://www.deancare.com/about-dean/news/2011/important-patient-safety-notification/>

Page 3- State Survey Agency Directors

Questions may be sent to Karen Hoffmann at [Karen.Hoffmann@cms.hhs.gov](mailto:Karen.Hoffmann@cms.hhs.gov) or phone (919)-622-4811.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

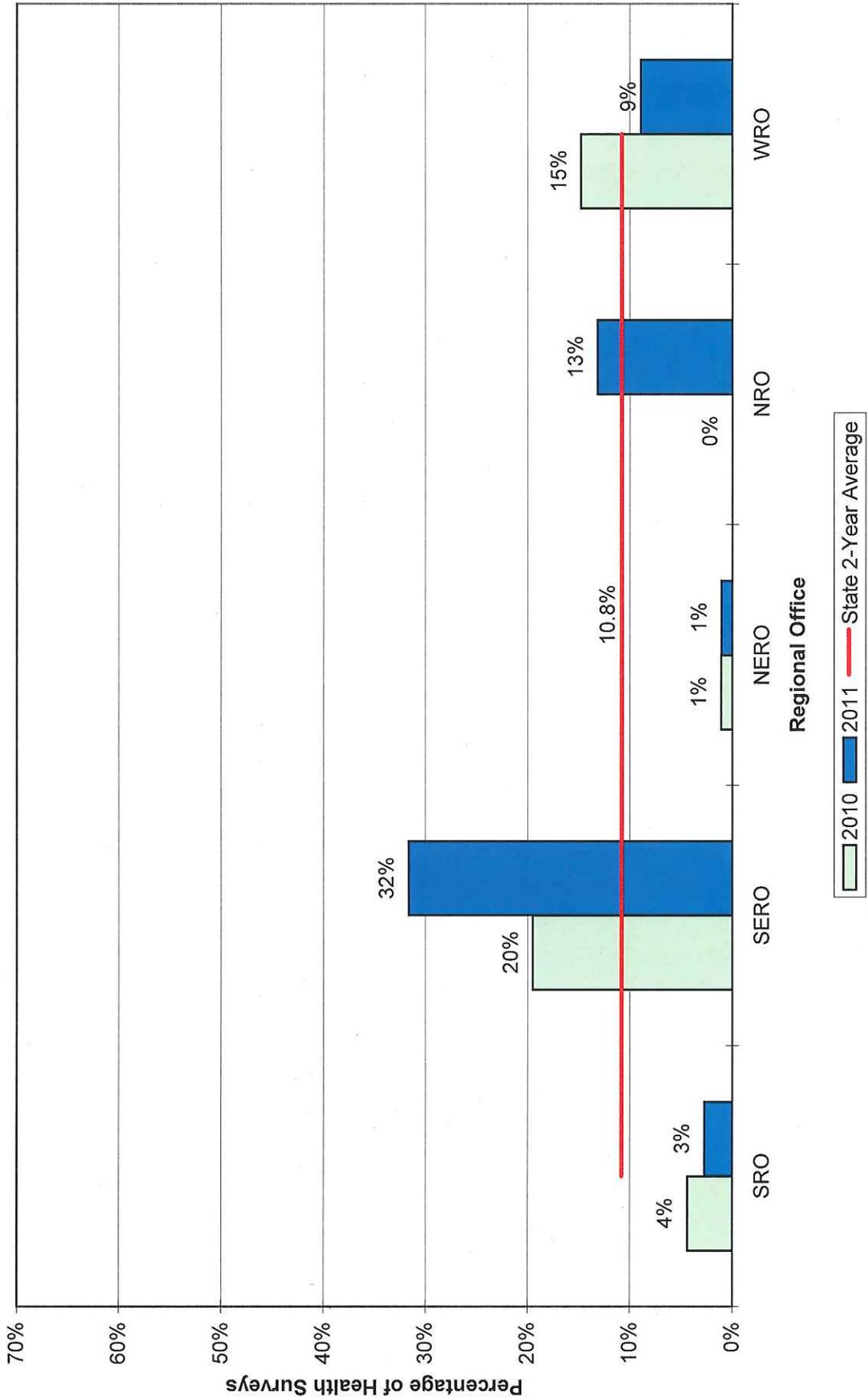
# STATE AND FEDERAL CITING STATISTICS FOR 2011



State citing information obtained from ASPEN CENTRAL OFFICE  
Federal citing information obtained from CMS S & C PDQ

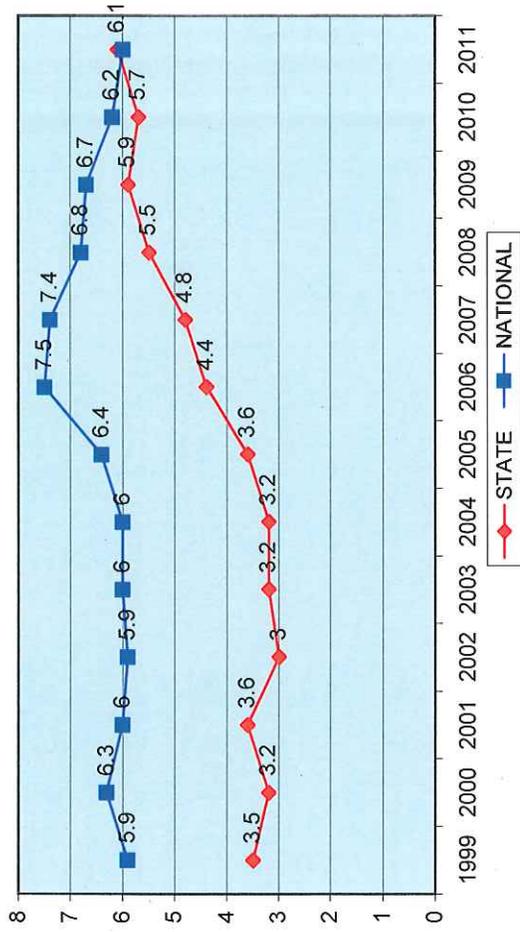
State of Wisconsin  
Department of Health Services  
Division of Quality Assurance

# % of Deficiency Free Health Surveys 2010 - 2011

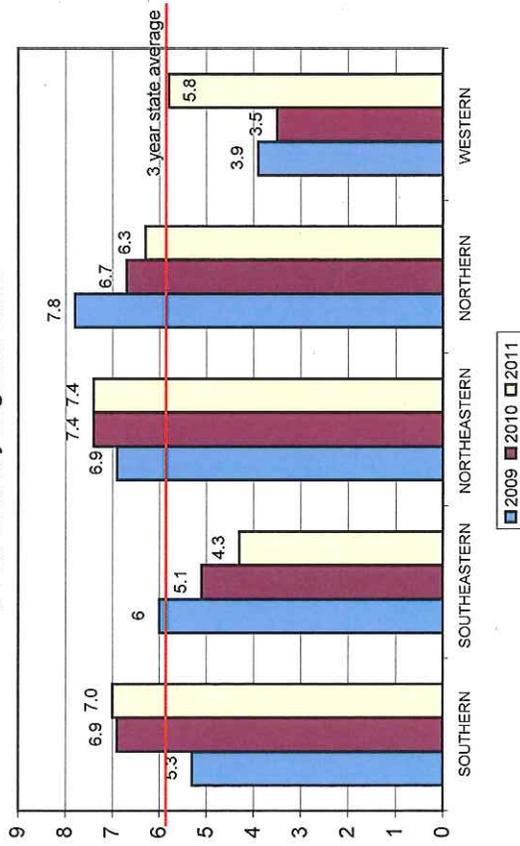


# Recertification Surveys Average # Federal Health Citations

U.S. and State Trend 1999 - 2011

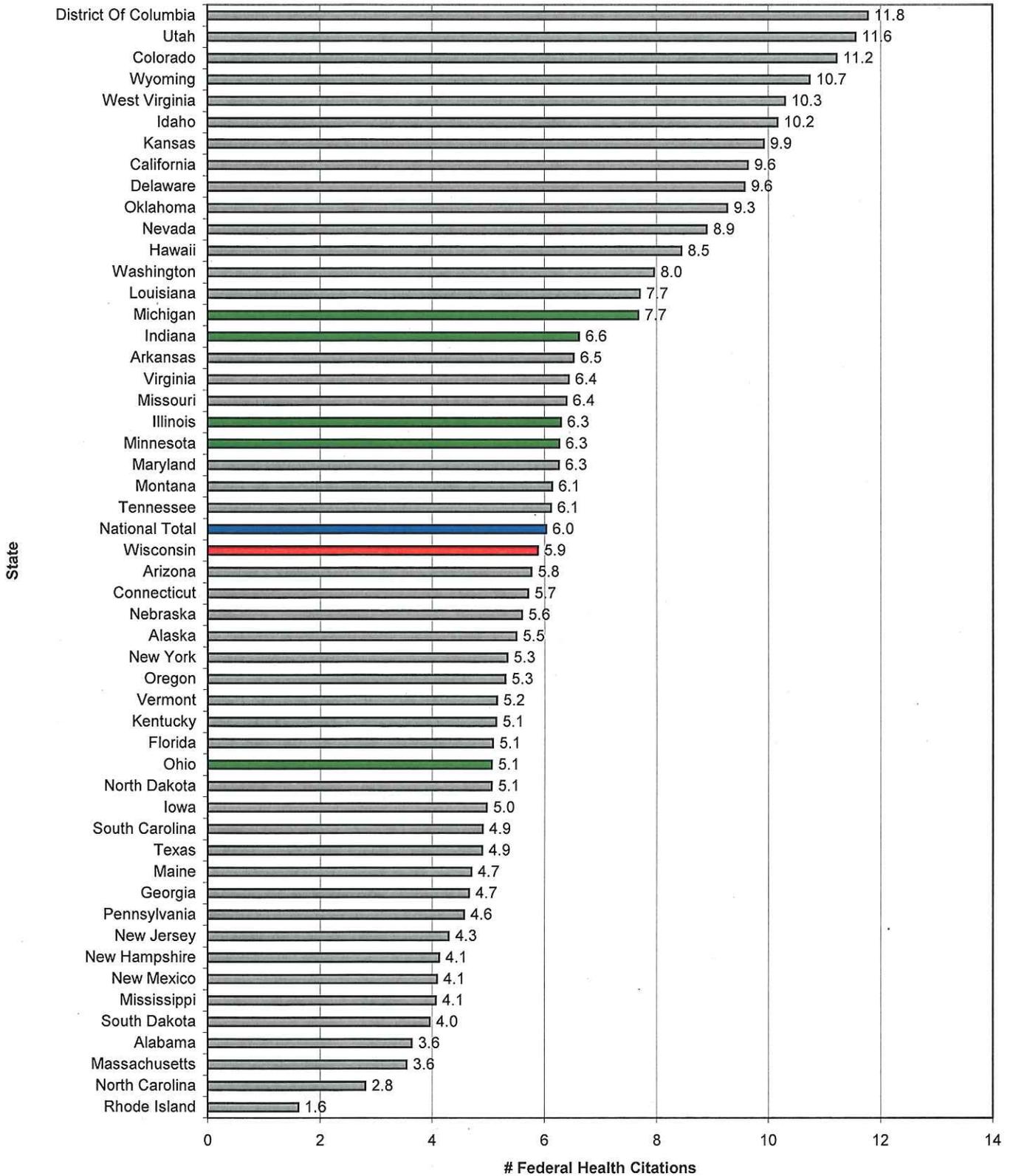


3-Year Trend by Regional Office



## Average # Federal Health Citations per Recertification Survey 2011

S&C PDQ data



**TOP TEN FEDERAL HEALTH CITATIONS – NATIONAL, STATE, REGIONAL OFFICE – 2011**

National	State	Southern (Madison)	Southeastern (Milwaukee)	Northeastern (De Pere)	Northern (Rhinelander)	Western (Eau Claire)
F323 – supervision to prevent accidents (6773)	F323 – supervision to prevent accidents (230)	F282 – care in accordance with care plan (48)	F323 – supervision to prevent accidents (45)	F441 – infection control (80)	F441 – infection control (27)	F441 – infection control (48)
F441 – infection control (6228)	F441 – infection control (230)	F371 – food prepared/served under sanitary conditions (48)	F225 – investigate allegations of abuse (44)	F323 – supervision to prevent accidents (77)	F323 – supervision to prevent accidents (26)	F323 – supervision to prevent accidents (38)
F309 - care promotes highest level of functioning and well being (5251)	F282 – care in accordance with care plan (151)	F323 – supervision to prevent accidents (44)	F226 – develop and implement policies prohibiting abuse (40)	F282 – care in accordance with care plan (74)	F225 - investigate allegations of abuse (18)	F371 – store, prepare, distribute food under sanitary conditions (25)
F371 – food prepared/served under sanitary conditions (5045)	F225 - investigate allegations of abuse (148)	F441 – infection control (41)	F441 – infection control (34)	F314 – prevention of pressure (53)	F309 – care promotes highest level of well-being (16)	F514 - documentation (22)
F279 – develop comprehensive care plan (3751)	F371 – food prepared/served under sanitary conditions (140)	F279 – develop comprehensive care plan (35)	F279 – develop comprehensive care plan (29)	F371 – store, prepare, distribute food under sanitary conditions (50)	F314 – prevention of pressure ulcers (15)	F225 - investigate allegations of abuse (20)
F281 – professional standards of practice (3262)	F279 – develop comprehensive care plan (134)	F514 - documentation (31)	F309 – care promotes highest level of well-being (28)	F279 – develop comprehensive care plan (42)	F282 – care in accordance with care plan (14)	F279 – develop comprehensive care plan (20)
F329 – Drug regimen is free of unnecessary drugs (3129)	F314 – prevention of pressure ulcers (130)	F225 - investigate allegations of abuse (29)	F314 – prevention of pressure (25)	F156 – notice of rights, rules, services, charges (40)	F226 – develop and implement policies prohibiting abuse (12)	F156 – notice of rights, rules, services, charges (18)
<b>F514 - documentation (3085)</b>	F329 – Drug regimen is free of unnecessary drugs (102)	F157 – contact MD after significant condition change (27)	F425 – medication system assures accurate receipt/administration (24)	F329 – Drug regimen is free of unnecessary drugs (39)	F312 – Services to help carry out activities of daily living (12)	F226 – develop and implement policies prohibiting abuse (15)
F225 - investigate allegations of abuse (2750)	F309 - care promotes highest level of functioning and well being (49)	F329 – Drug regimen is free of unnecessary drugs (26)	F156 – notice of rights, rules, services, charges (18)	F225 - investigate allegations of abuse (37)	F315 - services to restore bladder function and to prevent UTIs (11)	F314 – prevention of pressure ulcers (14)
F241 – resident dignity (2736)	F226 – develop and implement policies prohibiting abuse (93)	F314 – prevention of pressure ulcers (23)	F157 – contact MD after significant condition change (18)	F425 – medication system assures accurate administration (34)	F371 – store, prepare, distribute food under sanitary conditions (10)	F309 – care promotes highest level of well-being (13)
					F281 – professional standards of practice (10)	

*BOLD ITALICS – not in State's top ten*    *New to Top Ten compared to entity's 2010 data*

## Wisconsin Top Ten Federal Health Citations 2011

Rank	Rank 2010	Tag	Description of Regulation	# Citations	# Cites at Harm or IJ
1	1	F323	Facility is free of hazardous environment/Supervision and assistive devices to prevent accidents	230	50
1	2	F441	Infection control program designed to prevent the development and spread of infection	230	7
3	6	F282	Services provided in accordance with the plan of care	151	0
4	3	F225	Reporting and investigation of allegations of abuse, mistreatment, neglect and mistreatment	148	3
5	4	F371	Food stored, prepared, distributed, and served in a manner that prevents food borne illness	140	0
6	7	F279	Development of comprehensive care plan	134	0
7	9	F314	Services and treatment to prevent and/or to heal pressure ulcers	130	25
8		F329	Unnecessary drugs	102	2
9	8	F309	Services to attain/maintain highest practicable level of well being	94	30
10	5	F226	Development and implementation of policies to prevent abuse, mistreatment, neglect, and misappropriation of property	93	0
11		F425	Pharmaceutical system assures accurate acquiring, receiving, dispensing, and administration of drugs	91	0

**Northern Regional Office  
Top Ten Federal Health Citations  
January 1, 2012 – May 21, 2012**

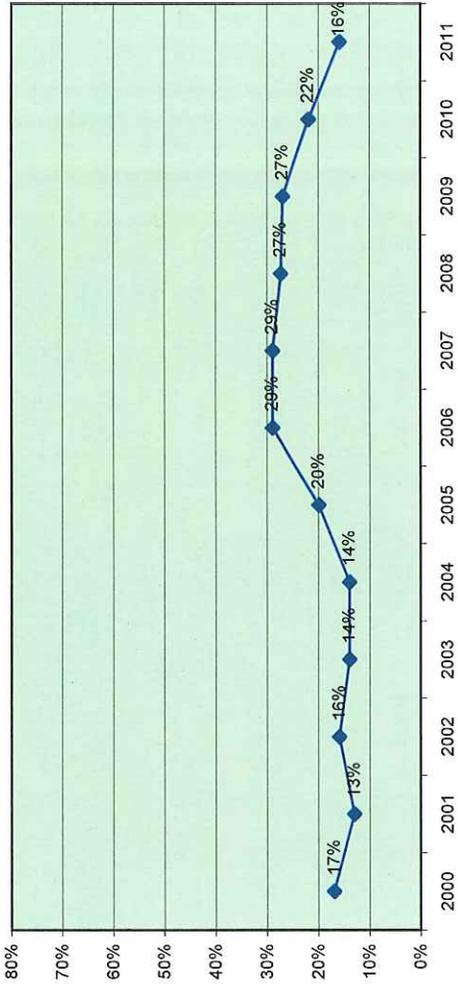
<b>Rank</b>	<b>NRO Rank 2011</b>	<b>Tag</b>	<b>Description of Regulation</b>	<b># Citations</b>	<b># Cites at Harm or IJ</b>
1	1	F441	Infection control program designed to prevent the development and control the spread of infection	14	0
2	2	F323	Facility is free of hazardous environment/Supervision and assistive devices to prevent accidents	11	2
3	4	F309	Care and services to attain/maintain highest practicable level of well being	10	4
4	9	F315	Care and services to restore as much normal bladder function as possible	8	3
5T	6	F282	Services provided in accordance with the plan of care	7	0
5T		F329	Each resident's drug regimen is free of unnecessary drugs	7	0
7T		F241	Care for residents in a manner and environment that promotes resident dignity	6	0
7T		F279	Facility must develop a comprehensive care plan that is periodically reviewed and updated	6	0
7T		F425	Medication administration system must ensure accurate acquiring, dispensing and administration of medications	6	0
10T			Six tied with five citations each (F314, F371, F514, F157, F225, F226)	5	3

**Western Regional Office  
Top Ten Federal Health Citations  
January 1<sup>st</sup> – April 24<sup>th</sup> 2012**

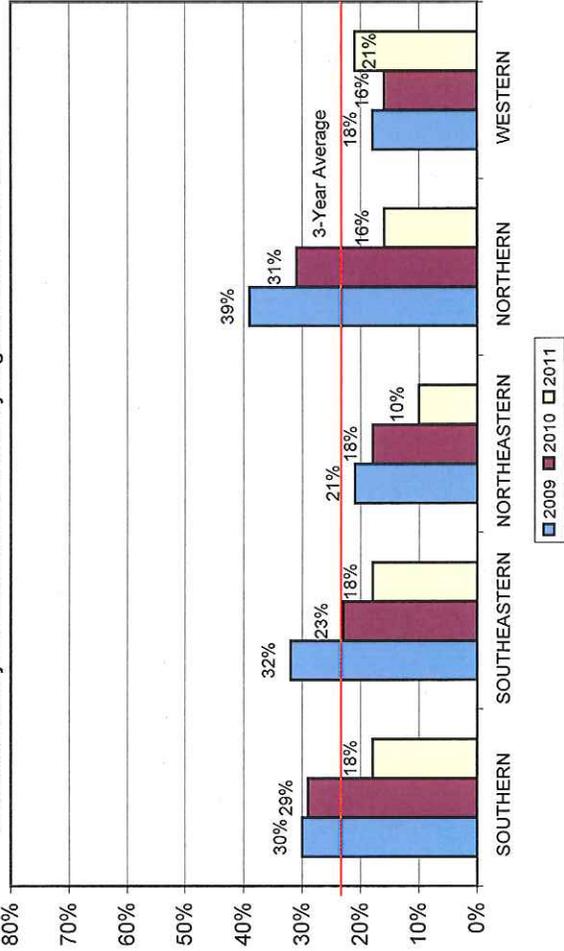
<b>Rank</b>	<b>WRO Rank 2011</b>	<b>Tag</b>	<b>Description of Regulation</b>	<b># Citations</b>	<b># Cites at Harm or IJ</b>
1	1	F441	Infection control program designed to prevent the development and control the spread of infection	13	1
2	2	F323	Environment is free of hazards/Supervision and assistive devices to prevent accidents	8	4
3T	5T	F225	Reporting and investigation of allegations of abuse, mistreatment, neglect and mistreatment	7	0
3T	3	F371	Food stored, prepared, distributed, and served in a manner that prevents food borne illness	7	0
5T	7	F156	Information to be posted or provided at admission or when resident becomes eligible for Medicaid	4	0
5T	5T	F279	Develop comprehensive care plan	4	0
5T		F280	Periodically review and revise care plan	4	0
5T	10	F309	Care and services to attain/maintain highest practicable level of well being	4	4
5T		F329	Drug regimen free of unnecessary drugs	4	0
5T	4	F514	Documentation is complete and accurate	4	6

# Recertification Surveys % of Surveys Identifying Actual Harm or Immediate Jeopardy

State Trend 2000 - 2011

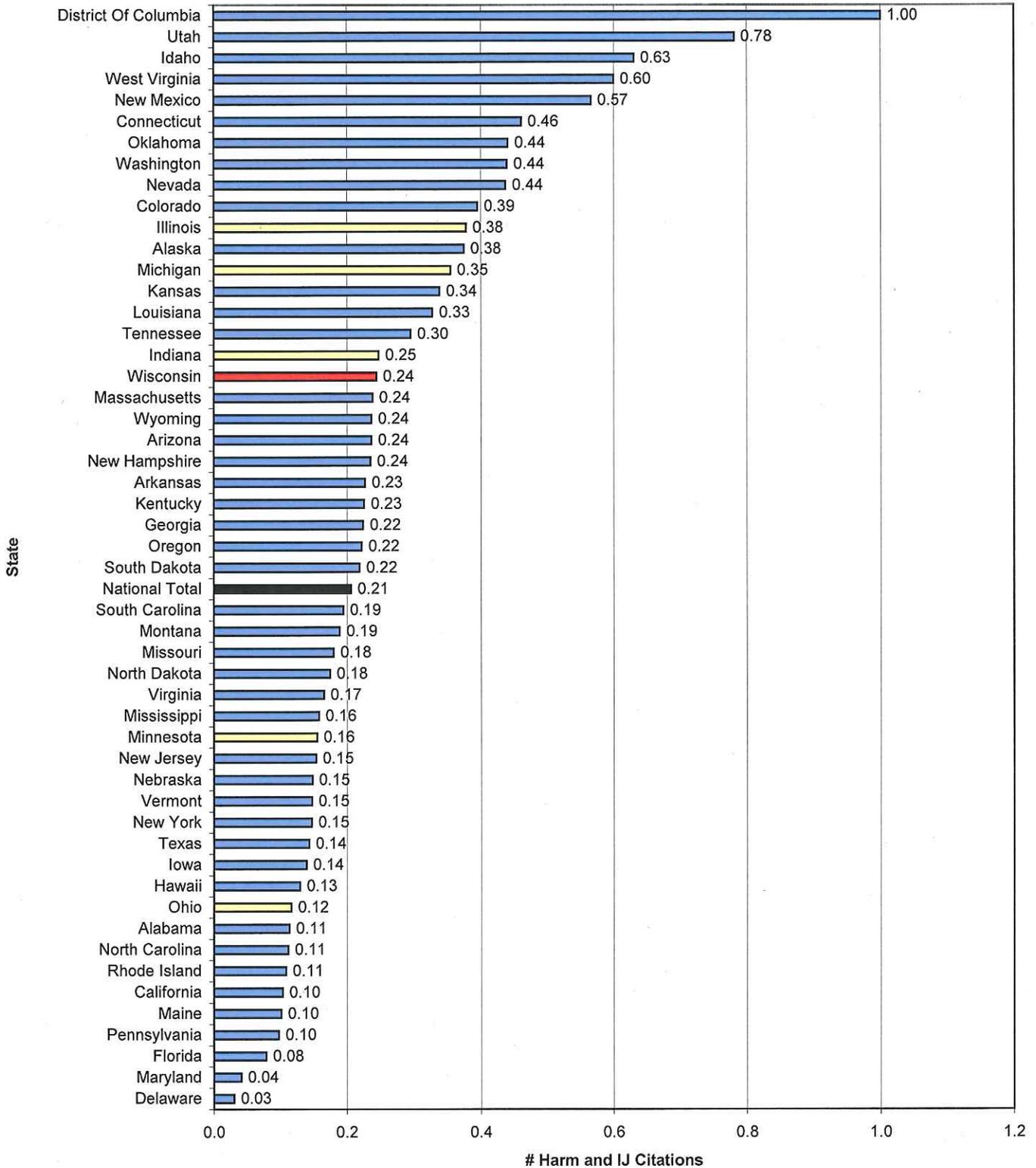


% of Recert Surveys with Harm or IJ Citations by Regional Office 2009 - 2011



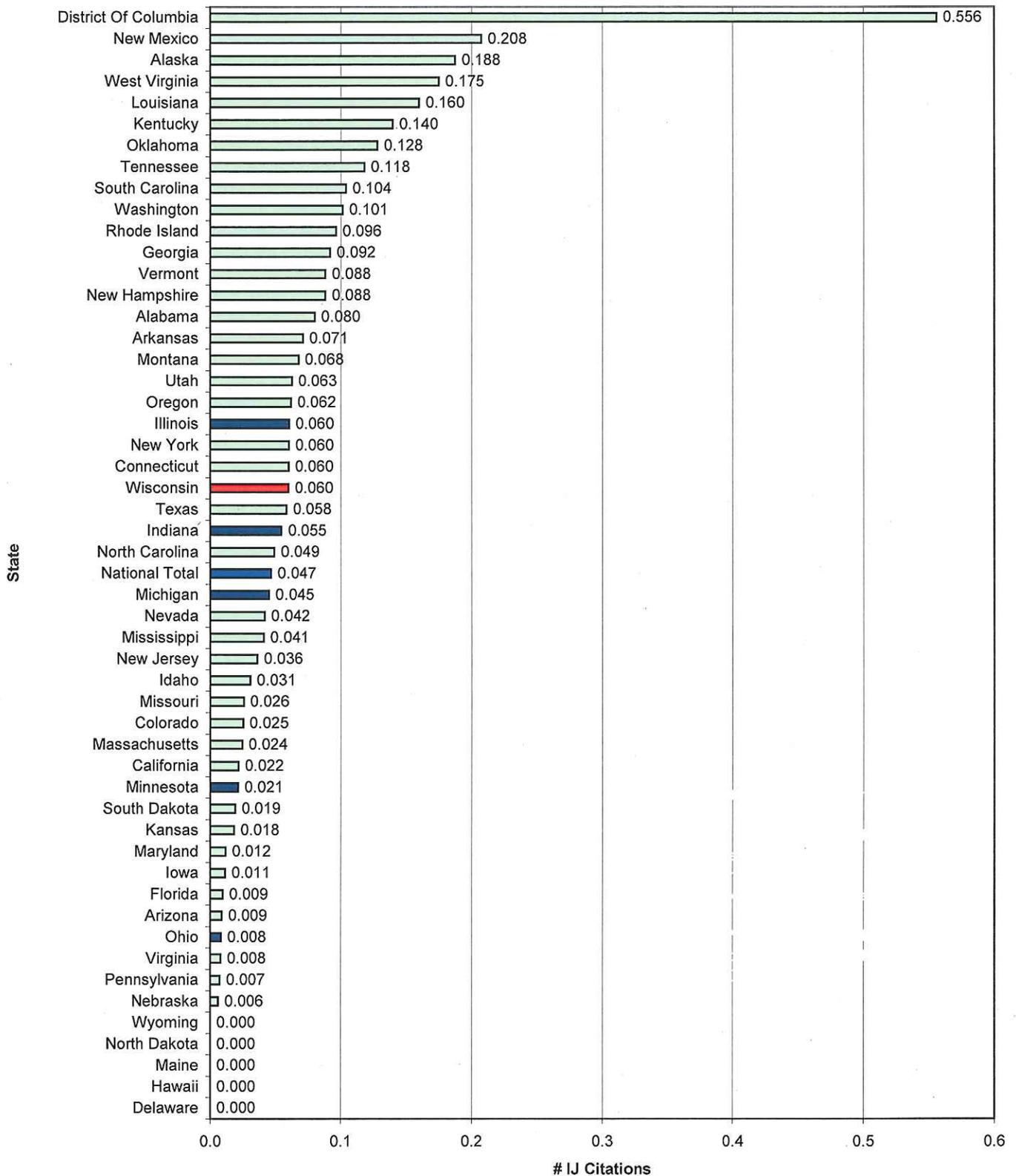
## Average # Harm and Immediate Jeopardy Citations per Recertification Survey 2011

S&C PDQ data



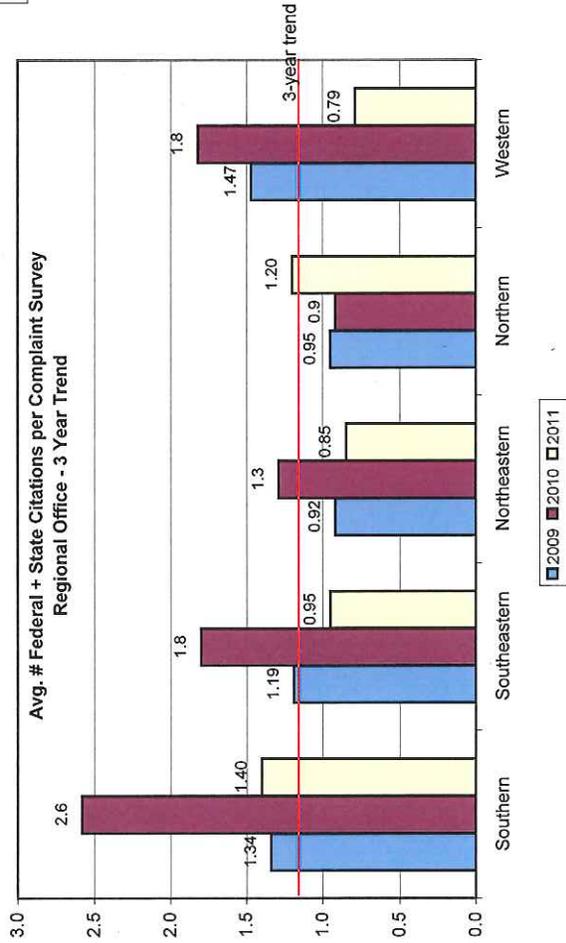
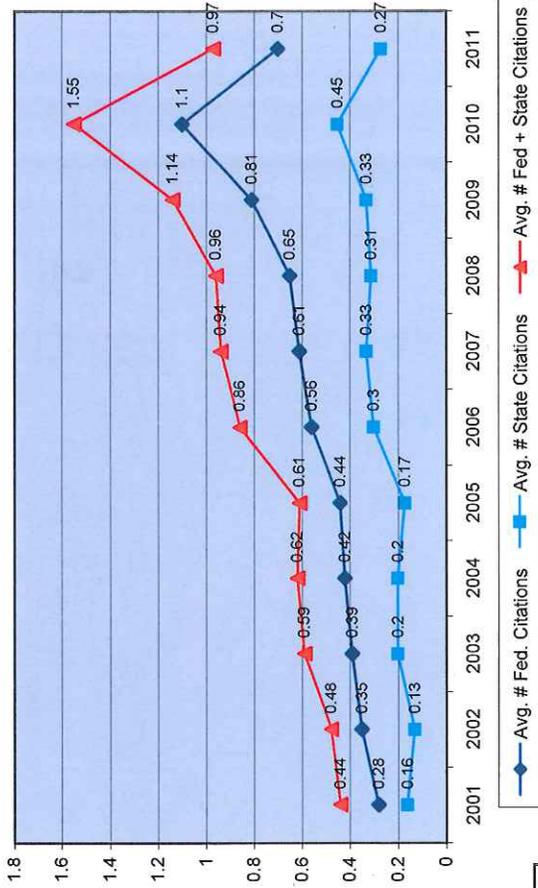
## Average # IJ Citations per Recertification Survey 2011

S&C PDQ data



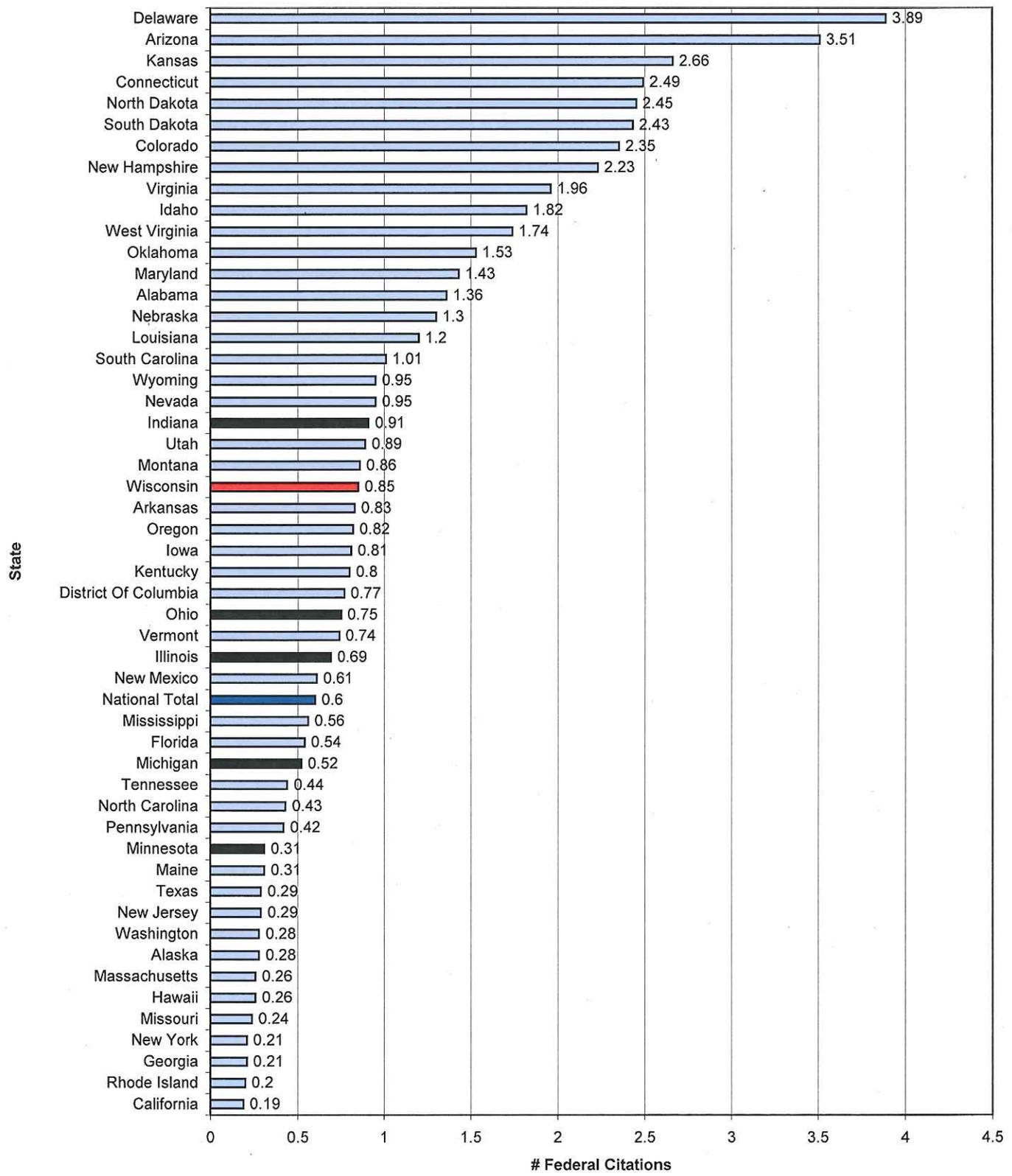
# Complaint Surveys Average # Federal and State Health Citations

State Trend 2001 - 2011



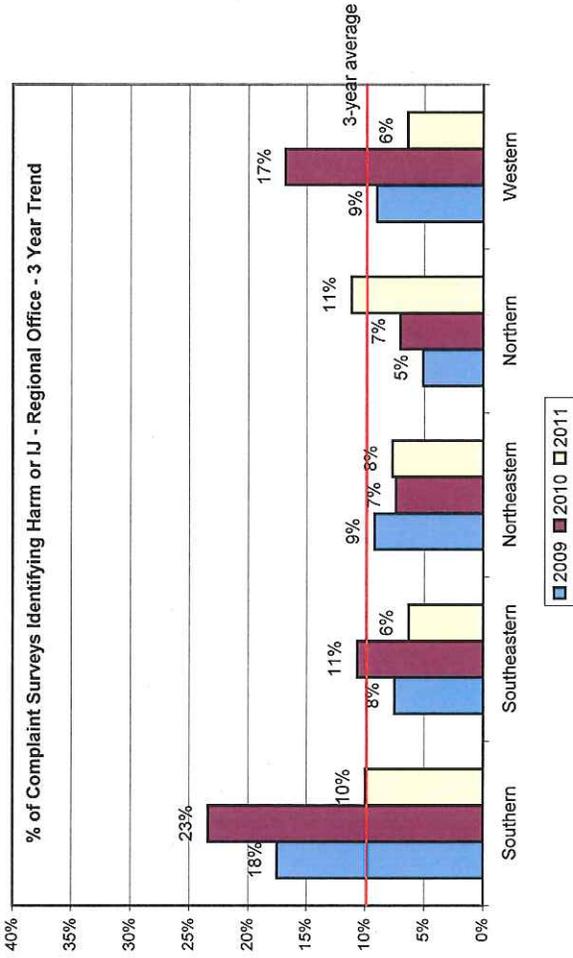
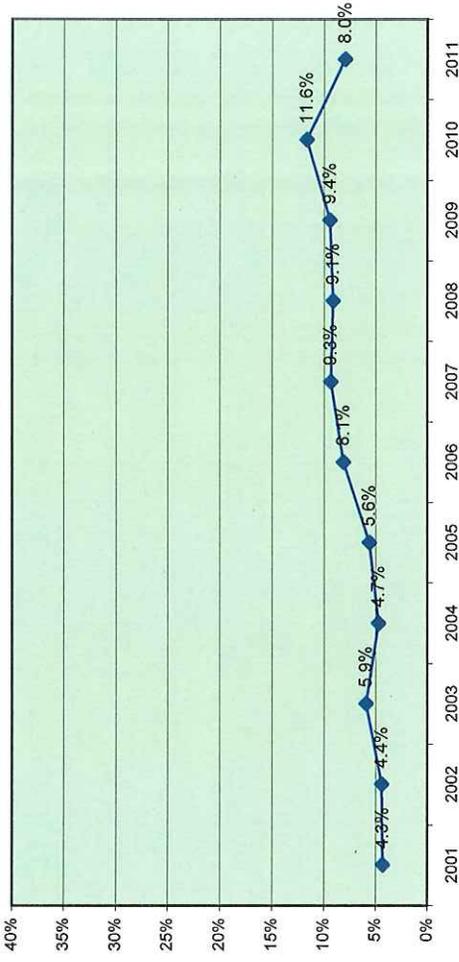
# Average # Federal Health Citations per Complaint Survey 2011

S&C PDQ Data



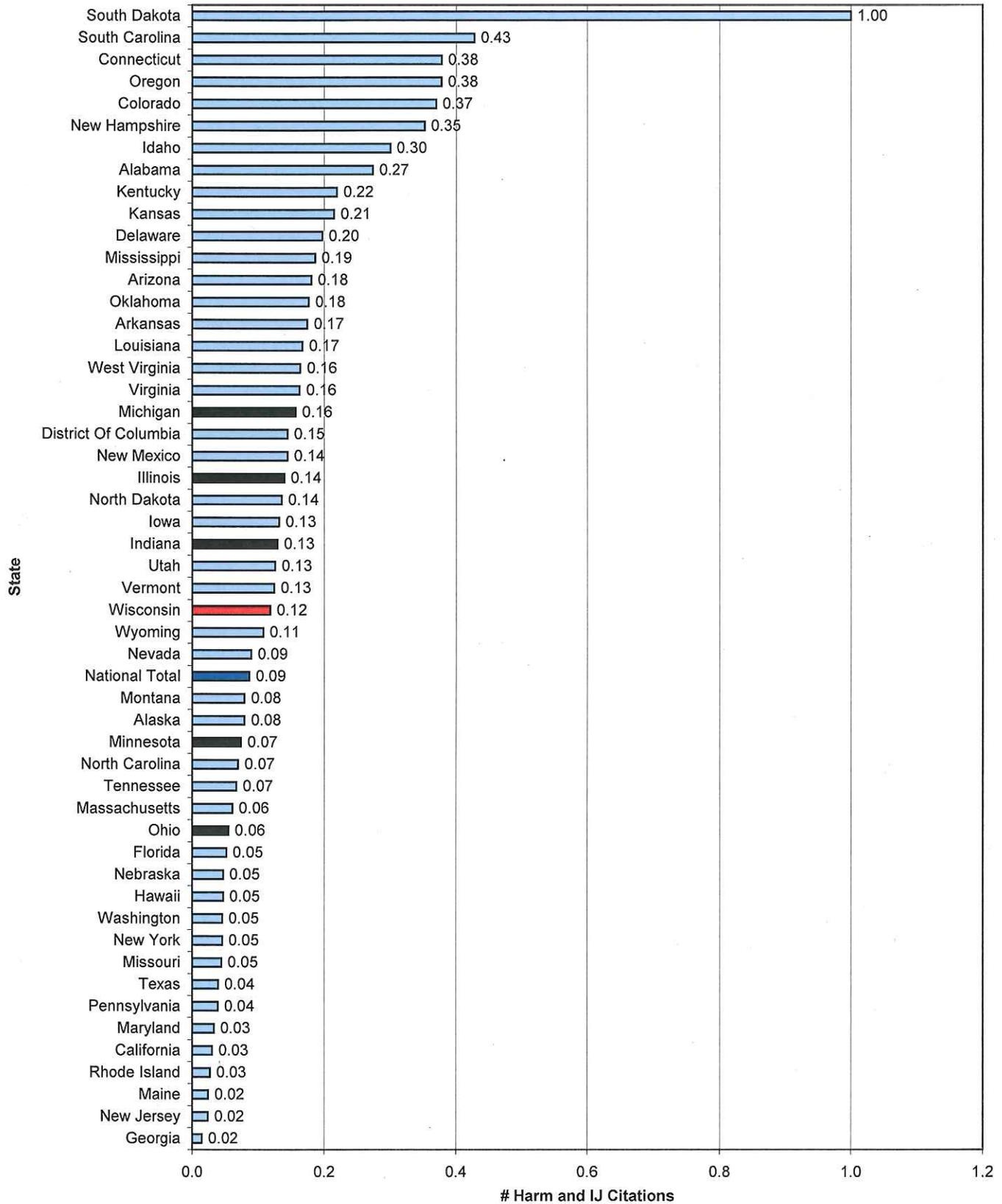
# Complaint Surveys % of Complaint Surveys Identifying Actual Harm or Immediate Jeopardy

State Trend 2001 - 2011



# Average # Harm and IJ Citations per Complaint Survey 2011

S&C PDQ Data



**Wisconsin Top Ten Federal Health Citations Identifying  
Actual Harm or Immediate Jeopardy  
2011**

<b>Rank</b>	<b>Rank 2010</b>	<b>Tag</b>	<b>Description of Regulation</b>	<b># Cites at Harm or IJ</b>
1	1	F323	Facility is free of hazardous environment/Supervision and assistive devices to prevent accidents	51
2	2	F309	Services to attain/maintain highest practicable level of well being	31
3	3	F314	Treatment to prevent and heal pressure ulcers	25
4		F281	Services provided in accordance with professional standards of practice	11
5T	6	F315	Treatment and services to retain/restore as much bladder function as possible	10
5T	4	F157	Immediately consult with physician following a significant change in condition	10
7T	7	F325	Maintain acceptable parameters of nutrition	8
7T	10	F441	Infection control program investigates, controls, and prevents spread of infection	8
9	5	F327	Provide sufficient fluids to maintain hydration	5
10T	9	F225	Reporting and investigation of allegations of abuse, mistreatment, neglect and mistreatment	3
10T	8	F223	Right to remain free of physical, verbal, mental and sexual abuse	3

**TOP 10 FEDERAL HEALTH CITATIONS CITING IMMEDIATE JEOPARDY – NATIONAL, STATE, REGIONAL OFFICE – 2011**

National	State	Southern (Madison)	Southeastern (Milwaukee)	Northeastern (De Pere)	Northern (Rhinelander)	Western (Eau Claire)
F323 – supervision to prevent accidents (402)	F323 – supervision to prevent accidents (12)	F314 – prevention of pressure ulcers (3)	F281 – professional standards of practice (4)	F441 – infection control (4)	F309 – care promotes highest level of well-being (1)	F323 – supervision to prevent accidents (4)
F309 – care promotes highest level of functioning and well being (207)	F309 – care promotes highest level of functioning and well being (9)	F223 – free from abuse (2)	F323 – supervision to prevent accidents (4)	F281 – professional standards of practice (2)	F323 – supervision to prevent accidents (1)	F309 – care promotes highest level of well-being (2)
F490 – administration (200)	F281 – professional standards of practice (9)	F309 – care promotes highest level of functioning and well being (2)	F309 – care promotes highest level of well-being (3)	F309 – care promotes highest level of well-being (2)	F441 – infection control (2)	F441 – infection control (2)
F225 – investigate allegations of abuse (105)	F441 – infection control (8)	F157 – contact MD after significant condition change (2)	F225 – investigate allegations of abuse (2)	F323 – supervision to prevent accidents (2)		F281 – professional standards of practice (1)
F226 – develop and implement policies prohibiting abuse (105)	F314 – prevention of pressure ulcers (6)	F225 – investigate allegations of abuse (1)	F441 – infection control (2)	F157 – contact MD after significant condition change (1)		F314 – prevention of pressure ulcers (1)
F224 – free from neglect (93)	F157 – contact MD after significant condition change (3)	F226 – develop and implement policies prohibiting abuse (1)	F157 – contact MD after significant condition change (1)	F329 – Drug regimen is free of unnecessary drugs (1)		F353 – Nurse staffing (1)
F281 – professional standards of practice (73)	F223 – free from abuse (3)	F281 – professional standards of practice (1)	F223 – free from abuse (1)	F314 – prevention of pressure (1)		
F157 – contact MD after significant condition change (65)	F225 – investigate allegations of abuse (3)	F333 – significant medication error (1)	F224 – free from neglect (resident-to-resident abuse) (1)			
F441 – infection control (60)	F226 – develop and implement policies prohibiting abuse (2)		F226 – develop and implement policies prohibiting abuse (1)			
F223 – free from abuse (60)	F490 – administration (2)		F314 – prevention of pressure (1)			
			F365 – Diet served as ordered (1)			
			F490 – administration (1)			

State data includes past noncompliance citations, which do not show up in ASPEN reports and would not be reflected in national data



Scott Walker  
Governor

Dennis G. Smith  
Secretary

**State of Wisconsin**  
Department of Health Services

**DIVISION OF QUALITY ASSURANCE**

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**Date:** May 4, 2012

DQA Memo 12-005

**To:** Adult Family Homes  
Community Based Residential Facilities  
Facilities Serving People with Developmental Disabilities  
Nursing Homes  
Residential Care Apartment Complexes

AFH 02  
CBRF 02  
FDD 01  
NH 04  
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**From:** Kevin Coughlin, Director  
Bureau of Assisted Living

Juan Flores, Director  
Bureau of Nursing Home Resident Care

**Via:** Otis Woods, Administrator  
Division of Quality Assurance

**Guidance for the Safe Use of Oxygen – Use of Hair Dryers**

The purpose of this memorandum is to provide guidance regarding the safe use of oxygen in residential and health care facilities. Recent observations of residents using oxygen in facility beauty salons have prompted this memorandum. The Division of Quality Assurance (DQA) is asking facilities to evaluate the use of oxygen in their facility when residents are using hair dryers. Facilities may need to re-evaluate and consider changes to their policies and procedures to promote a safe environment.

**Oxygen Therapy**

The number of people using oxygen in residential and health care facilities to treat emphysema, chronic bronchitis and congestive heart disease has risen over the past several years. Oxygen therapy allows people to increase the quality of their life but it also puts the person at risk for injury. While smoking when oxygen is in use creates the highest risk for fire, injury or death, other sources of heat or electrical sparks, when in contact with oxygen, can also result in serious harm.

**Electric Hair Dryers**

Using electric hair dryers near oxygen use is potentially dangerous. Sparks can be caused by problems with the hair dryer, the cord or with a loose electrical connection. In addition, electric

dryers produce hot air which can be dangerous in an oxygen-enriched environment. The U.S. Consumer Product Safety Commission warns consumers not to operate an electric hair dryer where aerosol or spray products are being used, or where oxygen is being administered. Most manufacturers' product labels for electric hair dryers carry warnings to not use electric hair dryers where oxygen is in use. CMS Region V refers to the Compressed Gas Association publication CGA P-2.7 - 2000 edition, section 5.3, which addresses use of oxygen near a source of ignition. This section states that oxygen use should be at least five feet from hair dryers.

### **Quality of Life - Alternatives**

Enhancing the self-esteem of residents goes a long way to reducing the risk of depression or even deteriorating health. Taking care of outward appearances enhances a person's mental and emotional well-being. There are options available that make it possible for residents who are on oxygen to safely use a facility's beauty salon.

The majority of residents in nursing homes and assisted living facilities do not rely on oxygen for life support, and therefore are not reliant on continual access to oxygen. For these residents the facility should verify the physician order and if they have any questions consult the resident's physician. Oxygen can be intermittently discontinued to minimize the fire hazard exposure to the resident. Note: Oxygen remains in the air and on a person's clothes, hair and body for a period of time after the oxygen is turned off. Manufacturers recommend a wait time of 15 – 20 minutes before using the hair dryer. Facilities should also instruct salon staff to keep hair dryer settings on low heat to minimize a potentially hazardous situation.

Another option facilities may want to consider is having residents or tenants who require continuous access to oxygen use a battery-operated hair dryer. The Ohio State University Medical Center advises that battery-operated hair dryers of less than 10 volts are safe, but recommends checking the appropriate conditions of use with the person's physician.

### **Maintenance**

The manufacturer's recommended instructions for use and handling of oxygen should be consulted to ensure full compliance with all applicable requirements. The facility should have a system for routine maintenance of hair dryers to ensure that the machines, electrical cords, etc. are in good operating condition.

### **Resources**

For additional information regarding safety considerations when using oxygen, please see:

- eHow Health What are the Dangers of Oxygen Use Around Hair Dryers?  
[http://www.ehow.com/about\\_6511764\\_dangers-use-around-hair-dryers\\_.html](http://www.ehow.com/about_6511764_dangers-use-around-hair-dryers_.html)
- Ohio State University Medical Center Oxygen Safety at Home  
<https://ckm.osu.edu/sitetool/sites/lungcenterpublic/documents/ox-sf-rg.pdf>

- ACCE Healthcare Technology Foundation, Fire Safety & Oxygen : A Patient Guide  
[http://thehtf.org/documents/HomeDevice\\_Oxygen.pdf](http://thehtf.org/documents/HomeDevice_Oxygen.pdf)
- The U.S. Consumer Product Safety Commission Cautions Hair Dryer Owners  
<http://www.cpsc.gov/cpscpub/prerel/prhtml82/82010.html>

Please see the following memorandums previously issued by DQA and the Centers for Medicare and Medicaid Services (CMS) regarding the storage, handling and safe use of oxygen.

- Certified nursing homes, CMS S&C Memo 12-04-NH Alert: Smoking Safety  
[http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter12\\_04.pdf](http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter12_04.pdf)
- DQA memo 04-15 Oxygen use in Assisted Living facilities  
[http://www.dhs.wisconsin.gov/rl\\_dsl/Publications/04-015.htm](http://www.dhs.wisconsin.gov/rl_dsl/Publications/04-015.htm)
- DQA memo 88-062 Use of liquid oxygen devices  
[http://www.dhs.wisconsin.gov/rl\\_DSL/Publications/pdfmemos/88062.pdf](http://www.dhs.wisconsin.gov/rl_DSL/Publications/pdfmemos/88062.pdf)

### **Contact information of staff in DQA to answer questions**

Questions from nursing homes and facilities serving people with developmental disabilities should be directed to the Regional Field Operations Director for the region in which your facility is located. Regional contact information is located at:

[http://www.dhs.wisconsin.gov/rl\\_DSL/Contacts/reglmap.htm](http://www.dhs.wisconsin.gov/rl_DSL/Contacts/reglmap.htm)

Questions from adult family homes, community-based residential facilities and residential care apartment complexes should be directed to the Assisted Living Regional Director for the region in which your facility is located. Regional contact information is located at:

[http://www.dhs.wisconsin.gov/rl\\_DSL/Contacts/ALSreglmap.htm](http://www.dhs.wisconsin.gov/rl_DSL/Contacts/ALSreglmap.htm)

### **Applicable Administrative Codes**

#### **Adult Family Homes**

DHS 88.04 (2) (f) The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm.

DHS 88.10 Resident rights (3) (L) *Safe physical environment*. To a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or handicap.

#### **Community-Based Residential Facilities**

DHS 83.32 (3) (n) *Safe environment*. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed,

including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents' conditions or disabilities.

DHS 83.40 Oxygen storage. Oxygen storage shall be in an area that is well ventilated and safe from environmental hazards, tampering, or the chance of accidental damage to the valve stem. If oxygen cylinders are in use, oxygen cylinders shall be secured in an upright position. If stored upright, cylinders must be secured. If stored horizontally, cylinders shall be on a level surface where they will remain stationary.

### **Residential Care Apartment Complexes**

DHS 89.34 Rights of tenants (17) SAFE ENVIRONMENT. To a safe environment in which to live.

### **Nursing Homes**

DHS 132.71 (7) OXYGEN. (a) No oil or grease shall be used on oxygen equipment.

(b) When placed at the resident's bedside, oxygen tanks shall be securely fastened to a tip-proof carrier or base.

(c) Oxygen regulators shall not be stored with solution left in the attached humidifier bottle.

(d) When in use at the resident's bedside, cannulas, hoses, and humidifier bottles shall be changed and sterilized at least every 5 days.

(e) Disposable inhalation equipment shall be presterilized and kept in contamination-proof containers until used, and shall be replaced at least every 5 days when in use.

(f) With other inhalation equipment such as intermittent positive pressure breathing equipment, the entire resident breathing circuit, including nebulizers and humidifiers, shall be changed daily.

DHS 132.72 Housekeeping services. (1) REQUIREMENT. Facilities shall develop and implement written policies that ensure a safe and sanitary environment for personnel and residents at all times.

DHS 132.82 Life safety code. (1) APPLICABILITY. Facilities shall meet the applicable provisions of the 2000 edition of the Life Safety Code.

The 2000 edition of the Life Safety Code has a mandatory reference to NFPA 99 Standard for Health Care Facilities. Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within oxygen storage location per NFPA 99 section 8-3.1.11.2 (i).

### **Facilities Serving People with Developmental Disabilities**

DHS 134.71 (5) OXYGEN. Facilities that have residents who require oxygen shall meet the following requirements:

(a) No oil or grease may be used on oxygen equipment;

(b) When placed at the resident's bedside, oxygen tanks shall be securely fastened to a tip-proof carrier or base;

(c) Oxygen regulators may not be stored with solution left in the attached humidifier bottles;

(d) When in use at the resident's bedside, cannulas, hoses, and humidifier bottles shall be changed and sterilized at least every 5 days;

- (e) Disposable inhalation equipment shall be presterilized and kept in contamination– proof containers until used, and shall be replaced at least every 5 days when in use;
- (f) With nondisposable inhalation equipment such as intermittent positive pressure breathing equipment, the entire resident breathing circuit, including nebulizers and humidifiers, shall be changed daily; and
- (g) Warning signs shall be posted when oxygen is in use.

DHS 134.72 Safety and sanitation. (1) GENERAL REQUIREMENT. Facilities shall develop and implement policies that provide for a safe and sanitary environment for residents and personnel at all times.

DHS 134.82 Life safety code. (1) APPLICABILITY. Facilities shall meet the applicable provisions of the 2000 edition of the life safety code. The 2000 edition of the Life Safety Code has a mandatory reference to NFPA 99 Standard for Health Care Facilities. Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within oxygen storage location per NFPA 99 section 8-3.1.11.2 (i).

Center for Medicaid and State Operations/Survey and Certification Group

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Ref: S&C-05-20

**DATE:** March 10, 2005

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** All Provider Types - Independent but Associated Deficiency Citations

**Letter Summary**

- The purpose of this memorandum is to affirm our expectation that when noncompliance with a federal requirement has been identified, the facility or provider will receive a deficiency associated with the noncompliance.
- This memorandum restates existing CMS policy in Appendix P regarding independent but linked deficiency citations.
- This clarification applies to all provider types.

Attached you will find documents supporting this requirement including:

- Regulatory language that identifies facility compliance requirements; and
- Relevant areas of the State Operations Manual (SOM), Appendix P Task 5C and 6. This guidance addresses the necessity of survey teams to review all requirements in order to determine if there was noncompliance with any of the regulations.

There are instances in which a deficient practice creates noncompliance with more than one regulation. In those situations, noncompliance with each requirement should be cited. This situation may be referred to as “independent but associated” citations. This guidance applies to all provider types.

Some investigative protocols (such as those for pressure ulcers, hydration, and weight loss) include a list of regulations that may or may not be a concern depending upon investigation. The surveyor is expected to conduct further investigation, if concerns are identified, to determine whether non-compliance is present with those additional requirements.

For Example:

If a resident develops avoidable pressure ulcers after admission, the surveyor may make the determination that the facility failed to meet the requirement that a resident entering a facility without a pressure ulcer does not acquire one unless it is unavoidable. In that case, the pressure ulcer (sore) requirement (tag F314) is out of compliance. During the investigation, the surveyor might also find the facility did not conduct a comprehensive assessment of the resident's risk for development of a pressure ulcer. If so, the facility has also failed to comply with the regulatory language at F272. This tag requires a comprehensive assessment and is not specific to just pressure ulcers.

If the facility fails to do a comprehensive assessment of residents in other care areas, these would be combined with the pressure ulcer finding into a citation that describes the facility failure at F272. This example is not simply a matter of referencing non-compliance of one requirement with a second requirement. Rather, it reflects determining two distinct requirements have not been met after conducting a thorough review.

Another facility may have failed to meet the requirement for F314 because the resident developed an avoidable pressure ulcer. During the review the surveyor noted there was not sufficient staff to implement the care plan. In that case, the staffing requirement at F353 would also be out of compliance, since that regulation requires the facility to employ sufficient staff to provide care to the residents based on their care plan. In these two cases only determining non-compliance with F314 does not account for what the facility failed to do. Equally important, it does not inform the facility of the problems they need to fix.

In General:

1. Cite to the regulatory language, summarizing or describing the deficient practice as it relates to the requirement:
  - If the failure led to a negative or potentially negative outcome, cite the appropriate outcome tag; and
  - Cite the specific process and/or structure requirement if specific failures in the areas of process or structure are identified through investigation.
2. While writing the survey finding on Form CMS-2567, it is important to remember that the language for related deficiencies should not merely be repeated. Language should be written at each tag that reflects noncompliance for that specific requirement.

We expect the survey process to be conducted consistent with Federal guidance and the Centers for Medicare & Medicaid Services (CMS) remains committed to monitoring adherence with our program requirements. The expectation that the certification program will be conducted consistent with our guidance is the basis on which the State performance review is conducted.

Concerns:

We have heard from some providers that citation of more than one deficiency for a single type of negative outcome simply represents “piling it on” by states or CMS. The regulations do not support this view. Nor do we agree as a matter of proper management and practice. Often one citation will focus on or manifest cause for a poor outcome, while another citation may focus on a systemic or root cause. It is vital that health care providers address all factors that contribute to negative outcomes.

If you have any further questions or concerns regarding the issues in this letter, please contact Cindy Graunke at (410) 786-6782 or Beverly Cullen at (410) 786-6784.

**Effective Date:** The information in this memorandum should be shared with survey staff within 30 days of the publication date.

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

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Attachment

## ADDENDUM

The survey process requires surveyors to determine a facility's compliance with the applicable requirements. In order to maintain certification in the Medicare/Medicaid program, nursing homes must be in compliance with all of the regulations. This is in regulation at the following:

**42 CFR 483.1 (b) - Scope.** The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a Skilled Nursing Facility (SNF) in the Medicare program, and as a Nursing Facility (NF) in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.

**42 CFR 483.75 (b) - Compliance with Federal, State and local laws and professional standards.** The facility must operate and provide services in compliance with **all** applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility (emphasis added).

**42 CFR 488.301 - Definitions.** Deficiency means a SNF's or NF's failure to meet a participation requirement specified in the Act or in part 483, subpart B of this chapter.

### **Excerpts from Appendix P of the State Operations Manual (SOM) – Survey Protocol for Long Term Care Facilities**

The survey process contains specific procedures, which are delineated in the SOM, Appendix P, to provide guidance for a surveyor in how to conduct the standard, extended, revisits and complaint surveys. Within the guidance, in order to promote consistency, investigative protocols have been developed that provide specific processes for the surveyor to utilize in evaluating areas of concern such as the following: Hydration; Unintended Weight Loss; Dining and Food Service; Nursing Services - Sufficient Staffing; Adverse Drug Reactions, and the Abuse Prohibition Protocol. Within each protocol, at the end, is a section titled Task 6, Determination of Compliance. This section provides guidance for the surveyor to investigate regulatory requirements related to the issue that may be out of compliance and to cite deficiencies if negative findings are identified. This section includes a list of several regulatory requirements. An example of the Investigative Protocol – Hydration, is attached for review.

### **TASK 6 - Information Analysis for Deficiency Determination**

A component of the survey process is the decision making by the survey team to determine if the facility is in compliance with **all** the requirements (emphasis added). The surveyors are required to conduct a review of all the requirements as a team to ascertain whether they identified any areas of non-compliance and to delineate the areas of non-compliance that will be cited. For the purpose of this paper, only excerpts of the Task 6, which describe the review of the regulatory requirements, will be attached.

This section also defines a "deficiency as a facility's failure to meet a participation requirement." It should be noted that the guidance states that all regulatory requirements that are deficient may be issued based upon findings. (Please refer to Task 6 in the SOM, Appendix P for the complete version.)

## **Investigative Protocol Hydration**

### **Objectives:**

- To determine if the facility identified risk factors which lead to dehydration and developed an appropriate preventative care plan; and
- To determine if the facility provided the resident with sufficient fluid intake to maintain proper hydration and health.

### **Task 5C: Use:**

Use this protocol for the following situations:

- A sampled resident who flagged for the sentinel event of dehydration on the Resident Level Summary;
- A sampled resident who has one or more QI conditions identified on the Resident Level Summary, such as:
  - #11 - Fecal impaction;
  - #12 - Urinary tract infections;
  - #13 - Weight loss;
  - #14 - Tube feeding;
  - #17 - Decline in ADLs;
  - #24 - Pressure Ulcer
- A sampled resident who was discovered to have any of the following risk factors: vomiting/diarrhea resulting in fluid loss, elevated temperatures and/or infectious processes, dependence on staff for the provision of fluid intake, use of medications including diuretics, laxatives, and cardiovascular agents, renal disease, dysphagia, a history of refusing fluids, limited fluid intake or lacking the sensation of thirst.

### **Procedures:**

- Observations/interviews conducted as part of this procedure should be recorded on the Forms CMS-805 and/or the Form CMS-807.
- Determine if the resident was assessed to identify risk factors that can lead to dehydration, such as those listed above and also whether there were abnormal laboratory test values which may be an indicator of dehydration.

**NOTE:** A general guideline for determining baseline daily fluid needs is to multiply the resident's body weight in kilograms (kg) x 30ml (2.2 lbs = 1 kg), except for residents with renal or cardiac distress, or other restrictions based on physician orders. An excess of fluids can be detrimental for these residents.

- Determine if an interdisciplinary care plan was developed utilizing the clinical conditions and risk factors identified, taking into account the amount of fluid that the resident requires. If the resident is receiving enteral nutritional support, determine if the tube feeding orders included a sufficient amount of free water, and whether the water and feeding are being administered in accordance with physician orders?
- Observe the care delivery to determine if the interventions identified in the care plan have been implemented as described.
  - What is the resident's response to the interventions? Does staff provide the necessary fluids as described in the plan? Do the fluids provided contribute to dehydration, e.g., caffeinated beverages, alcohol? Was the correct type of fluid provided with a resident with dysphagia?
  - Is the resident able to reach, pour and drink fluids without assistance? Is the resident consuming sufficient fluids? If not, is staff providing the fluids according to the care plan?
  - Is the resident's room temperature (heating mechanism) contributing to dehydration? If so, how is the facility addressing this issue?
  - If the resident refuses water, are alternative fluids offered that are tolerable to the resident?
  - Are the resident's beverage preferences identified and honored at meals?
  - Does staff encourage the resident to drink? Are they aware of the resident's fluid needs? Is staff providing fluids during and between meals?
  - Determine how the facility monitors to assure that the resident maintains fluid parameters as planned. If the facility is monitoring the intake and output of the resident, review the record to determine if the fluid goals or calculated fluid needs were met consistently.
- Review all related information and documentation to look for evidence of identified causes of the condition or problem. This inquiry should include interviews with appropriate facility staff and health care practitioners, who by level of training and knowledge of the resident, should know of, or be able to provide information about the causes of a resident's condition or problem.

**NOTE:** If a resident is at an end of life stage and has an advance directive, according to State law, (or a decision has been made by the resident’s surrogate or representative, in accordance with State law) or the resident has reached an end of life stage in which minimal amounts of fluids are being consumed or intake has ceased, and all appropriate efforts have been made to encourage and provide intake, then dehydration may be an expected outcome and does not constitute noncompliance with the requirement for hydration. Conduct observations to verify that palliative interventions, as described in the plan of care, are being implemented and revised as necessary, to meet the needs/choices of the resident in order to maintain the resident’s comfort and quality of life. If the facility has failed to provide the palliative care, cite noncompliance with [42 CFR 483.25, F309, Quality of Care](#).

- Determine if the care plan is evaluated and revised based on the response, outcomes, and needs of the resident.

**Task 6: Determination of Compliance:**

- Compliance with [42 CFR 483.25\(j\)](#), F327, Hydration:
  - For this resident, the facility is compliant with this requirement to maintain proper hydration if they properly assessed, care planned, implemented the care plan, evaluated the resident outcome, and revised the care plan as needed. If not, cite at F327.
- Compliance with [42 CFR 483.20\(b\)\(1\) & \(2\)](#), F272, Comprehensive Assessments:
  - For this resident in the area of hydration, the facility is compliant with this requirement if they assessed factors that put the resident at risk for dehydration, whether chronic or acute. If not, cite at F272.
- Compliance with [42 CFR 483.20\(k\)\(1\)](#), F279, Comprehensive Care Plans:
  - For this resident in the area of hydration, the facility is compliant with this requirement if they developed a care plan that includes measurable objectives and timetables to meet the resident’s needs as identified in the resident’s assessment. If not, cite at F279.
- Compliance with [42 CFR 483.20\(k\)\(3\)\(ii\)](#), F 282, Provision of care in accordance with the care plan:
  - For this resident in the area of hydration, the facility is compliant with this requirement if qualified persons implemented the resident’s care plan. If not, cite at F282.

**EXCERPTS FROM SOM APPENDIX P – TASK 6 – Information Analysis for  
Deficiency Determination  
(For complete text refer to SOM Appendix P)**

**A. General Objectives**

The objectives of information analysis for deficiency determination are:

- To review and analyze all information collected and to determine whether or not the facility has failed to meet one or more of the regulatory requirements;

**C. Decision-Making Process**

Each member of the team should review his/her worksheets to identify concerns and specific evidence relating to requirements that the facility has potentially failed to meet. In order to identify the facility's deficient practices and to enable collating and evaluating the evidence, worksheets should reflect the source of the evidence and should summarize the concerns on relevant data tags.

- In order to ensure that no requirements are missed, proceed through the requirements sequentially as they appear in the interpretive guidelines, preferably section by section. Findings/evidence within each section should be shared by each team member during this discussion. Consider all aspects of the requirements within the tag/section being discussed and evaluate how the information gathered relates to the specifics of the regulatory language and to the facility's performance in each requirement. The team should come to consensus on each requirement for which problems have been raised by any member. If no problems are identified for a particular tag number during the information gathering process, then no deficiency exists for that tag number.

**D. Deficiency Criteria**

To determine if a deficiency exists, use the following definitions and guidance:

- A “deficiency” is defined as a facility's failure to meet a participation requirement specified in the Social Security Act or in Part 483, Subpart B (i.e., [42 CFR 483.5 - 42 CFR 483.75](#)).
- **To help determine if a deficiency exists, look at the language of the requirement. Some requirements need to be met for each resident. Any violation of these requirements, even for one resident, is a deficiency.**
- Other requirements focus on facility systems.

Certain facility systems requirements must be met in an absolute sense, e.g., a facility must have an RN on duty 7 days a week unless it has received a waiver. Other facility system requirements are best evaluated comprehensively, rather than in terms of a single incident. In evaluating these requirements the team will examine both the individual parts of the system, e.g., the adequacy of the infection control protocol, the adequacy of facility policy on hand washing, as well as the actual implementation of that system.



**Office of Clinical Standards and Quality/Survey & Certification Group**

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**Ref: S&C-12-21-LSC**

**DATE:** March 9, 2012

**TO:** State Survey Agency Directors  
State Fire Authorities

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Instructions Concerning Waivers of Specific Requirements of the 2012 Edition of the National Fire Protection Association (NFPA) 101, the Life Safety Code (LSC), in Health Care Facilities – Clarification Effective Immediately

**Memorandum Summary**

- **Updates to Previous Instructions:** This letter addresses updates to the Centers for Medicare & Medicaid Services (CMS) policy regarding Capacity of the Means of Egress; Cooking Facilities; Heating, Ventilating, and Air Conditioning; and Furnishings, Mattresses, and Decorations.
- **Permitting Nursing Homes to Utilize Certain Changes to Life Safety Code Provisions Immediately:** Since these changes are included in the 2012 Life Safety Code, CMS is permitting nursing homes to use the new provisions immediately.
- **Waiver Processing:** Waiver requests will be processed in accordance with standard operating procedures.

Recent changes to the NFPA, LSC 2012 edition allow:

- Previously restricted items to be placed in exit corridors;
- The recognition that a kitchen is not a hazardous area and can be open to an exit corridor under certain circumstances;
- Changes allowing the installation of direct-vent gas fireplaces and solid fuel burning fireplaces; and
- Changes to the requirements allowing the installation of combustible decorations.

A National task force developed these changes over three years subsequent to public comments at the CMS/Pioneer Network 2008 National Symposium on Culture Change and the Environment Requirements. These NFPA approved changes give nursing home providers additional ways to enhance resident autonomy and quality of life.

In support of these changes and the positive impact they may have on residents' lives, CMS will allow providers to implement these four changes by considering waivers of the current LSC requirements found in the 2000 edition of the LSC without showing "unreasonable hardship".

These changes include (1) increasing the amount of wall space that may be covered by combustible decorations; (2) permitting gas fireplaces in common areas; (3) permitting permanent seating groupings of furniture in corridors; (4) allowing kitchens, serving less than 30 residents, to be open to corridors as long as they are contained within smoke compartments. The waivers will be applicable to both new and existing health care occupancies. Specifically, CMS will consider a waiver to allow uses that meet the requirements found in the 2012 edition:

- LSC sections 18/19.2.3 Capacity of Means of Egress and more specifically the requirements at 18/19.2.3.4 which allow, under certain circumstances, projections into the means of egress corridor width for wheeled equipment and fixed furniture;
- LSC section 18/19.3.2.5 Cooking Facilities, more specifically the requirements at 18/19.3.2.5.2, 18/19.3.2.5.3, 18/19.3.2.5.4 and sections 18/19.3.2.5.5 which allow certain types of alternative type kitchen cooking arrangements;
- LSC section 18/19.5.2 Heating, Ventilating, and Air Conditioning more specifically the requirements at 18/19.5.2.3(2), (3) and (4) which allow the installation of direct vent gas fireplaces in smoke compartments containing patient sleeping rooms and the installation of solid fuel burning fireplaces in areas other than patient sleeping areas;
- And lastly, CMS will consider a waiver to allow the use of the requirements found at LSC section 18/19.7.5 Furnishings, Mattresses, and Decorations including sections 18/19.7.5.6 which allow the installation of combustible decorations on walls, doors and ceilings.

No changes were made to the Corridor Access provisions at 18/19.2.5.6.1 that requires “every habitable room shall have an exit access door leading directly to an exit access corridor, unless otherwise provided ...” Also, previous guidance concerning “not in use” criteria found in S&C-10-18-LSC is still applicable.

Due to the complex nature of some of the requirements, each waiver request will have to be evaluated separately in the interest of fire safety and to ensure that the facility has followed all LSC requirements and the equipment has been installed properly by the facility. All waiver requests will be processed in the regular fashion with input from the State Survey Agency and final approval by the CMS Regional Office.

No other requirements of the 2012 edition of the LSC are being implemented at this time. Further changes to the Fire Safety requirements will be done through the formal rule-making process.

**Effective Date:** The information contained in this memorandum is current policy and is in effect for all applicable healthcare facilities such as Hospitals and Nursing Homes. This clarification should be shared with all survey and certification staff, fire authorities, plan reviewers, surveyors, their managers and the State/Regional Office training coordinators within 30 days of the date of this memorandum.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management