Each edition of the IHCA Regulatory Beat will feature focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

2012 Life Safety Code Finalized
Final, updated fire safety rules for long term care facilities were recently released by the Centers for Medicare & Medicaid Services, including provisions to “modernize” care environments and make them more welcoming to residents. This rule impacts all SNFs, NFs and ICFs/IID facilities and is effective July 5, 2016.

The finalized rule, first proposed in 2014, relaxes some operational and construction requirements for long term care facilities in order to give providers more flexibility and make the atmosphere more homelike, CMS officials said. The final rule is quite similar to the proposed rule.

Some of the general changes made that we believe are good for providers include:

- Cooking facilities will be allowed to be to the corridors under the updated rule, which will allow residents to “make food for themselves or others if they choose to” under staff supervision, CMS said.
- The new rules also allow for long term care facilities to place fixed seating in corridors. Facilities also can now hang “combustible decor” like pictures in residents' rooms, as long as that decor is flame-retardant or treated with fire-retardant coating. Fireplaces are also permitted under the updated rules.
- All Tentative Interim Amendments (TIAs) to the Life Safety Code and the Health Care Facilities Code that were adopted by NFPA prior to April 16, 2014 are also adopted. This means NFPA adopted specific changes to code language through a TIA after publication of the Codes, and CMS will recognize these as applicable NFPA Code.
- Where the needs of patients require specialized protective measures for their safety, door-locking arrangements are permitted. This is applicable, for example, to living areas for individuals with dementia.
- For SNFs and NFs (and ICFs/IID that choose to be surveyed under long term care chapter of the LSC), when a sprinkler system is out of service for more than 10 hours in a 24-hour period, the evacuation of a building or the instituting of an approved fire watch is required until the system has been returned to service. NOTE: This is changed from the proposed rule that required a fire watch or evacuation if the sprinkler system was out of service for more than 4 hours.
- SNFs and NFs (and ICFs/IID that choose to be surveyed under long term care chapter of the LSC) built after the effective date of the final rule must have a window sill height of 36” in resident rooms. NOTE: This is changed from the proposed rule, which required this window sill height of 36” for existing as well as new buildings.

“This final rule meets health care facilities' desire to modernize their environments while also ensuring the necessary steps to provide patients and staff with the appropriate level of safety,” wrote Kate Goodrich, M.D., MHS, director of
CMS's Center for Clinical Standards and Quality, in a press release. “Health care facilities can now be more homelike while ensuring that the most modern fire protection practices are in place.”

The updates also require health care facilities in buildings taller than 75 feet to install automatic sprinkler systems within 12 years of the rule's effective date, if they haven't already. Facilities will also have to have a fire watch, or evacuate the building, in the event that their sprinkler system is out of service for more than ten hours.

The final rule was published in the Wednesday (5-4-16) Federal Register. Providers must comply with the rule's provision within 60 days of publication, CMS said. A detailed summary of the adopted rulemaking is as follows:

Changes in the 2012 edition of NFPA 101: Life Safety Code (LSC) provide design and compliance options for health care facilities (including LTC facilities) that don’t exist in the 2000 LSC. For example, a 6-inch projection into the corridor is permitted for mounting equipment and alcohol-based hand-rub dispensers; allowance for cooking facilities open to the corridor under certain conditions, just to name a few. Federal CMS has adopted the 2012 LSC as the edition of the LSC Code that they will require states to use in evaluating facility design, function and operation. Also, with adoption of the 2012 LSC, all categorical waivers will go away and become part of the Code.

The purpose of this article is to review some of the major changes from the 2000 to the 2012 NFPA 101 (LSC) and related references. Along with changes made to the 2012 NFPA 101 (LSC), there are also several referenced publications that have been updated and included in the 2012 LSC. They include:

- 2010 NFPA 10 – Portable Fire Extinguishers
- 2010 NFPA 13 – Installation of Sprinkler Systems
- 2011 NFPA 25 – Sprinkler System Maintenance
- 2010 NFPA 72 – National Fire Alarm and Signaling
- 2010 NFPA 80 – Fire Doors
- 2011 NFPA 96 – Kitchen Hood Systems
- 2010 NFPA 110 – Emergency Power
- 2009 NFPA 241 – Safeguards During Construction

As with the 2000 LSC, the 2012 LSC is separated by new versus existing; Chapter 18 is for new health care occupancies and Chapter 19 is for existing health care occupancies. Many of the new changes to the 2012 LSC affect both Chapters, but there are some exceptions and they are noted below.

Requirements specific to only Chapter 18 – New facilities

- Aisles, corridors and ramps required for exit access in a nursing home shall not be less than 8 feet in clear and unobstructed width, except that non-continuous projections not more than 6 inches from the corridor wall, positioned not less than 38 inches above the floor shall be permitted.

Requirements specific to only Chapter 19 – Existing facilities

- Where corridor width is at least 6 feet, non-continuous projections not more than 6 inches from the corridor wall, above the handrail height, shall be permitted.

New or revised requirements for both New and Existing facilities

- Projections into the required corridor width shall be permitted for wheeled equipment, provided that all of the following conditions are met:
  - The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches.
  - The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.
  - The wheeled equipment is limited to:
    - Equipment in use and carts in use;
    - Medical emergency equipment not in use; and
- Patient lift and transport equipment.

- Where the corridor width is at least **8 feet**, projections into the required width shall be permitted for **fixed** furniture, provided the following conditions are met:
  - The fixed furniture is securely attached to the floor or the wall.
  - The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 feet.
  - The fixed furniture is located only on one side of the corridor.
  - The fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet.
  - The fixed furniture groupings addressed above are separated from each other by a distance of at least 10 feet.
  - The fixed furniture is located so as to not obstruct access to building service and fire protection equipment.
  - Corridors throughout the smoke compartment are protected and by an electronically supervised automatic smoke detection system or the fixed furniture spaces are arranged and located to allow for direct supervision by the facility staff from a nurses’ station or similar space.

- **Cooking Facilities**
  - Within a smoke compartment, where residential or commercial cooking equipment is used to prepare meals for 30 or fewer persons, one cooking facility shall be permitted to be open to the corridor, provided that **all** of the following conditions are met:
    - The portion of the health care facility served by the cooking facility is limited to 30 beds and is separated from other portions of the health care facility by a proper smoke barrier.
    - The cooktop or range is equipped with a range hood or a width at least equal to the width of the cooking surface, with grease baffles or other grease-collecting and cleanout ability.
    - The hood systems have a minimum airflow of 500 cubic feet per minute.
    - The hood systems that are not ducted to the exterior additionally have a charcoal filter to remove smoke and odor.
    - The cooktop or range complies with all the following:
      - The cooktop or range is protected with a fire suppression system listed in accordance with UL 300, *Standard for Fire Testing of Fire Extinguishing Systems for Protection of Commercial Cooking Equipment*, or is tested and meets all requirements of UL 300A, *Extinguishing System Units for Residential Range Top Cooking Surfaces*, in accordance with the applicable testing document’s scope.
      - An interlock is provided to turn off all sources of fuel and electrical power to the cooktop or range when the suppression system is activated.
    - The use of solid fuel for cooking is prohibited.
    - Deep-fat frying is prohibited.
    - Portable fire extinguishers in accordance with NFPA 96 are located in all kitchen areas.
    - A switch meeting all of the following is provided:
      - A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range.
      - The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision.
      - The switch is on a timer, not exceeding 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action.
- Procedures for the use, inspection, testing, and maintenance of the cooking equipment are in accordance with Chapter 11 of NFPA 96 and the manufacturer’s instructions and are followed.
- Not less than two AC-powered photoelectric smoke alarms are interconnected and equipped with a silence feature, in accordance with NFPA 72, *National Fire Alarm and Signaling Code*, are located not closer than 20 feet from the cooktop or range.
- No smoke detector is located less than 20 feet from the cooktop or range.

- **Alcohol-Based Hand-Rub Dispensers (ABHRD)** – Note: New language is underlined.
  - Alcohol-based hand-rub dispensers shall be protected in accordance with applicable standards regarding the storage and handling of flammable liquids, unless all of the following conditions are met:
    - Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 feet.
    - The maximum individual dispenser fluid capacity shall be as follows:
      - 0.32 gallons for dispensers in rooms, corridors and areas open to the corridors; and
      - 0.53 gallons for dispensers in suites of rooms.
    - Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 ounces and shall be limited to Level 1 aerosols as defined in NFPA 30B, *Code for the Manufacture and Storage of Aerosol Products*.
    - Dispensers shall be separated from each other by horizontal spacing of not less than 48 inches.
    - Not more than an aggregate 10 gallons of alcohol based hand-rub solution or 1135 ounces of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed in total, the equivalent of 10 gallons or 1135 ounces, shall be in use outside of a storage cabinet in a single smoke compartment, with the exception to the next dot point below.
    - One dispenser of no more than 0.32 gallon or an aerosol container with no more than 18 ounces located within a resident’s room shall not be included in the 10 gallon aggregate quantity limitation.
    - Storage of quantities greater than 5 gallons in a single smoke compartment shall meet the requirements of NFPA 30, *Flammable and Combustible Liquids Code*.
    - Dispensers shall not be installed in the following locations:
      - Above an ignition source within a 1 inch horizontal distance from each side of the ignition source.
      - To the side of an ignition source within a 1 inch horizontal distance from the ignition source.
      - Beneath an ignition source within a 1 inch vertical distance from the ignition source.
    - Dispensers installed directly over a carpeted floors shall be permitted only in sprinklered smoke compartments.
    - The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.
    - Operation of the dispenser shall comply with the following criteria:
      - The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.
      - Any activation of the dispense shall occur only when an object is placed within 4 inches of the sensing device.
      - An object placed within the activation zone and left in place shall not cause more than one activation.
• The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.

• The dispenser shall be tested in accordance with the manufacturer’s care and use instructions each time a new refill is installed.

• Corridor Doors
  o Nonrated, factory or field-applied protective plates, unlimited in height, shall be permitted.

• Smoke Barrier Doors
  o Nonrated, factory or field-applied protective plates, unlimited in height, shall be permitted.

• Fireplaces – Direct-vent
  o Direct-vent fireplaces, as defined in NFPA 54, *National Fuel Gas Code*, shall be permitted inside of smoke compartments containing patient sleeping areas, provided that all of the following criteria are met:
    ▪ All such devices shall be installed, maintained and used in accordance with NFPA 91, *Standard for Exhaust Systems for Sire Conveying of Vapors, Gases, Mists and Noncombustible Particulate Solids*; NFPA 211, *Standard for Chimneys, Fireplaces, Vents and Solid Fuel-Burning Appliances*; NFPA 31, *Standard for the Installation of Oil-Burning Equipment*; NFPA 54, *National Fuel Gas Code*; or NFPA 70, *National Electrical Code*, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service.
    ▪ No such device shall be located inside of a patient sleeping room.
    ▪ The smoke compartment in which the direct-vent gas fireplace is located, shall be protected by an approved, supervised automatic sprinkler system with listed quick-response or listed residential sprinklers.
    ▪ The direct-vent fireplace shall include a sealed glass front with a wire mesh panel or screen.
    ▪ The controls for the direct-vent fireplace shall be locked or located in a restricted location.
    ▪ Electrically supervised carbon monoxide detection shall be provided in the room where the fireplace is located.

• Solid-Fuel Burning Fireplaces
  o Solid fuel-burning fireplaces shall be permitted and used only in areas other than patient sleeping areas, provided that all the following criteria are met:
    ▪ Such areas are separated from patient sleeping spaces by construction having not less than a 1-hour fire resistance rating.
    ▪ The fireplace is equipped with a fireplace enclosure guaranteed against breakage up to a temperature of 650 degrees and constructed of heat-tempered glass or other approved material.
    ▪ Electronically supervised carbon monoxide detection is provided in the room where the fireplace is located.

• Fire Safety Plan – Note: New language is underlined.
  o A written health care occupancy fire safety plan shall provide for all of the following:
    ▪ Use of alarms;
• Transmission of alarms to fire department;
• Emergency phone call to fire department;
• Response to alarms;
• Isolation of fire;
• Evacuation of immediate area;
• Evacuation of smoke compartment;
• Preparation of floors and building for evacuation; and
• Extinguishment of the fire.

• Draperies – Curtains – Note: New language is underlined.
  o Draperies, curtains and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the flame propagation performance criteria contained in NFPA 701, *Standard Methods of Fire Tests for Flame Propagation of Textiles and Films* and the following shall also apply:
    ▪ Such curtains shall include cubicle curtains.
    ▪ Such curtains shall not include curtains at showers and baths.
    ▪ Such draperies and curtains shall not include draperies and curtains at windows in patient sleeping rooms in smoke compartments properly sprinklered.
    ▪ Such draperies and curtains shall not include draperies and curtains in other rooms or areas where the draperies and curtains comply with all the following:
      • Individual drapery or curtain panel area does not exceed 48 square feet.
      • Total area of drapery and curtain panels per room or area does not exceed 20 percent of the aggregate area of the wall on which they are located.
      • Smoke compartment in which draperies or curtains are located is properly sprinklered.

• Recycling Containers
  o Containers used solely for recycling, clean waste or for patient records awaiting destruction shall be permitted to be excluded from the requirements for soiled linen or trach collection where all of the following conditions are met:
    ▪ Each container shall be limited to a maximum capacity of 96 gallons, except as noted below.
    ▪ Containers with capacities greater than 96 gallons shall be located in a room protected as a hazardous area when not attended.
    ▪ Container size shall not be limited in hazardous areas.
    ▪ Containers for combustibles shall be labeled and listed as meeting the requirements of Fire Marshal Approval Standard 6921, *Containers for Combustible Waste*, however, such testing, listing, and labeling shall not be limited to FM Approvals.

• Combustible Decorations
  o Combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met:
    ▪ They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied.
    ▪ The decorations meet the requirements of NFPA 701, *Standard Methods of Fire Tests for Flame Propagation of textiles and Films*.
    ▪ The decorations exhibit a heat release rate not exceeding 100kW when tested in accordance with NFPA 289, *Standard Method of Fire Test for Individual Fuel Packages*, using the 20kW ignition source.
The decorations, such as photographs, paintings and other art, are attached directly to the walls, ceiling and non-fire-rated doors in accordance with the following:

- Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations as noted below.
- Decorations do not exceed 20 percent of the wall, ceiling and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system.
- Decorations do not exceed 30 percent of the wall, ceiling and door areas inside any room or space of a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system.
- Decorations do not exceed 50 percent of the wall, ceiling or door areas inside patient sleeping rooms, having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system.
- Decorations do not exceed 20 percent of the wall, ceiling and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system.

They are decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present.

- Door-locking arrangements
  - Door-locking arrangements shall be permitted where the clinical needs of patients require specialized security measures or where patients pose a security threat, provided that staff can readily unlock doors at all times.

- Maintenance of Means of Egress
  - Health care occupancies that find it necessary to lock means of egress doors shall, at all times, maintain an adequate number of staff qualified to release locks and direct occupants from the immediate danger area to a place of safety in case of fire or other emergency.

- Number of Means of Egress
  - Not less than two exits shall be accessible from each smoke compartment, and egress shall be permitted through an adjacent compartment(s), provided that the two required egress paths are arranged so that both do not pass through the same adjacent smoke compartment.

- Laundry Chutes
  - Existing laundry chutes shall be permitted to discharge into the same room as rubbish discharge chutes, provided that the room is protected by automatic sprinklers.

Other Notable Reference Changes Contained in the 2012 LSC

- 2010 NFPA 10 – Portable Fire Extinguishers
  - Dry chemical stored-pressure extinguishers manufactured prior to October 1984 shall be removed from service at the next 6-year maintenance interval for the next hydrotest, whichever comes first.
  - Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals.
  - Inspections are performed on extinguishers 12 times per year, once per month.

- 2011 NFPA 25 - Sprinkler System Maintenance
  - Mechanical water flow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.
  - Vane-type and pressure switch-type water flow alarm devices shall be tested semiannually.
  - Diesel engine driven fire pumps shall be operated weekly.
  - Electric motor driven fore pumps shall be operated monthly.
• 2010 NFPA 72 - National Fire Alarm and Signaling
  o See http://www.firealarmtesting.org/ for testing requirements.

• 2010 NFPA 80 - Fire Doors
  o Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by surveyors.

• 2010 NFPA 110 - Emergency Power
  o Diesel-powered Engine Power Source (EPS) installations
    ▪ Section 8.4.2) Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods.
      1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.
      2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating.
      3) If the engine cannot be operated until the water temperature and the oil pressure have stabilized and then the test shall be terminated before the 30 minute time period expires
    ▪ Section 8.4.2.3 Diesel-powered EPS installation that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at
      • 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate for 30 minutes followed by
      • 75 percent of nameplate for 60 minutes, for a total of two continuous hours.

Several changes were also made to Chapters 32 – New Residential Board and Care Occupancies and Chapter 33 – Existing Residential Board and Care Occupancies. The key provisions that appear in the 2012 LSC are:

• For Chapter 32 – New Occupancies
  o Sprinkler systems must be installed in all habitable areas, closets, roofed porches, balconies and decks of new occupancies.
  o Approved smoke alarms are required to be installed inside every sleeping room, outside every sleeping area, in the immediate vicinity of the bedrooms, and on all levels within a resident area.

• For Chapter 33 – Existing Occupancies
  o For existing facilities with impractical evacuation capabilities, all hazardous areas must be separated from other parts of the building by smoke partitions.

• For both New and Existing Occupancies
  o Requires attics of new and existing facilities to be sprinklered. For both new and existing board and care facilities, if the attic is used for living purposes, storage, or housing of fuel fired equipment, it must be protected with an automatic approved sprinkler system. If the attic is used for other purposes or is not used, then it must meet one of the following requirements: (1) Have a heat detection system that activates the building fire alarm system; (2) have automatic sprinklers; (3) be of noncombustible or limited-combustible construction; or (4) be constructed of fire-retardant-treated wood.

Special Note: Always remember that there are also IDPH state regulations with regard to construction. Both must be taken into account before and during any construction. In areas of difference between state and the Life safety Code, the stringent of the two requirements is required. It is important for providers to contact the Life Safety Section at IDPH before doing any remodeling or construction. They will assist you in making sure all construction/remodeling requirements are met.
As additional information or guidance is made available, we will immediately get it out to our members.

AHCA Building Prevention Into Every Day Practice:
Framework for Successful Clinical Outcome Series – Part 1 of 13

AHCA’s Clinical Practice Committee designed a framework series that outlines guiding elements such as individualized care approaches, effective transitions of care, QAPI concepts, safety, risk management, team-based care and diagnostic quality. Care providers that use these resources can more effectively apply knowledge through organizational approaches and clinical care that leads to optimal patient outcomes and quality of life.

Over the next several weeks we will feature one element of the Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcomes.

Success in achieving positive resident/patient outcomes is even more critical now than ever before. The link between quality and payment in long term and post-acute care is growing stronger, as evidenced by the SNF Value Based Purchasing Program (VBP), Improving Post-Acute Care Transformation (IMPACT) Act, SNF Quality Reporting Program (QRP) and more.

In addition, regulatory activity is intensifying through focused surveys on adverse events, dementia care and MDS. The Five-Star Rating system and Nursing Home Compare have been revised and will add items in the future as it broadens public reporting and transparency. Most importantly, consumers expect and deserve high quality care.

The entire framework outlines key elements from both an organizational and clinical nature that are critical to successful clinical and organizational outcomes. Positively, these elements reflect common denominators that cross multiple care situations. Therefore, instead of being yet another initiative or single focused project to achieve just one outcome, it is a way of acting, thinking and being that will benefit multiple areas across an organization. Each element is addressed in detail throughout the framework.

This week we will feature the element of Organizational Foundation: Culture of Safety:

Key Takeaways: Culture of Safety

- Safety is not compromised by other demands.
- Leadership engages and empowers patients, residents, families, staff, visitors and others to keep the culture of safety alive and well.
- Staff of all levels are encouraged to question and challenge work process and organizational decisions to support continuous learning and improvement.

Probing Questions for Team Reflection and Discussion:

1. Are patients, residents, family, staff, visitors and others engaged and empowered to keep the culture of safety alive and well? If so, how? If not, why not?
2. Do we live too much in “survey mode”?
3. How do we keep our “finger on the pulse” of the culture of safety and be vigilant to needs for improvement?

Visit the AHCA Clinical Practice website to learn more about the element of “Organizational Foundation: Culture of Safety” and answers to these key questions:

What does this mean? Why is this important? What are some examples? What is my part (as an individual employee, manager or practitioner)? What can my organization do?
Trending Statistics

Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.

U.S. Health Report Card Finds Racial, Ethnic Disparities Persist (HealthDay)
A report card (click here) on Americans' health finds that racial and ethnic disparities persist, with significant gaps in obesity, cesarean births and dental care.

But advances have been made in some important areas, including infant death rates, women smokers and numbers of uninsured, according to a new report from the U.S. Department of Health and Human Services.

"We have seen important improvements in some health measures for racial and ethnic minority populations since ... 1985," said Dr. J. Nadine Gracia, deputy assistant secretary for minority health and director of the HHS Office of Minority Health.

"While there has been significant progress in our journey toward health equity, disparities still exist and we must remain vigilant in our efforts to end health disparities in America," Gracia added in an agency news release.

The 39th annual report on the nation's health was prepared by the U.S. Centers for Disease Control and Prevention's National Center for Health Statistics.

Highlights include:

- Regarding infant mortality among five ethnic/racial groups analyzed, the difference between the highest (blacks) and lowest (Asian/Pacific Islander) infant death rates narrowed from 9.41 deaths per 1,000 live births in 1999 to 7.21 in 2013.
- Among women, the divide between the highest (white) and lowest (Asian) rates of current cigarette smokers narrowed from 17.5 percent in 1999 to 13.2 percent in 2014.
- The gap between the highest and lowest percentage of uninsured adults ages 18 to 64 decreased from 24.9 percent in 1999 (Hispanics versus whites) to 19.9 percent in the first six months of 2015 (Hispanics vs. Asians).
- Looking at low-risk cesarean deliveries from 1999 to 2014, researchers found that black mothers had the highest percentage (29.9 percent in 2014) among the five racial and ethnic groups while American Indian or Alaska Native mothers had the lowest (21.5 percent in 2014).
- Cuban mothers had the highest percentage of low-risk cesarean deliveries among the five Hispanic groups (41.4 percent in 2014) while Mexicans had the lowest (24.1 percent in 2014).
- Childhood obesity rates varied widely, too. Hispanics ages 2 to 19 had the highest rate of obesity (21.9 percent) between 2011 and 2014 while Asians had the lowest rate (8.6 percent).
- Hispanic adults were most likely to go without needed dental care in 2014. Nearly 16 percent had not received needed dental care in the past 12 months because of cost. This was true for just over 6 percent of Asians.
- Uninsured rates improved among adults between 2013 and 2014 -- falling 28 percent in states that expanded Medicaid programs to include low-income adults and 14 percent in states that did not expand Medicaid programs.
- Prescription drug spending continued to climb, totaling $297.7 billion in 2014 -- up 12.2 percent from the previous year.
**Important Regulations, Notices & News Items of Interest**

1) **RN Licensing:** For those RNs out there, remember that your licenses are due for renewal by **May 31, 2016.** The state is not sending notices anymore, so you’ll need to renew on your own through IDFPR. They recently announced implementation of electronic renewals for professions licensed and regulated by the Divisions of Real Estate and Professional Regulation. License renewals can be completed online via the agency website [click here](#). Proof of licensure can be found at the License Lookup page. And if you want to be reminded electronically, just visit the [online address change site](#) to provide a current email address and contact information.

2) The **Payroll Based Journal (PBJ)** deadline of **July 1, 2016** is quickly approaching. The most recent information shows that Illinois still has over **53 percent** of our nursing facilities **not** registered. As members are working on complying with this mandatory requirement, we'd like to highlight some of tools available to our members. Please review a template email and e-newsletter article that includes these links as a toolkit. The template and available resources were designed by the American Health Care Association (AHCA) to assist your facility prepare for PBJ.

3) The following federal Survey and Certification (S&C) Letter was released since the last issue of **Regulatory Beat:**

   - **S&C 16-21 – All** - Guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals. CMS is clarifying requirements for providing services to justice involved individuals in skilled nursing facilities (SNFs), nursing facilities (NFs), hospitals, psychiatric hospitals, critical access hospitals (CAHs) and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID). Specifically, this guidance seeks to assure high quality care that is consistent with essential patient rights and safety for all individuals.

4) Federal HHS/CMS released the following notices/announcements since the last issue of **Regulatory Beat:**

   - World Hand Hygiene Day was May 5, 2016. The Centers for Disease Control (CDC) provided some Clean Hands Count Campaign material that you may want to consider using in your facility. The information can be found [here](#).

   - On Friday (5-6-16) federal CMS published a final rulemaking ([click here](#)) in the *Federal Register* that modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The final rule aligns, where feasible, many of the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It also ensures appropriate beneficiary protections and enhances policies related to program integrity. This final rule also implements provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and addresses third party liability for trauma codes.

   - **New PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs** - Fourth quarter FY 2015 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for hospices, Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Inpatient Psychiatric Facilities (IPFs), Critical Access Hospitals (CAHs), and Long-Term Care Hospitals (LTCHs). PEPPERs are distributed by TMF® Health Quality Institute under contract with CMS. These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Providers can use the data to support internal auditing and monitoring activities.
Hospices, LTCHs and free-standing SNFs and IRFs: For instructions on obtaining your PEPPER, see the Secure PEPPER Access Guide. CAHs, IPFs, and SNF and IRF units of hospitals: PEPPER was distributed via the QualityNet secure portal.

For more information, including guides, recorded training sessions, information about QualityNet accounts, frequently asked questions, and examples of how other hospitals are using PEPPER, visit PEPPERresources.org. If you have questions or need help obtaining your report, visit the Help Desk. Send us your feedback or suggestions.

5) The Agency for Healthcare Research and Quality (AHRQ) recently released the 2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy. Each year since 2003, the AHRQ has produced the National Healthcare Quality Report and the National Healthcare Disparities Report. These reports to Congress are mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). Beginning with the 2014 reports, findings on health care quality and health care disparities are integrated into a single document. For the first time, this year’s National Healthcare Quality and Disparities Report and National Quality Strategy Update is a joint effort addressing the progress made against the National Quality Strategy (NQS) priorities at the 5-year anniversary of the Strategy. The NQS is backed by the National Healthcare Quality and Disparities Report data. Integration of these two efforts within AHRQ supports the development of this more comprehensive report on the success of efforts to achieve better health and health care and reduce disparities.

6) The Illinois Department of Healthcare and Family Services (HFS) released several announcements and one Notice:

- Announcement of a Webinar - Electronic Claims Submission of Long Term Care Service Claims as Direct Data Entry and Up Loaded File (click here). A second webinar on direct billing has been posted to the Long Term Care Direct Billing web page. You may view the webinar on “Electronic Claims Submission of Long Term Care Service Claims as Direct Data Entry and Up Loaded File” at the link noted.

- The Illinois Department of Healthcare and Family Services posted a schedule of In-Person Trainings for the New Monthly Billing Process for Long Term Care Services. You may view the training schedule here. To register for the In-Person Training for the new Long Term Care Monthly Billing Process, please email name, company, phone and date/time of desired training session with the Subject Title: In-Person Training Registration to HFS.LTC@illinois.gov.

- The Illinois Department of Healthcare and Family Services has posted the audio version of April 27, 2016 Webinar - Introduction to the New Electronic Claims Process of Long Term Care Services. You may view the audio version of the April 27, 2016 webinar by clicking here.

- The Illinois Department of Healthcare and Family Services has posted the audio version of the May 4, 2016 Webinar - Electronic Claims Submission of Long Term Care Service Claims as Direct Data Entry and Up Loaded File. You may view the audio version of the May 4, 2016 Webinar here.

- The Illinois Department of Healthcare and Family Services has posted a new Provider Notice regarding the Illinois Medicaid Program Advance Cloud Technology (IMPACT) Provider Type Selections available at the following link: http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx.

7) The Illinois Department of Public Health (IDPH) announcements:

- IDPH sent a notice about sessions on health insurance coverage parity sponsored by the Illinois Department of Insurance (DOI). DOI launched a consumer education awareness campaign in partnership with other state agencies and health care organizations across the state to help Illinois families navigate health insurance coverage for mental health and substance use disorders. Health insurance consumers and behavioral health/substance use disorder care providers are invited for an in-person training session on health insurance coverage parity. See flyer for times, dates and locations.
• The Department has scheduled the following Town Hall Meetings through June 30. **Individual notices will no longer be sent to each facility.** We are requesting that reservations be made in advance for ALL town hall meetings. This is due to limited space available in some locations, as well as respectfully considering time and resources of all parties involved. **Reservations should be at least two days prior to the date of the Town Hall Meeting.** All reservations should be made via email to Lisa.Reynolds@illinois.gov. Please include the words Town Hall Reservation in the subject line. They are regional meetings, very informal and an excellent opportunity to ask questions.

  5/26 – Oak Trace – 250 Village Drive - Downers Grove – 1-3 p.m.
  6/7 - Brookens Building – 500 South Art Bartell Drive - Champaign – 1-3 p.m.
  6/29 – Norridge HC and Rehab – 7001 West Collum – Norridge - 2-4 p.m.

8) The **American Health Care Association** (AHCA) recently sent two items of interest:

• Notice to the States regarding a “**Summary of Key Changes to State Direction of Medicaid Managed Care Plan Payments to Providers.**” On April 25, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the final Medicaid Managed Care regulations (“Final Rule”); this is the first update to the regulations governing Medicaid managed care organizations (MCOs) since 2002. The rule addresses many topics, including quality, network adequacy, and provider payments. CMS has indicated that subregulatory guidance on many of the provisions in the Final Rule is forthcoming, and AHCA will be monitoring CMS communications regarding implementation of key provisions. The final rule can be viewed in its entirety [here](https://www.medicaid.gov). AHCA/NCAL’s summary and comments on the proposed rule are available on the AHCA/NCAL website. AHCA is in the process of analyzing the key provisions of the Final Rule as they relate to members, but wanted to alert State Execs to the Final Rule’s key changes to state direction of managed care plan payments. We will be hosting a webinar on **Friday, May 20 at 2 PM Eastern** to discuss the provisions below as well as other key components of the Final Rule.

• Skilled nursing facilities will be required to electronically submit their **workplace injury and illness data to the U.S. Department of Labor’s Occupational Safety and Health Administration (OSHA)** under a new federal rule. On May 12, 2016, OSHA released a **final rule** on injury and illness electronic recordkeeping. The final rule is similar to the proposed rule and has two main elements, electronic submission and updates to how employers inform employees to report work-related injuries or illnesses. This final rule becomes effective on January 1, 2017, except for § 1904.35 (relating to employee involvement in the record-keeping system) and § 1904.36 (prohibiting an employer from discriminating against an employee for reporting an illness or injury), which become effective on August 10, 2016. Click here for a detailed AHCA summary.

9) The latest **Telligen** events/announcements can be found at [https://www.telligenqinqio.com/](https://www.telligenqinqio.com/).

10) **The Washington Post** reports that researchers have noted that “**Medical Errors Now Third Leading Cause of Death in United States**” after heart disease and cancer. Nightmare stories of nurses giving potent drugs meant for one patient to another and surgeons removing the wrong body parts have dominated recent headlines about medical care. Lest you assume those cases are the exceptions, a new study by patient-safety researchers provides some context. Their analysis, published in the BMJ on Tuesday, shows that “medical errors” in hospitals and other health-care facilities are incredibly common and may now be the third- leading cause of death in the United States — claiming 251,000 lives every year, more than respiratory disease, accidents, stroke and Alzheimer’s.

11) **The Business Insider** reports that “**A Drug That Could Change the Way We Treat Parkinson’s Disease Just Got Approved.**” A new drug that aims to treat a serious symptom of Parkinson’s disease just got approved by the Food and Drug Administration. The drug, called Nuplazid, was developed by Acadia Pharmaceuticals. It’s designed to treat psychosis, a symptom of Parkinson’s that can involve hallucinations and delusions, and it’s the first of its kind to ever get approved by the FDA.

12) **MedlinePlus** had several articles of interest:
• **Hepatitis C Now Leading Infectious Disease Killer in U.S.** The number of hepatitis C-linked deaths in the United States reached a record high in 2014, and the virus now kills more Americans than any other infectious disease, health officials report. There were 19,659 hepatitis C-related deaths in 2014, according to preliminary data from U.S. Centers for Disease Control and Prevention. Those tragically high numbers aren't necessary, one CDC expert said.

• **Poor Vision and Dangerous Falls Plague Many U.S. Seniors.** Millions of American seniors have severe vision impairment, and with it comes the risk of a fall that could lead to disability, a new report finds. About 2.8 million seniors are thought to have severe vision impairment -- defined as either blindness or difficulty seeing, even with eyeglasses, according to data from the U.S. Centers for Disease Control and Prevention. About 1.3 million of these older, vision-challenged Americans fell at least once in 2014, the new CDC report said. Experts say the link between vision and balance is crucial, especially as people age.

• **Seniors’ Worsening Depression May Sometimes Predict Dementia.** In some cases, worsening symptoms of depression in seniors might point to early dementia, a new study suggests. The Dutch study can't prove cause-and-effect, and certainly not every depressed senior is headed for dementia. But experts said the findings are intriguing.

13) **Medscape** had two article of interest:

• **One Third of Outpatient Antibiotic Rxs May Be Inappropriate.** With antibiotic overuse driving the rise of antibiotic-resistant infections, authors of a large study find that during 2010 to 2011, antibiotics were prescribed for outpatients across all conditions at a rate of 506 per 1000 population. Only an estimated 353 of these, however, were likely appropriate, suggesting that 30 percent of these antibiotics may have been unnecessary.

• **New Practice Guidelines on Antipsychotic Use in Dementia.** Judicious use of antipsychotics to treat agitation or psychosis in patients with dementia is the focus of a new practice guideline from the American Psychiatric Association (APA). The evidence-based recommendations call for assessing psychological and behavioral symptoms of dementia, developing a comprehensive treatment plan, performing a risk/benefit analysis before prescribing an antipsychotic, and using these medications judiciously and not indefinitely.

14) **Medical News Today** published several articles of interest:

• **Holistic Approach to Mealtimes Could Help Dementia Sufferers.** Eating together, providing social support and interaction during meals could help people with dementia avoid dehydration and malnutrition - according to new NIHR-funded research from the University of East Anglia. Findings published reveal that while no interventions were unequivocally successful, promising approaches focused on a holistic approach to mealtimes. The team found that eating family-style meals with care givers, playing music, and engaging with multisensory exercise - could all help boost nutrition, hydration and quality of life among people with dementia.

• **Early Detection System for Catheter Infections.** A research team led by the University of Bath has developed an early warning system for urinary catheter infections, a problem which can cause severe risk to patients' health and costs the NHS an estimated £120 million per year. Urinary catheters are used in people who have difficulty passing urine naturally and are often used during or after surgery, for patients with enlarged prostates or in some cases to manage incontinence. 100 million urinary catheters are used annually across the globe, but associated infections can be experienced by up to half of patients using catheters long-term and can lead to kidney failure, septicaemia and death. The research team led by the University of Bath and including scientists from the University of Brighton, has developed a chemical coating that can be applied to the catheter tip, which releases a colored dye when the urine becomes alkaline due to a bacterial infection.
• **Daily Chocolate Intake Linked to Lower Risk of Diabetes, Heart Disease.** Could a doctor's visit one day result in a prescription for chocolate? According to a new study, it is possible. Researchers suggest that consuming a small amount of chocolate every day may lower the risk of diabetes and heart disease.

• **Group Activities Reduced Depressive Symptoms Among Older People With Dementia.** Both a high-intensity functional exercise program and a non-exercise group activity, conducted among older care facility residents with dementia, reduced high levels of depressive symptoms. However, exercise had no superior effect on depression, according to a dissertation from Umeå University.

• **Malnutrition: A Hidden Epidemic in Older Americans.** Malnutrition does not just happen to seniors who suffer from hunger, or who do not have access to healthy food. Older adults are more likely to have chronic conditions that put them at risk for malnutrition. Cancer, diabetes, Alzheimer's disease, and other conditions can impact appetite, make eating difficult, change metabolism, and require dietary restrictions. Alarmingly, the increased economic burden in the U.S. for disease-associated malnutrition in older adults is estimated at $51.3 billion each year.

15) *McKnight’s* reported on the following:

• **CMS Update Lets Auditors Request More Documents.** Recovery audit contractors would be allowed to request additional documents from providers with high Medicare claim denial rates, CMS said recently. In an update released May 3, CMS said providers’ denial rates — the number of claims containing improper payments divided by the total number of reviewed claims — will be used to calculate their adjusted additional document request limit every three 45-day review cycles. For providers with a denial range between 0 and 3 percent, they'll receive no additional document reviews for the next three cycles. The adjusted limits top out at 5 percent for providers with denial rates between 91 and 100 percent.

• **Experts Warn of Skilled Nursing Market Changes, Researchers Offer Strategies to Avert Havoc.** Preliminary results of a survey of 36 large skilled nursing company CEOs paint a challenging picture for operators, who will either rise profitably from already strong positions, improve with proper initiatives or fail resoundingly, researchers said recently. They discussed their findings and offered six critical strategies in a kick-off session at the LTC 100 conference in Dana Point, CA. To cope with a potent cocktail of new initiatives, regulations and market forces, however, the researchers offered a half dozen distinct steps providers should take, beginning with “strategic pruning.” This includes renovating old physical plants, selling weaker performers (“a great time to sell”), planning eventual acquisitions (“scale will matter but wait about two years for prices to drop”) and concentrating holdings geographically.

• **Most Stroke Patients Should Go to Inpatient Rehab Facilities, Not Nursing Homes, Heart/Stroke Association Says.** The majority of people recuperating from a stroke should be treated in an inpatient rehabilitation facility, rather than a nursing home, according to new recommendations from the American Heart Association/American Stroke Association. The new recommendations urge stroke patients to receive treatment in an inpatient rehabilitation facility “whenever possible,” unless they have a condition that would require more skilled nursing care.

• **Corporate Ownership Changes Linked to Poor Nursing Home Quality.** Nursing homes that are bought and sold frequently by corporate chains tend to provide a lower quality of care, according to research from Harvard Medical School released on Monday. Many nursing homes that experienced a chain-related transaction between 1993 and 2010 had a higher number of deficiency citations than facilities that did not undergo a transaction, according to researchers from Harvard, the University of Michigan, the University of Rochester and Vanderbilt University. In many instances, nursing homes that were the subject of a transaction were already having quality issues, which continued after the transaction. Those pre-existing quality issues led the researchers to believe that the transaction wasn’t to blame for any drops in quality, but rather that corporate transactions can be an indicator of a low-quality facility.
• **SNF Occupancy Rates and Revenues Fall as Discharges Rise, CDC Says.** The number of nursing home discharges climbed while occupancy rates, number of facilities and revenues fell, according to a recently released federal “report card” on health. The Centers for Disease Control and Prevention's *Health, United States* report for 2015 found the number of nursing facilities dropped from 16,389 in 1995 to 15,643 in 2014. The number of licensed beds also fell, from 1.75 million in 1995 to 1.69 million in 2014. The number of residents decreased from 1.48 million to 1.37 million in that same time frame. Occupancy rates for the country's nursing homes also took a hit across the last decade, dropping from 84.5 percent to 80.8 percent, the report found. North Dakota, Rhode Island, South Dakota and the District of Columbia led the states in highest occupancy rates for 2014, the report said, while Oregon, Utah and Idaho ranked with the lowest rates. Between 2005 and 2014, total expenditures for the country's nursing homes grew from $2.5 billion in 2005 to $4.1 billion in 2014, while the percentage of the nation's overall health expenditures attributable to nursing home care fell from 8.4 percent to 7 percent. During that same time period, nursing home discharges climbed from 61,000 to 68,000 annually.

• **The federal HHS Office of the Inspector General Slams Insufficient Medicare Documentation, Especially From Nursing Homes.** The reported error rate for Medicare Fee-for-Service in fiscal year 2015 was 12.09 percent, well above the compliance threshold of 10 percent, a new government report finds. The Office of the Inspector General report specifically called out skilled nursing facility claims last week, noting the improper payment rate increased 4.1 percent.

16) **Interesting Fact:** A recent poll conducted by Common Sense Media shows that 50 percent of teens and 27 percent of parents feel they are addicted to their mobile devices.