State Operations Manual
Appendix I – Survey Procedures for Life Safety Code Surveys

(Rev. 209, 12-09-22)

Transmittals for Appendix I

I. Introduction

(Rev. 209; Issued: 12-09-22; Effective: 10-01-22; Implementation: 10-01-22)

Use the survey procedures in this appendix section for all Life Safety Code (LSC) surveys (initial and recertification) of facilities subject to *Quality, Safety and Oversight surveys* for Medicare/Medicaid certification. This includes, but is not limited to, Skilled Nursing Facilities (SNFs), Nursing Facilities (NFs) whether freestanding, distinct parts, or dually certified, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), Ambulatory Surgical Centers (ASC), inpatient Hospice facilities*, Religious Nonmedical Health Care Institutions (RNHCIs),* Program for All-inclusive Care for the Elderly (PACE) facilities, Critical Access Hospitals (CAH), Psychiatric and General Hospitals, including validation surveys of accredited facilities. These procedures also apply to complaint investigations. When conducting LSC complaint investigations, focus your review on those requirements relevant to the complaint.

All *LSC* surveys must be unannounced. The LSC survey **may** precede the survey of *health* requirements and can be done independent of a health survey. LSC surveys must be conducted and completed on consecutive days. Survey team members need not be onsite for the entire survey. For example, special consultants participating in the survey (such as, a fire protection engineer, or fire alarm technician) have the option of being onsite only during that portion of the survey that require their area of expertise; however, they must conduct that portion while the rest of the LSC survey team is present. The special consultant(s) should present their findings to the team or team leader before departing the facility. If any deficiencies are to be cited, supporting documentation should be left with the team. The consultant should be available during the exit conference to supply any additional information required. This can be in-person or by telephone.

II. The Survey Tasks

Task 1 – Offsite Survey Preparation

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

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

- Correspondence to or from the SA and the facility.

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

Determine the occupancy or use of the facility such as a hospital, nursing home, ambulatory surgical center, etc. Then determine which chapters of the LSC should be used in the survey process based on the occupancy or use of the building. The basic fire safety requirement for participating facilities at this time is compliance with the National Fire Protection Association (NFPA) 101, LSC, *2012* edition *and the NFPA 99, Health Care Facilities Code, 2012 edition (see 81 FR 26871, May 4, 2016)*. Specific Interpretive Guidelines and survey procedures pertaining to the various participating facilities can be found in their respective sections of the SOM.

Determine whether to apply the EXISTING or NEW chapters of the LSC*, which* depends on the date of *construction* plan approval or the date of construction (if there is no plan approval process). If *pre-construction governmental approvals were received* or construction started *before July 5, 2016 (*effective date of the final regulation*),* survey *to the EXISTING Occupancy chapters of the* LSC. If *pre-construction governmental approvals were not received before* or construction started *after July 5, 2016*, *survey to the NEW* Occupancy chapters of the LSC.

If the building is a hospital and has a SNF located within or attached to it, then a determination has to be made as to whether the SNF is considered a "distinct part." If there is two-hour fire-*rated separation* between the hospital and the SNF, then a LSC survey of the SNF section alone is allowed. If there is no fire-*rated separation*, then a LSC survey of the complete building, hospital and SNF, is to be conducted regardless of whether the hospital is accredited. All deficiencies found will be reported whether they were found in the deemed hospital portion or in the distinct part SNF.

Validation surveys of deemed *providers and suppliers* must use the appropriate chapters, NEW or EXISTING, of the *2012* LSC.

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

The FSES can be completed by qualified facility personnel, consultants, or the SA at their discretion. FSES's submitted by the facility as part of the survey Plan of Correction (POC) must be reviewed by the SA or CMS approved Accreditation Organization (AO).

Those FSES's that receive a passing score and a SA or AO recommendation must be forwarded to the CMS Location for review and final approval. The CMS Location will notify the SA or AO, and the facility once it has granted final approval of the submitted FSES

NFPA 101A, Guide on Alternative Approaches to Life Safety, *2013* Edition, is to be used to complete all FSES's *as the mandatory values presented in the worksheets of this edition are calibrated to measure against the provisions in the 2012 edition of the LSC. The 2013 FSES is to be used for surveys completed after November 1, 2016.*

Existing Long-Term Care Facilities that had an approved by CMS FSES/HC on record before July 5, 2016 may continue to use existing scoring in Table 1 found below:

Table 1. Mandatory Values— Existing Nursing Homes/Long Term Care Facilities

	Containment (Sa)		Extinguishment (Sb)		People Movement (Sc)	
Zone Location	New	**Exist.**	New	**Exist.**	New	**Exist.**
1st story	11	**5**	15(12)*	**4**	8(5)*	**1**
2nd or 3rd story **	15	**9**	17(14)*	**6**	10(7)*	**3**
4th story or higher	18	**9**	19(16)*	**6**	11(8)*	**3**

* Use ( ) in zones that do not contain patient sleeping rooms.

An FSES evaluation is to be done in conjunction with the completion of the regular Fire Safety Survey form (CMS Form 2786). If the building is certified in compliance with the LSC on the basis of an FSES evaluation, an FSES evaluation must be completed *for all building smoke compartments and reapproved by CMS* each time a LSC survey is completed.

A new FSES must be completed and submitted for review and approval each time the prescriptive LSC survey is completed and deficiencies are identified by the survey. This is to ensure that any deficiencies found on the survey that may affect the facilities life safety features are accounted for on the FSES and submitted as part of the facility's POC.

A facility that achieves a passing score on the 2013 FSES or an existing Long-Term Care Facility that had approved CMS FSES/HC on record before July 5, 2016 using the 2001 FSES Mandatory Values in Table 1 above will be considered to meet the fire safety requirements for certification into the Medicare and Medicaid programs.

The FSES is only available for buildings surveyed using the Health Care Occupancies and Residential Board and Care Occupancies chapters. There is no FSES available for use when surveying *to Ambulatory Health Care Occupancies*, which are surveyed using the prescriptive requirements of the *LSC, C*hapter*s* (20 *or* 21).

Task 2 – Entrance Conference/Onsite Preparatory Activities

Entrance Conference:

Upon arrival at the facility, proceed to the Administrator's office and identify yourself and state the purpose of your visit: to perform a fire safety survey under the regulations of Medicare/Medicaid. The team coordinator or individual surveyor conducts the Entrance Conference, informing the facility's administrator about the survey and introducing any team members. The team coordinator then explains the survey process and answers any questions from facility staff.

While the team coordinator conducts the Entrance Conference, other LSC team members, may begin Task 3 Orientation Tour.

Ask the Administrator to describe any special features of the facility's physical plant. For example, was the facility constructed at different times and were different types of construction used, or is the facility only partially sprinklered? Have any changes or remodeling occurred since the last inspection?

Does the facility have an emergency generator or admit patients/residents that may require life support equipment? Request *fire safety* documentation *such as:* evacuation plan; fire drills; disaster plan; smoking policy; fire alarm testing; sprinkler maintenance records if applicable; kitchen range hood maintenance; fire extinguisher maintenance and testing reports; generator testing logs; flame spread ratings of interior finishes; *and smoke stopping, fire stopping and fire proofing specification sheets*.

Obtain a list of key facility personnel and their location (*for example*, administrator, director of nursing services, dietitian and/or food supervisor, charge nurses, *facility* engineer, and housekeeping supervisor).

These individuals will be able to provide specific information about fire safety issues in their departments, which is needed by surveyors to complete the fire safety survey report form (Form CMS-2786).

Ask the administrator or building plant engineer to provide the surveyor with a copy of the facility's building layout, indicating the location of exits, individual resident rooms, and common areas if available.

The existence of any waivers of the LSC requirements should be confirmed at this time by the facility. Inform the facility that a detailed inspection will be conducted and that it may include any building used by the residents or patients. At this time, request that someone from the facility staff, preferably from the maintenance department, accompany the surveyor. It is not mandatory that a representative from the facility accompany the surveyor on the facility inspection.

Determining Which LSC Chapter to Use and Which Building(s) to Survey

Determine which LSC chapters apply for each building, including buildings that do not house residents or patients on a 24-hour basis. This situation is most common in large campus type facilities such as medical centers, teaching hospitals, or large state-operated ICFs/IID.

To determine which buildings to survey, the term "customary access" is critical. Buildings that house offices or spaces to which residents do not have normal access do not require a LSC survey. However, buildings which are used by residents (e.g., a school or therapy building, cafeteria, workshop, gym, chapel, etc.) must be surveyed.

In many cases, the *Health Care Occupancies* chapters of the Code may not be the most appropriate sections to use as survey guides. Instead, the most appropriate *occupancy* could be Chapter*s* 12/13 – Assembly Occupancies, Chapter*s* 14/15 - Educational Occupancies or, *Chapters 38/39 – Business Occupancies*, etc. Since there are no *CMS* survey report forms for these chapters, deficiencies are reported on the CMS-2567 *form* and identified using the appropriate *provision* reference number *located* in the applicable chapter(s) of the code.

To determine which LSC chapters are applicable to ICFs/IID, the type and extent of services provided need to be determined. The New Residential Board and Care Occupancy Chapter (Chapter 32) or the Existing Residential Board and Care Occupancy Chapter (Chapter 33) of the *2012* edition of the LSC is applicable to *an* ICF/IID in the Medicaid program which provide "personal care services." *P*ersonal care*,* as defined *by the* LSC*, is considered* as "protective care of a resident who does not require chronic or convalescent medical or nursing care." Generally, protective oversight and personal care is *considered providing residents with* assistance in meeting daily needs (e.g., being aware of residents' whereabouts, reminding them of appointments). This may include "transient medical care," such as the kind of care provided in the home by one family member to another when he/she is sick. In an ICF/IID*,* this means supervising client's movements and daily living skills. An RN or LPN on staff at the board and care home solely to dispense medication is not an indication of chronic medical or nursing care.

If a resident receives skilled/acute nursing or medical care such as is provided in a hospital, nursing home or an inpatient hospice, Chapter 18/19 (Health Care Occupancies) must be applied.

If the LSC surveyor determines that an ICFs/IID will be surveyed under the Residential Board and Care Occupancy of chapters 32 and 33, it must be further broken down into one of two categories based on size and evacuation capability before the survey can continue.

Small facilities are those with sleeping accommodations for not more than 16 residents (section 32.2 or 33.2). Large facilities are facilities with sleeping accommodations for more than 16 residents (section 32.3 or 33.3). This means that an apartment building containing several ICFs/IID in separate apartments must meet Section 32.2 or 33.2 for the individual units, and the apartment building must meet the requirements of Chapter 30/31 Apartment Buildings which are listed in section 32.4 or 33.4.

Most large facilities tend to fall into the category of health care, while smaller facilities tend to be residential board and care occupancies.

Task 3 – Orientation Tour

An orientation tour may be *conducted* in order to provide an overview of the facility, and serve as an introduction of the surveyors to the staff. This may be helpful if the facility is a very large single building or has multiple buildings that have to be surveyed.

Task 4 – Information Gathering

Upon completion of the review of the documentation provided by the facility, the more detailed inspection begins. Using the layout of the building as a guide, begin an observation tour that includes the outside of the building as well as the inside.

At this time determine the type of building construction. This can be accomplished by review of the construction drawings, if available, and must be confirmed by direct observation of the structure and building materials used in constructing the building (exposed areas above the ceilings or vertical pipe shafts may provide insight).

Check floor-to-floor separations, corridor wall construction, smoke barrier locations, construction and condition, and any vertical opening construction, including access doors. If multiple buildings or wings are involved, any fire barriers present should be inspected for construction materials used, the protection of penetrations through the barriers and the type and arrangement of any doors thru the barriers. Buildings separated by a vertical two-hour fire barrier can be considered separate buildings for the purposes of a Life Safety Code survey. (Note: If the two-hour fire barrier has been so severely compromised by penetrations or other construction defects that it may not provide the required fire protection, it may be necessary to ignore this feature and consider combining the two buildings together. If this is done, the two buildings will be surveyed as if there were only one building. The facility may elect to repair the two-hour separation and have the buildings surveyed as two separate buildings.)

When separate buildings are surveyed, each building requires the use of an individual set of reporting forms.

Proceed next to a complete room-by-room, floor-by-floor, walk through of the facility. This includes a representative sample of bedrooms (Table2. At a minimum, inspect: all

smoke barrier, fire barriers, and hazardous areas, including doors, on each floor or wing; all exit stairs, doors, signs; patient and resident room doors for condition, latching and fit in the door frame; the fire alarm system; the sprinkler system; the emergency power generator set; corridor walls; emergency lighting; and medical gas storage, if applicable.

Inspect the smoke and fire barriers for construction materials and continuity, completeness from outside wall to outside wall and from the floor to the bottom of the floor above where applicable. Inspect any penetrations to determine if they are sealed properly. Where ductwork penetrates the barrier, inspect any dampers, fire or smoke that have been installed in the ductwork.

For each room inspected, check the corridor door for latching, operation and fit into the doorframe. The fire rating of the door should also be inspected, if applicable. The interior of the room should then be inspected for hazards such as electrical outlets, extension cords, oxygen in use signs (posted where applicable), and portable space heaters.

Wastebasket size, drapes and cubicle curtains are checked for flammability. Where applicable, cubicle curtains are checked for the correct mesh opening size. If the facility is sprinklered, the location of the sprinkler head in relation to the cubicle curtain and walls are checked for obstruction or interference to the water spray pattern. The walls and ceilings are inspected for unsealed penetrations and proper construction.

Inspect the corridor walls and ceilings for proper construction. This inspection should include areas above the ceiling.

Inspect all hazardous areas for proper door type and, where applicable, sprinkler installation or fire separation construction.

Note the maintenance of fire extinguishers and exit signs on an ongoing basis throughout the inspection.

Inspect the fire alarm pull stations and alarm devices while moving along the corridors. Similarly, review smoke detectors where they are required or provided.

Note any corridor obstructions and the distances to exits. At the same time the exit ways, including the doors and door hardware are inspected, as well as the exit way lighting and exterior walkways.

Inspect the fire alarm control panel noting any areas/zones not covered by the detection system. Inspection tags or labels should be reviewed. Any system trouble lights should be noted and the facility questioned. Determine if the fire alarm system is connected to the fire department or a remote station outside of the facility.

Review sprinkler systems to determine if the system is providing complete coverage or only partial coverage. Complete coverage means that the entire facility, including all closets, storage areas, and walk-in coolers and freezers, is sprinklered. Proper testing and maintenance records must be maintained by the facility, as required by the LSC. The connection between the sprinkler system and fire alarm system should be confirmed. Tamper switches and waterflow detection devices must be operational.

Inspect the facility kitchen range hood fire extinguisher system to determine if the proper maintenance of the system is being carried out and the activating mechanism is in a clearly marked location. The staff should be questioned regarding the operation of any fire suppression systems in an emergency.

Inspect the emergency lighting or power system for operability and coverage; including on-site generators. Review records of testing and maintenance of the generator(s). A demonstration of the emergency power system should not be requested due to the large amount of computerization and the use of life support equipment that may be affected.

Inspect laboratories for proper sprinkler system, fire separation construction, door type, emergency eye wash equipment, storage of flammable liquids and gases, and fume hood ventilation.

Inspect medical gas storage areas for proper construction, ventilation, gas system controls/alarms and proper restraint of cylinders.

Review the facility fire plan including fire drill records and staff interviews to determine staff actions and responsibilities during a fire or emergency. The surveyor may request an actual fire drill demonstration based on a review of the facility fire drill records and interviews with the staff to verify the adequacy of staff response. This should be done only if there is a question of the adequacy of staff response found in the documentation of the monthly fire drills.

Determining the ICFs/IID "E" Score

The technique for surveying and determining compliance with the LSC of ICFs/IID is very similar to previous parts of this protocol with several additional requirements. After determining the type and size of the ICF/IID, determine the level of evacuation difficulty if the facility chooses to comply with the requirements for *R*esidential *B*oard and *C*are *Occupancies*. This is done for each of the types of *existing* facilities*, including* small, large, and apartment house. The three levels of evacuation difficulty are known as Prompt (level A), Slow (level B) and Impractical (level C). CMS regulations require the use of NFPA 101A, Guide on Alternative Approaches to Life Safety, *2013* Edition, Chapter 6, Evacuation Capability Determination for Board and Care Occupancies to determine the evacuation difficulty index (EDI). *Timed fire drills are not allowed by CMS for the determination of the Evacuation Capability Score.*

- The E Score of the facility is determined by using the six worksheets found in Chapter 6 of NFPA 101A. The worksheet for rating residents contains a cover sheet for the inclusion of facility information and date of the survey.

- When completing the *Worksheets for Determining Evacuation Capability*, Form CMS-2786*M*, interview the staff person who is most familiar with the resident's risk factors, whenever possible. Rate each resident on each of the *seven* risk factors (Risk of Resistance, Impaired Mobility, Impaired Consciousness, Need for Extra Help, Response to Instructions, *Walking Response to Alarm*, and Response to *Fire Drills*) by checking the appropriate circle on each line. Calculate the score and write the score for each circle checked in the boxes in the far right column. For the seventh parameter (Response to Fire Drills) write the checked scores in the three large circles. Write the sum of the three scores in the box to the right**.** **NOTE**: In a small facility complete one form for each resident.

- The Residents Overall Need for Assistance is now determined by comparing the seven score boxes in *Worksheet 6.8.2* and writing the HIGHEST score in the box labeled "Evacuation Assistance Score."

- The worksheet for "Calculating Evacuation *Capability* Score" (E-score) is now filled out. The five questions must all be answered "Yes" to satisfy the requirements for obtaining the E-score.

- Complete *Worksheet 6.8.4,* Resident Scores by listing each resident's name and *E-*score in the *table* and total the individual scores. Enter the total at the bottom in the box to the right of the word "*Evacuation Assistance Score* Total."

- Complete *Worksheet 6.8.8*, Staff Shift Scores by listing the names of each staff member required to remain in the facility for the shift being evaluated. Evaluate the shift with the highest E-Score (least amount of staff), usually the night shift. Enter the appropriate rating for the *Alarm E*ffectiveness (as determined by the table on the lower left) for each staff member. The terms "*A*ssured" and "*N*ot *A*ssured" are used in the alarm *effectiveness* rating. "Assured" means that the alarm is "easily noticeable" in all locations where staff is allowed to go, regardless of the ratings on the promptness of response. "Not assured" means the alarm does not satisfy the conditions of "assured." Then add the *Promptness of Response Scores* and enter the total in the box marked "*Staff Shift Score* Total."

- *Calculate* the *h*ome's Evacuation *Capability* Score by completing *Worksheet 6.8.9 – Rating the Facility*. Indicate the vertical distance of bedrooms (that is the stories) from the exits. Proceed to section *Worksheet 6.8.10* Calculation of E*vacuation Capability Score*. Enter *Total Resident* Evacuation Assistance *S*core and the *Vertical Distance from Sleeping Room to Exit Score*, which compose the numerator of this fraction and multiply them by each other. Enter the Staff Shift

Score in the denominator and divide them into the product of the numerator. This is the E-Score.

- The Evacuation Difficulty Score is found by using the chart *in Worksheet 6.8.11* and entering the *Level of Evacuation Capability* in the box at the bottom right. A score equal to or less than 1.5 is Prompt. A score greater than 1.5 but not more than 5 is Slow. A score of greater than 5 is Impractical. Transfer the score to the cover page of the Survey Report Form CMS-2786.

As an additional safeguard, the health facilities surveyor, who visits the facility before the fire authority's visit, should complete Items I thru VI on Worksheet *6.8.2 -* Rating *the* Residents *on the Risk Factors* for each client included in the health facility survey sample. This will help to corroborate the findings of the fire authority obtained through their interviews with staff about residents. This is done to determine if there is any cause to question the validity of staff reports of predicted client behavior. The health facilities surveyor is not required to complete all of the forms or calculate the Evaluation *Capability Score* unless required to by State regulations, but simply completes item I to VI*I*.

The fire authority should obtain from the *SA* health surveyors the completed Worksheet *6.8.4 - Resident Scores* and compare the results obtained from the two surveys. If there is a pattern of discrepancies in any of items I to *VII* for one or more of the clients in the sample, the *SA* cannot certify the facility until these discrepancies are reconciled. Both the Fire Authority and the State *Health Surveyor* must be satisfied that the *Evacuation Assistance Score* is representative of client capability.

ICFs/IID Survey Procedures

After you determine the size of the facility and level of evacuation *capability*, rate the building. There are two alternative methods of rating the building.

- Use the prescriptive requirements in the appropriate section of *Residential Board and Care Occupancies* Chapter 32/33, Prompt, Slow or Impractical; or

- Use NFPA 101A, Guide on Alternative Approaches to Life Safety, *2013* Edition, Chapter 7, A Fire Safety Evaluation System for Board and Care Occupancies (FSES/BC).

There are two separate series of forms for completion and certification of the facility depending on which method above was followed. If the survey *is to be performed* using *Residential Board and Care Occupancies* prescriptive requirements method then complete the *appropriate F*ire *S*afety *Evaluation Report for Small, Large, or Apartment House (2786V, 2786W, 2786X)*, as well as the Worksheet for *Determining Evacuation*

Capability (2786M) using Chapter 6, NFPA 101A. In addition, complete a Statement of Deficiencies and Plan of Correction (CMS-2567), in the usual manner if deficiencies are found.

If the facility is certified or is to be certified using the FSES/BC, Chapter 7, NFPA 101A and you have determined an Evacuation *Capability* Score for the facility, and completed a prescriptive survey of the facility you may apply the FSES/BC (Chapter 7, NFPA 101A), to determine compliance. Please note that the entire Fire Safety Survey Report must be completed when applying the FSES/BC. This is no different from the usual survey procedure for *H*ealth *C*are *Occupancies*. Complete a Form CMS-2786 along with the FSES/BC worksheets, which are part of the form, for each facility certified as a Residential Board and Care Occupancy.

Multiple buildings or parts of buildings on a campus are sometimes used by a facility to house clients. In such cases, rate each building separately. On a large campus, such as a State School for the Mentally Disabled or State Developmental Center, a large building may be surveyed under Chapter 18/19 Health Care and a small building may be surveyed as a Residential Board and Care Facility under Chapter 32/33. In some cases, buildings may be divided into separate wings, with one wing housing Residential Board and Care occupants and the other wing housing Health Care patients. You may use different chapters for different wings only if there is a 2-hour fire wall separating the two parts.

Large buildings previously meeting health care requirements such as a facility with 17 beds or more, which currently meets the health care provisions of the LSC, can continue to be surveyed either under the Health Care Chapter or the FSES/Health Care. If the large facility qualifies as Residential Board and Care occupancy, it may elect to be surveyed under Health Care.

If the facility is to be certified based upon achieving a passing score on the FSES/BC, complete a Statement of Deficiencies, Form CMS-2567, for both the regular Survey Report and the FSES/BC for any deficiencies found. The provider will indicate whether it chooses to correct the deficiencies on the Form CMS-2786, or the deficiencies on the FSES/BC.

There are no provisions for the granting of waivers when using the prescriptive requirements under the Residential Board and Care Occupancies Chapters 32/33. Providers may elect to be surveyed under the Health Care chapters to take advantage of the ability to obtain waivers.

Only surveyors that have completed CMS's basic Life Safety Code, FSES/HC and, if appropriate, the FSES/BC training courses may apply the FSES in Medicare/Medicaid facilities.

TABLE *2*. SAMPLE SIZE OF RESIDENT/PATIENT ROOMS

The table below gives the sample size (number of patient/resident rooms to be checked) needed.

Number of Bedrooms in the Facility	Bedrooms to be Checked
20	19
40	36
60	52
80	66
100	80
200	132
300	169
400	196
500	217
600	234
800	260
1000	278
2000	322

Task – 5 Information Analysis and Decision Making

General Objective

The general objective is to review and analyze all observations and findings in order to determine whether the facility has a deficiency in one or more of the regulatory requirements. A deficiency is defined as observed problems of sufficient severity and/or frequency so as to identify the facility as responsible, and which require some form of corrective action by the facility.

Frequency means the incidence or extent of the occurrence of an observed problem in the facility.

Severity means the seriousness of the observed problem, e.g., the degree to which the problem compromises the residents' health and safety.

A deficiency may be cited when a deficient practice occurs once, or when it occurs frequently.

Procedures

The fire safety survey report forms, worksheets and procedures are designed to assist in the gathering information about the level of fire safety provided by the facility. The K-tags refer to the data tags on the Fire Safety Survey Report form. For each item on the report form page indicate "Met" or "Not Met" or "Not Applicable." For each item

marked "Not Met," enter the appropriate documentation in the Explanatory Remarks section explaining the nature of the deficiency and the degree of hazard it presents. Use additional sheets of paper for additional comments. Throughout the survey, discuss your observations with any other LSC team members and the facility staff. This interaction will assist you in identifying facility problems and will permit the facility the opportunity to provide additional information that may alleviate your concerns.

At the end of the survey, meet with any other LSC team members to draw conclusions about the level of fire safety provided by the facility, and the facility's compliance with the *LSC*.

Deliberately review the negative findings and documentation from each task, and decide whether any further information or documentation is required. Consider your findings and observations in terms of credibility and reliability. Also, consider whether there are any rival or competing explanations related to particular negative findings. If necessary, ask the facility for additional information for clarification about particular findings and carefully weigh any countervailing explanations before making a deficiency determination.

The threshold at which the frequency of occurrences amounts to a deficiency varies from situation to situation. One occurrence directly related to a life-threatening or fatal outcome can be cited as a deficiency. On the other hand, a few sporadic occurrences may have so slight an impact on the life safety of residents or patients that they do not warrant a deficiency citation.

Determining compliance with the LSC should be based on the facility meeting all the *prescriptive* requirements of the LSC. Alternatively, if there are deficiencies, facilities can be found in compliance *with* an acceptable *survey* plan of correction *(POC).* A revisit may be needed to confirm that the deficiencies have been corrected *or may* include a *verbal or written* confirmation of correction of cited deficiencies*,* when appropriate. *An acceptable POC may be achieved* if the *CMS Location* has *approved a LSC* waiver *of* a specific LSC *deficiency*. *In addition, an acceptable POC may be achieved if the CMS Location has approved an FSES.* If the facility is *unable to achieve* compliance with *the* LSC, a recommendation of certification is not appropriate.

If the facility is *deemed by* a *CMS-approved* accredit*ation organization (AO)*, the facility is found to meet the *requirements* of the LSC *by complying with the AO's accreditation standards*. If*, during a SA survey of a deemed* facility, *it is* found not to be in compliance with the LSC*,* then the facility loses its "deemed" status and will be required to complete *the SA survey* POC. *The completion of a SA* POC cannot occur until a certification decision is made to remove the facility's "deemed" status by the *Location*. The deficiencies cited will have to be corrected before the facility's "deemed" status can be restored. A follow-up survey may be required to confirm that the deficiencies have been corrected *before* "deemed" status can be restored.

When the plan of correction contemplates meeting the equivalency criteria, mark the facility in compliance based upon the findings of the FSES on page one of the Fire Safety Survey Report Form. The use of the *FSES* does not necessarily eliminate the use of waivers. For example, if an item in the Facility Fire Safety Requirements Worksheet, of the FSES is deficient, it does not enter into the computation portion of the FSES and must either be met, not meet or could be waived. The Fire Safety Requirements Worksheet includes requirements for such items as building utilities, heating and air conditioning regulations. CMS encourages the use of the FSES in those cases where a facility could achieve a passing score without waivers.

Waiver of LSC Requirements

When the facility meets the LSC based on a waiver of a specific requirement in the LSC, the POC completed by the facility will indicate which items *they* are requesting to be waived,:

- How compliance would impose an unreasonable hardship on the facility; and
- How a waiver would not adversely affect the health and safety of patient/residents in the facility.

There is no provision in the regulations for the granting of waivers of the LSC requirements under Chapter 32/33 (Residential Board and Care Occupancies). A facility may use the FSES survey or request to be surveyed under the requirements of Chapter 18/19 (Health Care Occupancies). There also cannot be a waiver of the requirement for a generator in a facility with life support equipment.

When recommending a waiver of a specific LSC requirement on the basis of correction of another deficiency, the waiver should not be granted until the corrective action on the other item is completed. For example, if a facility is requesting a waiver of the installation of return air ducts where corridors are being used as return air plenums on the condition that the facility install smoke detectors tied into an alarm system and the automatic shutdown of ventilation fans, do not waive the return air plenums until you verify that the facility has actually installed the detectors and that are appropriately connected to the fire alarm and air circulation systems. In the above cases, the first page of the Form CMS-2786 should be marked “Meets, Based Upon, 2. Acceptance of a Plan of Correction” and then upon completion of the corrective action it can be marked “Meets, Based Upon, 3. Recommended Waivers.”

Waivers of specific LSC criteria can be recommended for an extended length of time if correction of the deficiency is not possible.

When a waiver is recommended, both the surveyor and concurring fire authority official must sign the form at the bottom of Part IV, Recommendation for Waiver of Specific *LSC* Provisions, after the facility has responded to the Statement of Deficiencies.

In instances where CMS has issued policy which allows for a categorical waiver of specific *LSC* provisions, facilities must document their election to use a categorical waiver and notify the survey team of their decision in advance of being cited for a deficiency. The surveyor must review the facility's documented decision, confirm that the facility is meeting all of the categorical waiver requirements, and reference the use of the categorical waiver to achieve compliance under Tag K000 and in Part IV on the CMS-2786. Categorical waivers do not require a prior deficiency citation or *Location* approval, therefore the first page of the Form CMS-2786 should be marked "The Facility Meets, Based Upon, 3. Recommended Waivers."

Writing Deficiency Statements

Following the Principles of Documentation, (*A*ppendix P) write the deficiency statement in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the requirement(s) that is (are) not met. Indicate the data prefix tag and regulatory citation, followed by a summary of the deficiency and supporting findings using resident identifiers, not resident names. List the data tags in numerical order, whenever possible.

The statement of deficiencies should:

- Identify the Section(s) in the *LSC* and Mandatory References, where appropriate, that contain the requirements upon which the deficiency is based; and
- Specifically reflect the content of each requirement that is not met; and
- Clearly identify how/why the requirement is/was not met; and
- Identify the extent of each deficient practice; and
- Identify the source(s) of the evidence (e.g., interview, observation or record review); and
- If appropriate, identify the impact or potential impact of the facility's non-compliance on health and safety of the residents/patients.

Decision Making for Compliance with the LSC

The final part of the fire safety survey is sometimes considered the most difficult, and that is making a compliance decision on whether or not the facility meets the LSC. There is no number of deficiencies, that if exceeded makes the facility out of compliance with the LSC. It is possible to have one or two deficiencies are significant enough to be considered an immediate and serious threat to the residents/patients or a large number of less serious deficiencies that do not have the same impact. In the final analysis a decision

has to be made, one that is based on the facts and can be objectively defended if questioned.

If a facility has no deficiencies or non-consequential deficiencies the decision-making process is very simple; the facility is in compliance and no deficiencies are cited. The survey report form is marked "The Facility Meets, Based Upon 1. Compliance With All Provisions." No further action by the facility is expected regarding this survey. The facility is to be notified and the results posted and available to the residents and the public.

If the facility has deficiencies and they are not at the level that would constitute an immediate and serious jeopardy or threat to the health and safety of the residents/patients (see Appendix Q for criteria) then a compliance decision will have to be made based on the results of the survey. This decision needs to be based on the facts at hand and not biased one way or the other due to outside forces.

Deficiencies may be considered corrected by the approval of a waiver of a specific requirement of the *LSC*.

In the case of a building that is to be certified using the FSES and if a passing score is not achieved on the FSES form, the facility does not meet the requirements of the *LSC* and the Fire Safety Report Form part 7 B. should be marked "The Facility Does Not Meet the Standard." If this occurs then the Physical Environment Condition of Participation *or Condition for Coverage* must also be found not met. Termination action should be instituted if the facility was found not in compliance and the same deficiencies were cited on the survey the year before. In other words, if the facility did not complete their POC from the year before as approved then termination proceedings shall be instituted. If the facility was not previously found out of compliance or different deficiencies were found previously, then a POC could be accepted from the facility. A follow up revisit needs to be scheduled to inspect the progress being made to correct the deficiencies.

If an accredited *health care facility*, one which has "deemed status," is surveyed by the SA during a validation or complaint survey the compliance decision process is altered somewhat. If LSC deficiencies are found that require correction, they are documented on a Form CMS-2567 in the usual manner *and t*he SA transmits the survey findings to the *CMS Location*. The *Location*, if in agreement with the SA findings, removes the facility's "deemed status" and at that time a POC is requested from the facility, and corrective action is taken by the facility. The facility is placed under SA monitoring and the SA is requested to make periodic follow-up visits to insure timely completion of the POC. When the facility has completed its POC, the facility's "deemed status" is restored and *it* is no longer under SA monitoring.

Immediate and Serious Threat

An immediate and serious threat is defined in Appendix Q as having a high probability that serious harm or injury to residents/patients could occur at any time, or has already occurred and may well occur again if residents/patients are not protected effectively from the harm, or the threat is not removed.

The guiding principles to determine immediate and serious threat make it clear that the threat to life is imminent and can be related to the health and safety of the residents/patients. Some examples of life-threatening deficiencies are failure to maintain required fire protection systems in an operating condition, obstructed passageways that prevent egress in the event of an emergency, open stairways, missing tamper switch and water flow alarm in a sprinklered facility and unprotected wood frame construction which is not sprinklered.

If, at any time during the survey, an immediate and serious threat is identified, the surveyor should immediately consult with his/her supervisor and the *SA*. If the supervisor and *SA* concurs with the findings of the surveyor, then the facility administrator is notified that immediate and serious threat termination procedures are being invoked. The surveyor should explain to the administrator the nature of the threat. The surveyor should complete the remainder of the survey to determine the extent of deficiency.

The Form CMS-2786 should be marked as 7. B. "THE FACILITY DOES NOT MEET THE STANDARD" if the facility is found to have an immediate and serious threat. If the form is marked "MEETS WITH ACCEPTANCE OF A PLAN OF CORRECTION," the *SA* cannot make a finding of immediate and serious jeopardy at the facility.

See Appendix Q for guidance regarding the determination of immediate and serious threat, and §3010 of the State Operations Manual (SOM) for procedures to follow if the immediate and serious threat termination procedures are invoked.

Task 6 – Exit Conference

General Objective

The purpose of the exit conference is to inform the facility of the survey team's observations and findings.

Conduct of Exit Conference

Conduct the exit conference with the facility administrator or anyone designated by the administrator. Also, invite an Officer of the organized resident's group, if one exists, or a representative of the residents of the facility to the exit conference.

Provide the facility with specific information necessary for POC, if there is a need for a POC. Do not provide the facility worksheets that contain surveyor notes.

For LSC surveys, the survey team may follow the procedures for either non-LTC or LTC described in SOM Chapter 2, Section 2724C - Presentation of Findings. This would be determined depending on the degree to which, in the judgment of the team, the tag codes are important in helping the provider/supplier to understand the nature and location of the deficiency, and the corrective actions that would be necessary. Facility representatives are typically invited to accompany LSC surveyors during building tours, to improve familiarity with preliminary findings and exit conference proceedings.

Under no circumstances should you make general statements about the facility such as, "Overall the facility is very good." Stick to the facts. Do not rank regulatory requirements, but treat requirements as equally as possible. Cite problems that clearly violate regulatory requirements. The surveyors must not make statements such as, "The condition was not met," or "The standard was not met."

Provide the facility with the opportunity to discuss and supply additional information, if necessary, and attempt to resolve differences regarding deficiencies.

Review with the facility alternatives to compliance with the prescriptive requirements of the LSC if appropriate, such as, waivers of specific *LSC* requirements or the suitability of the facility to achieve compliance using the FSES.

If the provider asks for the specific regulatory basis or the specific tag code, the surveyors should generally provide this information (except as noted in Chapter 2, 2724C - Presentation of Findings), but must always caution the facility that such coding classifications are preliminary and are provided only to help the provider gain more insight into the issues through the information provided in the interpretive guidance. If the facility does not specifically ask for the regulatory basis or tag, the survey team may use its own judgment in determining whether this information would provide additional insight for the facility.

The level of scope and severity will be determined in accordance with procedures found in SOM, Chapter 7, §7400. The level of scope and severity will depend on the extent of the deficient practice and its impact on the health and safety of the residents. This can occur on-site or presented to the facility on the Form CMS-2567.

In accordance with your Agency's policy, present the Form CMS2567, on site or after supervisory review, no later than 10 calendar days following the survey.

III. Complaint Investigations

If a complaint alleges a deficient practice in fire safety, and the complaint is of a specific nature, use your discretion to investigate the complaint independent of the standard fire safety survey (a special survey) or incorporate the investigation of the complaint into that specific task that covers that issue in the standard fire safety survey.

The scope, duration and conduct of a complaint investigation are at the discretion of the State survey team. The investigation should be widespread enough to resolve the complaint. Base any citation of deficiencies upon observations at the time of the survey. If it can be determined that the facility was out of compliance at the time of the complaint but, is no longer out of compliance, this should be noted.

A Form CMS-2567 should be completed and forwarded to the facility in accordance with Agency policy if deficiencies are found.

IV. Post Survey Revisits

The purpose of the follow-up survey or revisit is to re-evaluate the specific deficient areas that were cited, as deficient, during the original survey. Determine the status of corrective actions being taken on all deficiencies cited on the original surveys Form CMS-2567. The nature of the deficiencies dictates the timing and scope of the follow-up survey. For example, LSC deficiencies that involve structural changes may require long construction periods, whereas maintenance driven items may be corrected fairly quickly. Focus on the previously cited deficiencies but the surveyor is not prohibited from gathering information related to any of the LSC requirements during a follow-up survey. If, after completing the follow-up activities, you determine that the cited deficiencies were not corrected by the date specified in the facility's approved plan of correction, initiate adverse action procedures, as appropriate. Document the revisit to the facility using the appropriate CMS forms. It may be possible, if the need for documentation is minimal, to use the Surveyor Notes Worksheet (Form CMS681) to record the results of the revisit survey.

Transmittals Issued for this Appendix

Rev #	Issue Date	Subject	Impl Date	CR#
R209SOM	12/09/2022	Revisions to Appendix I – Survey Procedures for Life Safety Code Surveys	10/01/2022	N/A
R159SOM	09/09/2016	Revisions to the State Operations Manual (SOM), Appendix I – Survey Procedures for Life Safety Code Surveys	09/09/2016	N/A
R101SOM	02/14/2014	State Operations Manual (SOM) Appendix I revisions for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	02/14/2014	N/A
R99SOM	01/31/2014	Revised State Operations Manual (SOM) Appendices A, I, L, and W	01/31/2014	N/A
R89SOM	08/30/2013	Revised State Operations Manual (SOM) Appendices A, I, L, and W – Rescinded and replaced by Transmittal 99	08/30/2013	N/A
R01SOM	05/21/2004	Initial Release of Pub 100-07	N/A	N/A