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IN THIS ISSUE

STEVEN HIRSCH & ASSOCIATES

This issue offers important updates on licensing issues that may impact your successful accreditation.

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DEADLINE APPROACHING FOR FIRE SPRINKLER INSTALLATION IN HIGH-RISE HEALTHCARE FACILITIES

by *Steven Hirsch, MPA, FACHE*

In July 2016, the U.S. Centers for Medicare & Medicaid Services (CMS) formally adopted the 2012 Edition of the National Fire Protection Association's (NFPA) Life Safety Code®, NFPA 101. Under the Final Rule published by CMS in the Federal Register at 81 FR 26872 (July 5, 2016), there are several noteworthy requirements that healthcare facilities need to address. As reported by The Joint Commission in the April edition of "Joint Commission Perspectives" and the April 16, 2025 Edition of "Joint Commission Online," high-rise healthcare facilities will be required to be equipped throughout with fire suppression systems (fire sprinklers) by **July 6, 2028**.

The Life Safety Code defines "high-rise building" as, "A building where the floor of an occupiable story is greater than 75 ft (23 m) above the lowest level of fire department vehicle access." NFPA 101, 2012 Ed., § 3.3.36.7. This roughly corresponds to the height a fire department aerial ladder can reach, generally 6-7 stories above ground level. There are some configurations of aerial ladders that are capable of extension to higher floors, but they are less common.

Fire sprinklers, by slowing the spread of fire, provide much needed time to aid in evacuation. There are a number of advantages to having fire sprinklers installed throughout the building. For example, under the Life Safety Code, travel distance between any point in a room and an exit may not exceed 150 ft (46 m), while in a building fully protected by a supervised fire sprinkler system, travel distance between any point in a room and an exit can be increased to 200 ft (61 m) [NFPA 101 §19.2.6.2.1 and §19.2.6.2.2.]. In a sleeping suite, travel distance between any point in a sleeping suite and an exit access door from that suite shall not exceed 100 ft (30m) [§19.2.5.7.2.4 (A)]. If the building is not provided throughout with a fire sprinkler system, the travel distance between any point in a sleeping suite and an exit shall not exceed 150 ft (46 m), and if the building is protected throughout by an electrically supervised fire sprinkler system, travel distance can be increased to 200 ft (61m) [§19.2.5.7.2.4(B)(1)(2)].

Under the CMS Final Rule, Long Term Care Facilities under 42 CFR 483.70, Physical Environment, all Long Term Care Facilities were required to be fully sprinklered August 13, 2013 in order to receive Medicare and Medicaid reimbursement. This includes distinct part Skilled Nursing Units located in general acute care and psychiatric hospitals.

Existing acute general hospitals, if not considered a high-rise as defined above, may be required to have fire sprinklers if mandated by the local jurisdiction or state authority. In new construction (where plans have been approved on or after March 5, 2016) fire sprinklers are required. This would include renovated space as well.

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Deadline Approaching for Fire Sprinkler Installation in High-Rise Healthcare Facilities

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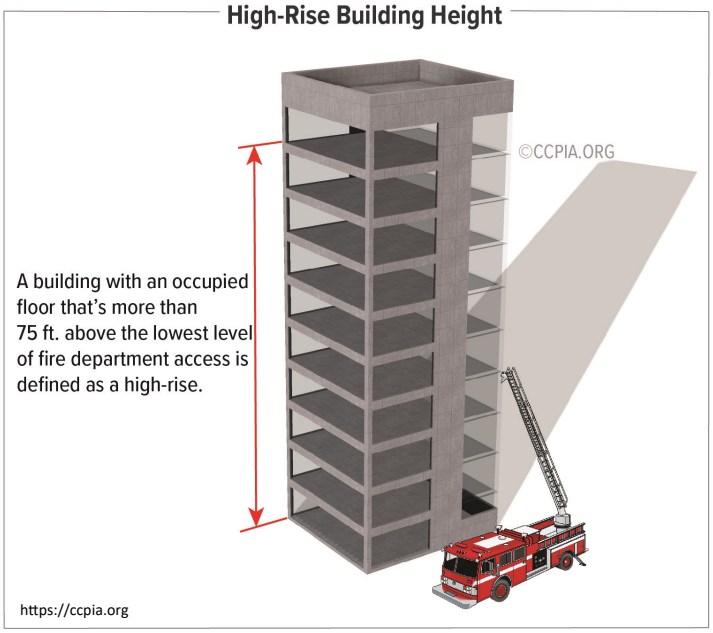
As stated in "Joint Commission Perspectives" and "Joint Commission Online," accredited healthcare organizations need to plan to be in compliance with the above fire suppression requirements. As installation of fire sprinklers is a significant capital project and can be disruptive to the accredited organization's operations, it is imperative that the organization carefully create a plan to accommodate this long term project. It should be noted as well that under the Medicare Conditions of Participation for Hospitals at 42 CFR 482.12(d)(3), a long term (3-year) capital expenditure plan is required. The cost of installation of fire sprinklers inclusive of design, permitting, and construction/installation should be reflected in this capital expenditure plan.



To recap, if your organization is located in a high-rise building where occupiable space is 75 feet or more above ground level, fire sprinklers are required to be installed not later than July 6, 2028. Having given healthcare facilities 12 years advance notice, it is unlikely that extensions will be easily approved by CMS except under the most extreme circumstances.

References:

Code of Federal Regulations.
42 CFR 482.12(d)(3); 42 CFR 483.70; 81 FR 26872 (July 5, 2016)
National Fire Protection Association.
Life Safety Code®, NFPA 101, 2012 Edition, Sections 3.3.36.7; 19.2.6.2.1; 19.2.6.2.2, 19.2.5.7.2.4(A), 19.2.5.7.2.4(B)(1)(2).
The Joint Commission. Joint Commission Perspectives (April 2025)/Joint Commission Online (April 16, 2025)

THE NATIONAL PRACTITIONER DATA BANK STANDARDS FOR IDENTIFYING AN INVESTIGATION

by Margo Smith, CPMSM

The National Practitioner Data Bank (NPDB) Guidelines published by the Health Resources and Services Administration (HRSA) has expanded the definition of "investigation." While the NPDB does not define "investigation," the NPDB Guidebook broadly describes what constitutes an "investigation." "The NPDB defines investigation broadly to include any professional review that focuses on one practitioner for competency or conduct concerns."[1]

"Reports in the National Practitioner Data Bank are records of actions taken by authorized organizations regarding health care practitioners, entities, providers, and suppliers who do not meet professional standards."[2]

"A health care practitioner, licensed health care practitioner, licensed practitioner, or practitioner . . . is defined as an individual who is licensed or otherwise authorized by a state to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized."[3]

Health care entities may find it difficult to determine when to report adverse clinical privilege actions to the NPDB. While the decision to report should always be based on facts that have been compiled, based on occurrence reports, observations of peers, or concerned staff or patients, entities must also follow statutory and regulatory requirements.

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"The NPDB considers an investigation to run from the start of an inquiry until a final decision on a [provider's] clinical privileges is reached. . . . [A]n investigation is not limited to a health care entity's gathering of facts or limited to the manner in which the term 'investigation' is defined in a hospital's by-laws [or policies and procedures]. An investigation begins as soon as the health care entity begins an inquiry and does not end until the health care entity's decision-making authority takes a final action or makes a decision to not further pursue the matter."[4]

Following the review of evidence provided by the requested committee i.e., Department/ Peer Review Committee, etc., the Medical Executive Committee can determine whether the physician or practitioner is subject to an investigation.

The Peer Review process, conducted by the entity, is not considered an investigation for the purpose of reporting to the NPDB. However, when a practitioner becomes the subject of a formal peer review investigation based on specific issues related to their professional competence or conduct, this is considered an investigation and is reportable to the NPDB.[5]

Actions reportable to the NPDB by the facility include the following:

- suspension of 30 days or more*****
- recommendation to terminate privileges
- resignation while under investigation or to avoid investigation
- physician request for a medical leave of absence while under or to avoid investigation
- physician self-restriction of clinical privileges while under or to avoid investigation

If a practitioner decides to take a leave of absence, surrender, restrict, or resign their clinical privileges during a targeted investigation, or to avoid an investigation, that is reportable to the NPDB.

Practitioners should be aware of the NPDB reporting requirements. If they choose to consider resigning after receiving notice of an investigation, the practitioner should consider whether resigning after the investigation has been closed, would be more favorable to their professional interests.[6]

Though it is not required to notify practitioners that they are under investigation, it is suggested that the Medical Staff Bylaws include language defining an investigation, including guidance on when notice is to be provided to the practitioners.

Once a Clinical Privileges Action Report is processed successfully by the NPDB, the health care entity must provide a copy of the report received from the NPDB to the appropriate state licensing board in the state in which the health care entity is located. Failure to submit the adverse clinical privileges report can result in loss of 3 years of immunity protections provided under Title IV for professional review actions the organization takes against physicians based on their professional competence and professional conduct.[7]

When there is closure of an investigation, whether due to an action taken or a determination that no action is warranted, the decision should be documented in meeting minutes and the practitioner should be notified of the final decision.[8]

"In addition, hospitals and other health care entities *may* report—and are encouraged to report—clinical privileges actions taken against health care practitioners *other than* physicians and dentists when those clinical privileges actions are based on the practitioner's professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient."[9]

When there are questions about reporting to the NPDB, the medical staff should refer to the NPDB Guidebook and to the medical staff or hospital attorney for clarification and guidance.

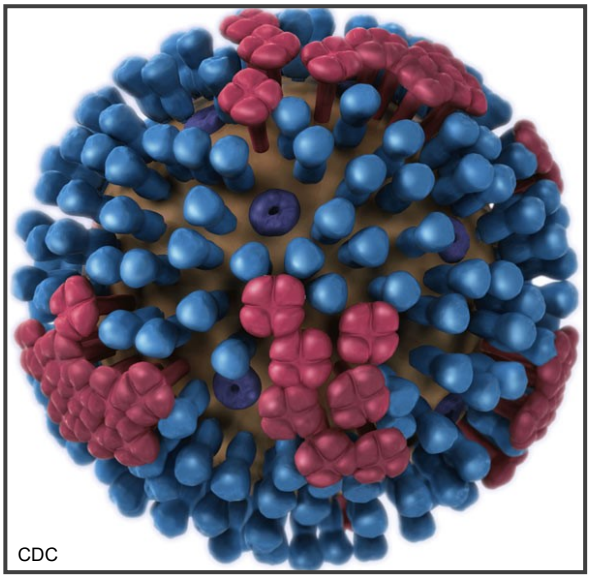
***** "[S]ummary suspensions must be reported if imposed or in effect for longer than 30 days. However, reports submitted for summary suspensions, regardless of how the restriction was written, must be voided if the reported suspension did not ultimately last longer than 30 days. As is the case with any restriction, the reportability of the action is determined by the number of days privileges are restricted." NPDB National Practice Data Bank, *Length of Action Requirement for Reporting Clinical Privileging Actions*, www.npdb.hrsa.gov/qa/policy8.jsp.

References:

[1] Credentialing Resource Center Digest, Understand what the NPDB considers an investigation, July 31, 2019, John Synowicki
[2] National Practitioner Data Bank, U.S. Dept. of Health & Human Services
[3] National Practitioner Data Bank Guidebook ("NPDB Guidebook"), at C1 [October 2018]
[4] NPDB Guidebook, at E36-E37
[5] NPDB Guidebook, at E37
[6] NPDB Guidebook, at E49, Q20
[7] NPDB Guidebook, at E41-42
[8] Do the Right Thing—Reporting Voluntary Actions Taken While "Under Investigation" to the NPDB, National Law Review
[9] NPDB Guidebook, at E32.

PREVENTION AND MANAGEMENT OF RESPIRATORY VIRUS OUTBREAKS IN LOCKED BEHAVIORAL HEALTH FACILITIES

by Marietta Hickman, RN, MSN, CIC


CDC

The 2024-2025 influenza virus season has demonstrated the highest levels of influenza cases in the United States in the last 15 years, with almost all jurisdictions reporting "high" and "very high" levels of the flu. The Centers for Disease Control and Prevention (CDC) estimates the flu has contributed to at least 47 million illnesses and 610,000 hospitalizations, with at least 26,000 fatalities.[10] While COVID-19 cases are historically down from this time in previous years, the virus is still circulating. Additional threats such as respiratory syncytial virus (RSV), norovirus, human metapneumovirus, and others also remain a concern.

The high disease burden poses an increased challenge for locked behavioral health facilities. The congregated living conditions can lead to rapid transmission of illnesses between staff and residents. Often, the therapeutic needs of patients in the behavioral health setting conflict with infection control policies and procedures that are effectively utilized in acute care settings. The therapeutic milieu in behavioral health requires that patients participate in group therapy, dine together and socialize throughout the day with other patients in the unit and, possibly, other units in the facility.

Psychiatric patients are at increased risk of contracting infectious diseases due to multiple factors, including potential homelessness or crowded living conditions, and untreated chronic medical conditions such as diabetes or hypertension. Cognitive impairment also contributes to lack of routine medical care and inability to recognize illness or the need to seek treatment and lack of adherence to infection control practices. Patients in behavioral health settings may be unable or unwilling to wear appropriate personal protective equipment and engage in safe behaviors such as frequent hand hygiene and cough etiquette.

The scarcity of inpatient psychiatric beds across the country makes it essential to ensure that these beds remain open for admissions, even during community surges in viral illness. With some adjustments, inpatient behavioral health units can remain a safe and therapeutic environment for patients, staff, and visitors.

Surveillance

Surveillance of circulating diseases is important in providing awareness of current threats to staff and patient safety. Databases exist for national, state and local respiratory virus surveillance reports and are publicly accessible online. National, state and local health alert networks provide information regarding outbreaks, threats and hazards. Many of these databases offer registration to email alerts and notifications such as "All Facilities Letters" from state health agencies. Educational materials available from these agencies provide resources to enhance staff knowledge and surveillance of diseases that may be present in local community populations. Daily active surveillance of all units should occur during respiratory virus season and times of high community transmission.

Masks

Masks should be encouraged for all staff, visitors and patients during respiratory virus season. Enforcement of mask wearing is recommended during surges in community transmission or facility outbreaks. Level one facemasks with the metal nosepiece removed should be offered to all patients to wear when in public areas and during group therapy.

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Vaccination

Vaccines remain the most effective way to reduce morbidity and mortality from illness. Vaccinations should be offered to all staff and patients with no contraindications. Vaccine hesitancy often exists for varying reasons in the behavioral health population. Vaccine should be offered frequently and individual barriers to vaccination should be addressed with patients in a multi-faceted approach through the therapeutic milieu.

Social Distancing

While social distancing is more difficult to accomplish in behavioral health than in acute care, steps can still be taken to reduce the risk of transmission while providing the appropriate therapy. If possible, consider moving group therapy sessions to settings that promote social distancing, such as an outdoor therapy setting or a larger indoor space that allows patients room to spread out.

Add additional dining times to accommodate a smaller number of patients in the dining room for meals. Meals can also be rotated to allow for some meals to be taken in the unit and some in the dining room. Consider taking meals outside, if weather and facilities permit.

If there is an outbreak involving one unit only, that unit should be isolated from other units in the facility until the outbreak is over. This should include outdoor activities and group therapy. Consider closing the affected unit to admissions until the outbreak is declared over. Do not move patients from the affected unit to another unit until ensured the patients are not contagious.

Testing

Testing for certain respiratory illnesses (Covid-19, influenza, RSV) may be recommended or required by facility protocol or state or local jurisdictions. All staff and patients with any signs and symptoms of a respiratory illness should be tested for influenza and Covid-19.[11] If your facility meets the definition of an outbreak, testing of all patients and/or staff may become necessary. Comprehensive testing during an outbreak can help to identify positive results in persons who are not yet symptomatic. This strategy facilitates early isolation and cessation of further transmission.

Treatment

Facilities should develop processes for rapid treatment of identified respiratory illnesses per clinical guidelines. If influenza is suspected, antiviral treatment should begin prior to receiving test results. When at least 2 patients are ill within 72 hours of each other and one has laboratory-confirmed influenza, antiviral chemo-prophylaxis should be provided to non-ill exposed individuals in the affected unit, regardless of vaccination status, per CDC guidance.[12] Antiviral chemoprophylaxis can also be considered for staff who provide care to high -risk individuals.

Environment

Enhanced cleaning of common areas with a focus on high -touch surfaces reduces viral bioburden. Amount and frequency of alcohol-based hand sanitizers on the unit will play an important role in reduction of transmission. Research indicates that “lack of hand hygiene products in key locations” is one of the greatest obstacles to hand hygiene compliance in behavioral health settings.[13] An environmental risk assessment can help determine the optimal number and placement of sanitizers.

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Prevention and Management of Respiratory Virus Outbreaks in Locked Behavioral Health Facilities

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Behavioral health settings pose unique challenges to the prevention of infections. Viral illnesses can be easily introduced into the facility and spread quickly amongst patients and staff due to the physical layout of the unit and close interactions between staff and patients. While this list of strategies is not all-inclusive, these steps can help prevent outbreaks, mitigate transmission during outbreaks, and increase staff and patient safety.

References:

[10]Centers for Disease Control and Prevention. Preliminary Estimated Flu Disease Burden 2024-2025 Flu Season. (Accessed 5/5/25)

[11]California Department of Public Health. Recommendations for Prevention and Control of COVID-19, Influenza, and Other Respiratory Viral Infections in CA SNFs 2024-2025

[12]Centers for Disease Control and Prevention. Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities. (Accessed 5/5/2025)

[13]Association for Professionals in Infection Control and Epidemiology

For more information on how to
keep your facility compliant with current Regulations and Standards,
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