

Codes and Standards

1. FHEA members, NFPA 99 and NFPA 101 are now closed to Public Input. This was your opportunity to have code changes considered. There were no submissions from FL hospitals to my knowledge.

2. Joint Commission

- SIG is understaffed and is creating some unusual responses to ESC's.
- Continue to have more picky surveys around the country

3. Working with ASHE on code improvements, current communications include :

1. Have been asked by ASHE to assist, still awaiting direction on this
2. Please send your code issues this way with your reason for rebuttal. Right now ASHE is working on IBC, NFPA and Joint Commission
3. Smoke detectors in sleep(physician) rooms, code is incidental use as dormitory, we believe it should remain healthcare
4. Use of door access controls in a stair should be considered acceptable. Being cited at multiple hospitals

4. As of August 15, 2018, NFPA clinical engineering frequency of surgical equipment inspections is now adopted by AHCA. This has been a two year undertaking, but it saves considerable money for hospitals.

5. Eddie Alday has shared that AHCA is following and enforcing the CMS Emergency Preparedness standard under appendix Z. This standard requires hospitals to provide temperature control via generators when there is an event that causes normal power loss.

Submitted

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59A-3.245 Surgical and Anesthesia Departments.

(1) Surgical Department. Each Class I and Class II hospital, and each Class III hospital providing operative and other invasive procedures, shall have a functionally and physically distinct surgical department within the hospital, organized under written policies and procedures regarding surgical privileges, maintenance of the operating rooms, and evaluation and recording of treatment of the patient. The surgical department shall have a physician member of the organized medical staff serve as medical advisor to the surgical department and a registered nurse to direct nursing services within the operating rooms of a surgical department. All surgical department policies and procedures shall be available to the Agency, shall be reviewed annually, dated to indicate time of last review, revised as necessary, and enforced.

(a) The determination of the appropriateness of the procedure for a patient shall be based on:

1. The patient's medical, anesthetic, and drug history;
2. The patient's physical status;
3. Diagnostic data;
4. The risks and benefits of the procedure; and,
5. The need to administer blood or blood components.

(b) The risks and benefits of the procedure shall be discussed with the patient prior to documenting informed consent and include:

1. Other treatment options, if they exist;
2. The need and risk of blood transfusions and available alternatives; and
3. Anesthesia options and risks.

(c) A preanesthesia evaluation of the patient shall be performed prior to surgery, except in the case of extreme emergency.

(d) Plans of care for the patient shall be formulated and documented in the medical record prior to the performance of surgery and shall include a plan for anesthesia, nursing care, the operative or invasive procedure, and the level of post-procedure care.

(e) The measurement of the patient's physiological status shall be assessed during the administration of anesthesia and the surgical procedure.

(f) The post-procedure status of the patient shall be assessed on admission to the recovery area and prior to discharge from the recovery area.

(g) The patient shall be discharged from the recovery area by a member of the organized medical staff.

(h) The operating room and accessory services shall be located in a manner to prevent through traffic, control traffic in and out, and maximize infection control.

(i) All infections of clean surgical cases shall be recorded and reported to the appropriate infections control authority, and a procedure shall exist for the investigation of such cases.

(j) The registered nurse shall document that all surgical nursing staff have received annual continuing education in safety, infection control and cardiopulmonary resuscitation.

(k) A roster of members of the organized medical staff specifying the surgical privileges of each, shall be maintained, reviewed annually and revised as necessary.

(l) A roster of "on-call" surgeons shall be promptly available at the operating room nursing stations. An on-call surgeon must be available to the hospital when a call for services has been placed.

(m) A record shall be maintained on a current basis that contains the following information:

1. Patient's name;
2. Hospital number;
3. Preoperative diagnosis;
4. Post-operative diagnosis;
5. Procedure;
6. Names of surgeon, first assistant, and anesthesiologist;
7. Type of anesthetic; and,
8. Complications, if any.

(n) Regardless of whether surgery is classified as major or minor, the surgical department shall ensure, prior to any surgery being performed, except in emergency situations:

1. That there is a complete history and physical workup in the chart of every patient or, if such has been transcribed, but not yet

recorded in the patient's chart, that there is a statement to that effect in the chart; and,

2. That there is evidence of informed consent for the operation in the patient's chart.

(o) The surgical department shall ensure that immediately following each surgery, there is an operative report describing techniques and findings that is written or dictated and signed by the surgeon.

(p) The following equipment shall be in each operating room suite:

1. Call-in system;
2. Oxygen, and means of administration;
3. Mechanical ventilatory assistance equipment, including airways, manual breathing bag, and ventilator and respirator;
4. Cardiac defibrillator with synchronization capability;
5. Respiratory and cardiac monitoring equipment;
6. Thoracentesis and closed thoracostomy sets;
7. Tracheostomy set, tourniquets, vascular cutdown sets, infusion pumps, laryngoscopes and endotracheal tubes;
8. Tracheobronchial and gastric suction equipment; and
9. A portable x-ray which shall be available, but need not be physically present in the operating suite.

(2) Anesthesia Department. Each Class I and Class II hospital, and each Class III hospital providing surgical or obstetrical services, shall have an anesthesia department, service or similarly titled unit directed by a physician member of the organized professional staff.

(a) The anesthesia department of each hospital shall have written policies and procedures that are approved by the organized medical staff, are reviewed annually, dated at time of last review, revised, and enforced as necessary. Such written policies and procedures shall include the following requirements:

1. A preanesthesia evaluation of the patient by the physician, or qualified oral surgeon in the case of patients without medical problems admitted for dental procedures, or certified registered nurse anesthetist where authorized by established protocol approved by the medical staff, except in the case of emergencies.
2. A review of the patient's condition immediately prior to induction of anesthesia.
3. A mechanism for release of patients from postanesthesia care.
4. A recording of all pertinent events taking place during the induction of, maintenance of, and emergence from anesthesia.
5. Guidelines for the safe use of all general anesthetic agents used in the hospital.

(b) The responsibilities and qualifications of all anesthesia personnel, including physician, nurse and dentist anesthetists and all trainees, must be defined in a policy statement, job description, or other appropriate document.

(c) Anesthetic safety regulations shall be developed, posted, and enforced. Such regulations shall include the following:

1. A requirement that all operating room electrical and anesthesia equipment be inspected on an annual basis and at intervals not exceeding the manufacturer's recommendations. A written record of the inspection results and corrective action shall be maintained by the hospital.

2. A requirement that flammable anesthetic agents be employed only in areas in which a conductive pathway can be maintained between the patient and a conductive floor.

3. A requirement that each anesthetic gas machine have a pin-index or equivalent safety system.

4. A requirement that all reusable anesthesia equipment coming in direct contact with the patient be cleaned or sterilized in the manner prescribed by current medical standards.

CMS appendix z

<https://www.calhospitalprepare.org/post/cms-issues-interpretive-guidelines-emergency-preparedness-final-rule>

E-0015

(Issued XX-XX-17)

§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)

[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:

- (i) Food, water, medical and pharmaceutical supplies
- (ii) Alternate sources of energy to maintain the following:
 - (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
 - (B) Emergency lighting.
 - (C) Fire detection, extinguishing, and alarm systems.
 - (D) Sewage and waste disposal.

**[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.*

(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:

- (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
 - (A) Food, water, medical, and pharmaceutical supplies.
 - (B) Alternate sources of energy to maintain the following:
 - (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
 - (2) Emergency lighting.
 - (3) Fire detection, extinguishing, and alarm systems.
 - (C) Sewage and waste disposal.

Interpretive Guidelines applies to: §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1).

Note: This does not apply to ASCs, Outpatient Hospice Providers [applies to inpatient hospices], Transplant Centers, HHA, CORFs, CMHCs, RHCs/FQHCs, ESRD facilities.

Facilities must be able to provide for adequate subsistence for all patients and staff for the duration of an emergency or until all its patients have been evacuated and its operations cease. Facilities have flexibility in identifying their individual subsistence needs that would be required during an emergency. There are no set requirements or standards for the amount of provisions to be provided in facilities, Provisions include, but are not limited to, food, pharmaceuticals and medical supplies. Provisions should be stored in an area which is less likely to be affected by disaster, such as storing these resources above ground-level to protect from possible flooding. Additionally, when inpatient facilities determine their supply needs, they are expected to consider the possibility that volunteers, visitors, and individuals from the community may arrive at the facility to offer assistance or seek shelter.

Alternate sources of energy depend on the resources available to a facility, such as battery-operated lights, or heating and cooling, in order to meet the needs of a facility during an emergency. Facilities are not required to upgrade their electrical systems, but after review of their risk assessment, facilities may find it prudent to make any necessary adjustments to ensure that occupants health and safety needs are met, and that facilities maintain safe and sanitary storage areas for provisions.

This specific standard does not require facilities to have or install generators or any other specific type of energy source. (However, for hospitals at §482.15(e), CAHs at §485.625(e) and LTC facilities at §483.73(e) please also refer to Tag E-0041 for Emergency and Stand-by Power Systems.) It is up to each individual facility, based on its risk assessment, to determine the most appropriate alternate energy sources to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, and alarm systems and sewage and waste disposal. Whatever alternate sources of energy a facility chooses to utilize must be in accordance with local and state laws as well as relevant LSC requirements.

Facilities must establish policies and procedures that determine how required heating and cooling of their facility will be maintained during an emergency situation, as necessary, if there were a loss of the primary power source.

If a facility determines the best way to maintain temperatures, emergency lighting, fire detection and extinguishing systems and sewage and waste disposal would be through the use of a portable generator, then the Life Safety Code (LSC) provisions, such as generator testing and fuel storage, etc. outlined under the NFPA guidelines would not be applicable. Portable generators should be operated, tested, and maintained in accordance with manufacturer, local and/or State requirements. If a facility, however, chooses to utilize a permanent generator to maintain emergency power, LSC provisions such as generator testing and maintenance will apply and the facility may be subject to LSC surveys to ensure compliance is met.

As an example, some ESRD facilities have contracted services with companies who maintain portable emergency generators for the facilities off-site. In the event of an emergency where the facility is unable to reschedule patients or evacuate, the generators are brought to the location in advance to assist in the event of loss of power. Facilities who are not specifically required by the

EP Final Rule to have a generator, but are required to meet provision for an alternate sources of energy, may consider this approach for their facility.

Facilities are encouraged to confer with local health department and emergency management officials, as well as and healthcare coalitions, where available, to determine the types and duration of energy sources that could be available to assist them in providing care to their patient population during an emergency. As part of the risk assessment planning, facilities should determine the feasibility of relying on these sources and plan accordingly.

Facilities are not required to provide onsite treatment of sewage but must make provisions for maintaining necessary services. For example, LTC facilities are already required to meet Food Receiving and Storage provisions at §483.35(i) Sanitary Conditions, which contain requirements for keeping food off the floor and clear of ceiling sprinklers, sewer/waste disposal pipes, and vents can also help maintain food quality and prevent contamination. Additionally, ESRD facilities under current CfCs at §494.40(a)(4) are also required to have policies and procedures for handling, storage and disposal of potentially infectious waste. We are not specifying any required provisions regarding treatment of sewage and necessary services under this tag; however, facilities are required to follow their current facility-type requirements (e.g., CoPs/CfCs, Requirements) which may address these areas. Additionally, we would expect facilities under this requirement to ensure current practices are followed, such as those outlined by the Environmental Protection Agency (EPA) and under State-specific laws. Maintaining necessary services may include, but are not limited to, access to medical gases; treatment of soiled linens; disposal of bio-hazard materials for different infectious diseases; and may require additional assistance from transportation companies for safe and appropriate disposal in accordance with nationally accepted industry guidelines for emergency preparedness.

Survey Procedures

- Verify the emergency plan includes policies and procedures for the provision of subsistence needs including, but not limited to, food, water and pharmaceutical supplies for patients and staff by reviewing the plan.
- Verify the emergency plan includes policies and procedures to ensure adequate alternate energy sources necessary to maintain:
 - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;
 - Emergency lighting; and,
 - Fire detection, extinguishing, and alarm systems.
- Verify the emergency plan includes policies and procedures to provide for sewage and waste disposal.

E-0041

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§482.15(e) Condition for Participation:

(e) *Emergency and standby power systems.* The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

§483.73(e), §485.625(e)

(e) *Emergency and standby power systems.* The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

§482.15(e)(1), §483.73(e)(1), §485.625(e)(1)

Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

482.15(e)(2), §483.73(e)(2), §485.625(e)(2)

Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

482.15(e)(3), §483.73(e)(3), §485.625(e)(3)

Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]

The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.

(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.

(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.

(ii) Technical interim amendment (TIA) 12–2 to NFPA 99, issued August 11, 2011.

- (iii) TIA 12–3 to NFPA 99, issued August 9, 2012.
- (iv) TIA 12–4 to NFPA 99, issued March 7, 2013.
- (v) TIA 12–5 to NFPA 99, issued August 1, 2013.
- (vi) TIA 12–6 to NFPA 99, issued March 3, 2014.
- (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.
- (viii) TIA 12–1 to NFPA 101, issued August 11, 2011.
- (ix) TIA 12–2 to NFPA 101, issued October 30, 2012.
- (x) TIA 12–3 to NFPA 101, issued October 22, 2013.
- (xi) TIA 12–4 to NFPA 101, issued October 22, 2013.
- (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.

Interpretive Guidelines applies to: 482.15(e), §485.625(e), §483.73(e).

Note: For CAHs under §485.625(e)(2) “maintenance” is not included in the regulatory language.

Note: This provision for hospitals, CAHs and LTC facilities requires these facility types to base their emergency power and stand-by systems on their emergency plan, risk assessment and policies and procedures. The determination for a generator should be made through the development of the facility’s risk assessment and policies and procedures. If these facilities determine that no generator is required to meet the emergency power and stand-by systems requirements, then §§482.15(e)(1) and (2), §483.73(e)(1) and (2), §485.625(e)(1) and (2), would not apply.

However, these facility types are must continue to meet the existing provisions and requirements for their provider/supplier types under physical environment CoPs or any existing LSC guidance.

Emergency and standby power systems

CMS requires Hospitals, CAHs and LTC facilities to comply with the 2012 edition of the National Fire Protection Association (NFPA) 101 – *Life Safety Code* (LSC) and the 2012 edition of the NFPA 99 – *Health Care Facilities Code* in accordance with the Final Rule (CMS–3277–F). NFPA 99 requires Hospitals, CAHs and certain LTC facilities to install, maintain, inspect and test an Essential Electric System (EES) in areas of a building where the failure of equipment or systems is likely to cause the injury or death of patients or caregivers. An EES is a system which includes an alternate source of power, distribution system, and associated equipment that is designed to ensure continuity of electricity to elected areas and functions during the interruption of normal electrical service. The EES alternate source of power for these facility types is typically a generator. (Note: LTC facilities are also expected to meet the requirements under Life Safety Code and NFPA 99 as outlined within the LTC Appendix of the SOM). In addition, NFPA 99 identifies the 2010 edition of NFPA 110 – *Standard for Emergency and Standby Power Systems* as a mandatory reference, which addresses the performance requirements for emergency and standby power systems and includes installation, maintenance, operation, and testing requirements.

In addition to the LSC, NFPA 99 and NFPA 110 requirements, the Emergency Preparedness regulation requires all Hospitals, CAHs, and LTC facilities to implement emergency and standby power systems based upon a facility's established emergency plan, policies, and procedures. Emergency preparedness policies and procedures (substandard (b) of the emergency preparedness requirements) are required to address the subsistence needs of staff and residents, whether the facility decides to evacuate or shelter in place. Subsistence needs include, but are not limited to, food, water, medical, and pharmaceutical supplies, and alternate sources of energy to maintain: temperatures to protect patient/resident health and safety and sanitary storage of provisions; emergency lighting; fire detection, extinguishing, and alarm systems; and sewage and waste disposal.

NFPA 99 contains emergency power requirements for emergency lighting, fire detection systems, extinguishing systems, and alarm systems. But, NFPA 99 does not specify emergency power requirements for maintaining supplies, and facility temperature requirements are limited to heating equipment for operating, delivery, labor, recovery, intensive care, coronary care, nurseries, infection/isolation rooms, emergency treatment spaces, and general patient/resident rooms. In addition, NFPA 99 does not require heating in general patient rooms during the disruption of normal power where the outside design temperature is higher than 20 degrees Fahrenheit or where a selected room(s) is provided for the needs of all patients (where patients would be internally relocated), then only that room(s) needs to be heated. Therefore, EES in Hospitals, CAHs and LTC facilities should include consideration for design to accommodate any additional electrical loads the facility determines to be necessary to meet all subsistence needs required by emergency preparedness plans, policies and procedures, unless the facility's emergency plans, policies and procedures required under paragraph (a) and paragraph (b)(1)(i) and (ii) of this section determine that the hospital, CAH or LTC facility will relocate patients internally or evacuate in the event of an emergency. Facilities may plan to evacuate all patients, or choose to relocate internally only patients located in certain locations of the facility based on the ability to meet emergency power requirements in certain locations. For example, a hospital that has the ability to maintain temperature requirements in 50 percent of the inpatient locations during a power outage, may develop an emergency plan that includes bringing in alternate power, heating and/or cooling capabilities, and the partial relocation or evacuation of patients during a power outage instead of installing additional power sources to maintain temperatures in all inpatient locations. Or a LTC facility may decide to relocate residents to a part of the facility, such as a dining or activities room, where the facility can maintain the proper temperature requirements rather than the maintaining temperature within the entire facility. It is up to each facility to make emergency power system decisions based on its risk assessment and emergency plan.

Emergency generator location

NFPA 110 contains minimum requirements and considerations for the installation and environmental conditions that may have an effect on Emergency Power Supply System (EPSS) equipment, including, building type, classification of occupancy, hazard of contents, and geographic location. NFPA 110 requires that EPSS equipment, including generators, to be designed and located to minimize damage (e.g., flooding). NFPA 110 requires emergency power supply systems to be permanently attached, therefore portable and mobile generators would not

be permitted as an option to provide or supplement emergency power to Hospitals, CAHs or LTC facilities.

Under emergency preparedness, the regulations require that the generator and its associated equipment be located in accordance with the LSC, NFPA 99, and NFPA 110 when a new structure is built or an existing structure or building is renovated. Therefore, new structures or building renovations that occur after November 15, 2016, the effective date of the Emergency Preparedness Final Rule must consider NFPA requirements to ensure that the EPSS equipment is in a location to minimize damage.

Emergency generator inspection and testing

NFPA 110 contains routine maintenance and operational testing requirements for emergency and standby power systems, including generators. Emergency generators required by NFPA 99 and the Emergency Preparedness Final Rule must be maintained and tested in accordance with NFPA 110 requirements, which are based on manufacture recommendations, instruction manuals, and the minimum requirements of NFPA 110, Chapter 8.

Emergency generator fuel

NFPA 110 permits fuel sources for generators to be liquid petroleum products (e.g., gas, diesel), liquefied petroleum gas (e.g., propane) and natural or synthetic gas (e.g., natural gas). Generators required by NFPA 99 are designated by Class, which defines the minimum time, in hours, that an EES is designed to operate at its rated load without having to be refueled. Generators required by NFPA 99 for Hospitals, CAHs and LTC facilities are designated Class X, which defines the minimum run time as being “other time, in hours, as required by application, code or user.” However, NFPA 110 does require facilities considering seismic events to maintain a minimum 96 hour fuel supply. NFPA 110 also requires that generator installations in locations where the probability of interruption of off-site (e.g., natural gas) fuel supplies is high to maintain onsite storage of an alternate fuel source sufficient to allow full output of the ESS for the specified class.

The Emergency Preparedness Final Rule requires Hospitals, CAHs and LTC facilities that maintain onsite fuel sources (e.g., gas, diesel, propane) to have a plan to keep the EES operational for the duration of emergencies as defined by the facilities emergency plan, policy and procedures, unless it evacuates. This would include maintaining fuel onsite to maintain generator operation or it could include making arrangements for fuel delivery for an emergency event. If fuel is to be delivered during an emergency event, planning should consider limitations and delays that may impact fuel delivery during an event. In addition, planning should ensure that arranged fuel supply sources will not be limited by other community demands during the same emergency event. In instances when a facility maintains onsite fuel sources and plans to evacuate during an emergency, a sufficient amount of onsite fuel should be maintained to keep the EES operational until such time the building is evacuated.

Survey Procedures

- Verify that the hospital, CAH and LTC facility has the required emergency and standby power systems to meet the requirements of the facility's emergency plan and corresponding policies and procedures
- Review the emergency plan for "shelter in place" and evacuation plans. Based on those plans, does the facility have emergency power systems or plans in place to maintain safe operations while sheltering in place?
- For hospitals, CAHs and LTC facilities which are under construction or have existing buildings being renovated, verify the facility has a written plan to relocate the EPSS by the time construction is completed

For hospitals, CAHs and LTC facilities with generators:

- For new construction that takes place between November 15, 2016 and is completed by November 15, 2017, verify the generator is located and installed in accordance with NFPA 110 and NFPA 99 when a new structure is built or when an existing structure or building is renovated. The applicability of both NFPA 110 and NFPA 99 addresses only new, altered, renovated or modified generator locations.
- Verify that the hospitals, CAHs and LTC facilities with an onsite fuel source maintains it in accordance with NFPA 110 for their generator, and have a plan for how to keep the generator operational during an emergency, unless they plan to evacuate.