Dated: January 20, 2012.

Waverly W. Gregory, Jr.,

Bridge Program Manager, Fifth Coast Guard District.

[FR Doc. 2012–2282 Filed 2–1–12; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2011–1171]

Drawbridge Operation Regulation; Northeast Cape Fear River, Wilmington, NC

AGENCY: Coast Guard, DHS.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, Fifth Coast Guard District, has issued a temporary deviation from the regulations governing the operation of the Isabel S. Holmes Bridge across the Northeast Cape Fear River, mile 1.0, at Wilmington, NC. The deviation restricts the operation of the draw span to accommodate the 100 year Anniversary of the Girl Scout Program Ceremonial walk. The deviation allows the bridge to remain in the closed position to vessels.

DATES: This deviation is effective from 10 a.m. until noon on March 10, 2012.

ADDRESSES: Documents mentioned in this preamble as being available in the docket USCG–2011–1171 and are available online by going to *http://www.regulations.gov,* inserting USCG–2011–1171 in the ''Keywords'' box, and then clicking ''Search''. This material is also available for inspection or copying the Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal Holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Mr. Jim Rousseau, Bridge Management Specialist, Fifth Coast Guard District, telephone (757) 398–6557. Email *James.L.Rousseau2@uscg.mil.* If you have questions on reviewing the docket, call Renee V. Wright, Program Manager, Docket Operations, (202) 366–9826.

SUPPLEMENTARY INFORMATION: The Event Director for the New Hanover County Girl Scouts, with approval from the North Carolina Department of Transportation, owner of the drawbridge, has requested a temporary deviation from the current operating schedule to accommodate the 100 year Anniversary of the Girl Scout Program Ceremonial walk.

The Isabel S. Holmes Bridge operating regulations are set out in 33 CFR 117.829(a). However on January 10, 2012 (77 FR 1406) the Coast Guard granted a deviation from 33 CFR 117.829(a) to facilitate structural repair on the bridge. Under the current operating deviation schedule, the drawbridge will be closed to navigation from 7 a.m. on January 16, 2012 until and including 11 p.m. on April 30, 2012; except that vessel openings will be provided if at least three hours advance notice is given to the bridge tender at (910) 251–5774 or via marine radio on channel 13 VHF. The Isabel S. Holmes Bridge across the Northeast Cape Fear River, mile 1.0,a bascule lift Bridge, in Wilmington, NC, has a vertical clearance in the closed position of 40 feet, above mean high water.

Under this temporary deviation, the drawbridge will be allowed to remain in the closed-to-navigation position from 10 a.m. to noon on Saturday, March 10, 2012 to accommodate the 100 year Anniversary of the Girl Scout Program Ceremonial walk.

Vessels able to pass under the closed span may transit under the drawbridge while it is in the closed position. Mariners are advised to proceed with caution. The Coast Guard will inform users of the waterway through our local and broadcast Notices to Mariners of the limited operating schedule for the drawbridge so that vessels can arrange their transits to minimize any impacts caused by the temporary deviation. There are no alternate routes for vessels and the bridge will be able to open in the event of an emergency.

In accordance with 33 CFR 117.35(e), when applicable the draw must return to its regular operating schedule immediately at the end of the designated time period. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: January 13, 2012.

Waverly W. Gregory, Jr.,

Bridge Program Manager, Fifth Coast Guard District.

[FR Doc. 2012–2284 Filed 2–1–12; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AN80

Medical Foster Homes

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the Department of Veterans Affairs (VA) ''Medical'' regulations to add rules relating to medical foster homes. Prior to this final rule, VA's medical foster home program had, whenever possible and appropriate, relied upon regulations governing community residential care facilities; however, those regulations did not cover all aspects of medical foster homes, which provide community based care in a smaller, residential facility and to a more medically complex and disabled population. This final rule reflects current VA policy and practice, and generally conforms to industry standards and expectations.

DATES: *Effective date:* March 5, 2012.

The Director of the Federal Register approved the incorporation by reference of certain publications listed in this rule as of March 5, 2012.

FOR FURTHER INFORMATION CONTACT: Rick Greene, Office of Patient Care Services (114), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, (202) 461–6786. (This is not a toll free number.)

SUPPLEMENTARY INFORMATION: Many veterans who are disabled due to complex chronic disease or traumatic injury may be unable to live safely and independently, or may have health care needs that exceed the capabilities of their families. Many of these veterans are placed in nursing homes. Others, with the proper support, can continue to live in a residential setting and delay, or totally avoid, the need for nursing home care. VA's community residential care program, specifically authorized by 38 U.S.C. 1730 and implemented at 38 CFR 17.61 through 17.72, has provided health care supervision to these veterans.

A medical foster home is a specific type of community residential care facility that provides home-based care to a small number of residents with serious chronic disease and disability. A medical foster home provides a greater level of care than a community residential care facility (and in this respect a medical foster home is more analogous to a nursing home), while allowing veterans to live in a home-like

setting and maintain a greater degree of independence. VA interprets 38 U.S.C. 1730 as authorizing a medical foster home program, as a subset of the community residential care program. In particular, we believe medical foster homes fit within the type of facility authorized by section 1730(f), since they provide ''room and board and * * * limited personal care.''

In a document published in the **Federal Register** on May 19, 2011 (76 FR 28917), VA proposed regulations to govern medical foster homes. We provided a 60 day comment period, which ended on July 18, 2011. We received one comment.

The commenter sought clarification regarding whether a veteran would ''have the option of receiving approved care in their own home rather than being forced into a local nursing home'' if there were no approved medical foster home in their area. The proposed rule stated in § 17.73(a) that the purpose of the medical foster home program is to ''approve[] certain medical foster homes for the placement of veterans'' and that placement in a medical foster home is voluntary on the part of the veteran. If the veteran is interested in this care option, VA will try to refer the veteran to a medical foster home as close to his or her residence as possible.

However, VA is aware that a medical foster home may not be located in the immediate vicinity of the veteran's residence. If a veteran is unable or unwilling to accept placement in a medical foster home that is located outside the immediate vicinity of the veteran's residence, VA offers several alternate health care programs that may better suit the veteran's needs. These alternate programs include home based primary care, where the veteran receives primary care in his home; community residential care, which provides care similar to that of the medical foster home; and nursing home care. Home Based Primary Care provides long-term primary care to chronically ill veterans in their own homes. Home Based Primary Care is appropriate for veterans with complex, chronic, and long-term conditions that would make it difficult to come to a VA facility for treatment. A VA treatment team coordinates the plan of care for each veteran and comes to the veteran's home to provide services. Home Based Primary Care provides primary care, palliative care, therapy, disease management, and coordination of care services.

The commenter noted that § 17.74(d)(3) requires the veteran to be placed in a single-occupancy bedroom, unless the veteran agrees to a multi-occupant bedroom. The commenter asked whether the spouse of a married veteran ''[c]an * * * move into the home with the veteran[,] or will the couple be forced to live apart?'' Nothing in the regulation would preclude the spouse of a veteran from living in the same medical foster home as the veteran. Such an arrangement would be a matter of agreement between the spouse of the veteran and the medical foster home caregiver. If the spouse of the veteran also requires medical care in addition to lodging, then the spouse of the veteran must be included in the total number of residents receiving care in the medical foster home, which § 17.73(b) limits to no more than three. The medical foster home would not be able to provide adequate care to all of its residents if the total number of residents receiving care exceeds three. If VA recommends a medical foster home that was unable to accommodate the veteran and his or her spouse, VA could provide the veteran an alternate location that would accommodate the veteran and the spouse's needs. However, any agreement between the medical foster home caregiver for the lodging and/or care of veteran's spouse in such home is beyond the scope of this rulemaking. Also, as noted above, if the option of a medical foster home does not adequately address the veteran's and the veteran's family's needs, the veteran may consider an alternate health care option. Therefore, no veteran will be ''forced to live apart'' from his or her spouse. Because the agreement for lodging and/or medical care for the spouse of the veteran is outside the scope of this rulemaking, except where it may impact compliance with § 17.73(b), we are not making any changes based on this comment.

The commenter also stated that, in the commenter's view, the proposed rule contained language that seemed to indicate that only elderly veterans were eligible to be placed in a medical foster home. The commenter further stated that ''there are a growing number of young military veterans who are severely injured and in need of daily medical assistance'' and questioned whether placement in a medical foster home would be an option for these veterans. We agree with the commenter that placement in a medical foster home should not be restricted based on the age of the veteran, and this final rulemaking does not place any such restriction. Age is referenced only in the proposed rulemaking in the supplementary information discussing § 17.73(c)(2), where we discussed the eligibility criteria for referral to a medical foster home. We had stated that one criterion is the veteran's enrollment in either the VA Home Based Primary Care or VA Spinal Cord Injury Homecare program. The proposed rule notice explained that ''VA Home Based Primary Care (HBPC) is a home care program designed to meet the longitudinal, primary care needs of an aging veteran population with complex, chronic, disabling disease.'' However, the HBPC program is not limited to elderly veterans. The program is designed to serve the chronically ill through the months and years before death, providing primary care, palliative care, rehabilitation, disease management and coordination of care services. The proposed rulemaking did not place any age restrictions on eligibility for placement in a medical foster home within the regulation text. We are, therefore, not making any changes based on this comment.

The proposed rule cited 38 U.S.C. 501, 1721, and as noted in specific sections as the authority for 38 CFR part 17. However, the correct authority for part 17 is 38 U.S.C. 501, and as noted in specific sections. We are amending the final rule to reflect the correct authority for part 17.

Based on the rationale set forth in the proposed rule and in this document, VA adopts the proposed rule as a final rule, with the above noted change.

Effect of Rulemaking

Title 38 of the Code of Federal Regulations, as revised by this final rule, represents VA's implementation of its legal authority on this subject. Other than future amendments to this regulation or governing statutes, no contrary rules or procedures are authorized. All existing or subsequent VA guidance must be read to conform with this final rule if possible or, if not possible, such guidance is superseded by this rulemaking.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a ''significant

regulatory action,'' which requires review by the Office of Management and Budget (OMB), as ''any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order.

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined and it has been determined not to be a significant regulatory action under Executive Order 12866.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any given year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

OMB assigns a control number for each collection of information it approves. Except for emergency approvals under 44 U.S.C. 3507(j), VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

In the proposed rule, we stated that proposed § 17.74(q) contains collection of information provisions under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521), and that we had requested public comment on those provisions in the notice published in the **Federal Register** on May 19, 2011 (76 FR 28917). We did not receive any comments on the proposed collection of information, which OMB has approved without an expiration date, under control number 2900–0777. Following § 17.74(q) in this final rule, we set out an information collection approval parenthetical displaying OMB control number 2900–0777.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. In addition to having an effect on individuals (veterans), the final rule will have an insignificant economic impact on a few small entities. Most of the minimum standards that will be established by this rulemaking are already required by state and local regulations, and medical foster homes should already be in compliance with those regulations or with the current NFPA codes. Any additional costs for compliance with this final rule would constitute an inconsequential amount of the operational cost for most facilities. Accordingly, pursuant to 5 U.S.C. 605(b), this final rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.005, Grants to States for Construction of State Home Facilities; 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.016, Veterans State Hospital Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; 64.022, Veterans Home Based Primary Care.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. John R. Gingrich, Chief of Staff, Department of Veterans Affairs, approved this document on January 9, 2012, for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs—health, Grant programs—veterans, Health care, Health facilities, Health professions, Health records, Homeless, Incorporation by reference, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Dated: January 26, 2012.

Robert C. McFetridge,

Director of Regulation Policy and Management, Office of the General Counsel, Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs amends 38 CFR part 17 as follows:

PART 17—MEDICAL

■ 1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, and as noted in specific sections.

■ 2. Revise § 17.1(b) to read as follows:

§ 17.1 Incorporation by reference.

* * * * *

(b) The following materials are incorporated by reference into this part.

(1) NFPA 10, Standard for Portable Fire Extinguishers (2010 edition), Incorporation by Reference (IBR) approved for §§ 17.63, 17.74, and 17.81.

(2) NFPA 101, Life Safety Code (2009 edition), IBR approved for §§ 17.63, 17.74 (chapters 1 through 11, 24, and section 33.7), 17.81, and 17.82.

(3) NFPA 101A, Guide on Alternative Approaches to Life Safety (2010 edition), IBR approved for § 17.63.

(4) NFPA 13, Standard for the Installation of Sprinkler Systems (2010 edition), IBR approved for § 17.74.

(5) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (2010 edition), IBR approved for § 17.74.

(6) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height (2010 edition), IBR approved for § 17.74.

(7) NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2008 edition), IBR approved for § 17.74.

(8) NFPA 30, Flammable and Combustible Liquids Code (2008 edition), IBR approved for § 17.74.

(9) NFPA 72, National Fire Alarm and Signaling Code (2010 edition), IBR approved for § 17.74.

(10) NFPA 720, Standard for the Installation of Carbon Monoxide (CO)

Detection and Warning Equipment (2009 edition), IBR approved for § 17.74.

* * * * *

■ 3. Sections 17.73 and 17.74 are added to read as follows:

§ 17.73 Medical foster homes—general.

(a) *Purpose.* Through the medical foster home program, VA recognizes and approves certain medical foster homes for the placement of veterans. The choice to become a resident of a medical foster home is a voluntary one on the part of each veteran. VA's role is limited to referring veterans to approved medical foster homes. When a veteran is placed in an approved home, VA will provide inspections to ensure that the home continues to meet the requirements of this part, as well as oversight and medical foster home caregiver training. If a medical foster home does not meet VA's criteria for approval, VA will not refer any veteran to the home or provide any of these services. VA may also provide certain medical benefits to veterans placed in medical foster homes, consistent with the VA program in which the veteran is enrolled.

(b) *Definitions.* For the purposes of this section and § 17.74:

Labeled means that the equipment or materials have attached to them a label, symbol, or other identifying mark of an organization recognized as having jurisdiction over the evaluation and periodic inspection of such equipment or materials, and by whose labeling the manufacturer indicates compliance with appropriate standards or performance.

Medical foster home means a private home in which a medical foster home caregiver provides care to a veteran resident and:

(i) The medical foster home caregiver lives in the medical foster home;

(ii) The medical foster home caregiver owns or rents the medical foster home; and

(iii) There are not more than three residents receiving care (including veteran and non-veteran residents).

Medical foster home caregiver means the primary person who provides care to a veteran resident in a medical foster home.

Placement refers to the voluntary decision by a veteran to become a resident in an approved medical foster home.

Veteran resident means a veteran residing in an approved medical foster home who meets the eligibility criteria in paragraph (c) of this section.

(c) *Eligibility.* VA health care personnel may assist a veteran by referring such veteran for placement in a medical foster home if:

(1) The veteran is unable to live independently safely or is in need of nursing home level care;

(2) The veteran must be enrolled in, or agree to be enrolled in, either a VA Home Based Primary Care or VA Spinal Cord Injury Homecare program, or a similar VA interdisciplinary program designed to assist medically complex veterans living in the home; and

(3) The medical foster home has been approved in accordance with paragraph (d) of this section.

(d) *Approval of medical foster homes.* Medical foster homes will be approved by a VA Medical Foster Homes Coordinator based on the report of a VA inspection and on any findings of necessary interim monitoring of the medical foster home, if that home meets the standards established in § 17.74. The approval process is governed by the process for approving community residential care facilities under §§ 17.65 through 17.72 except as follows:

(1) Where §§ 17.65 through 17.72 reference § 17.63.

(2) Because VA does not physically place veterans in medical foster homes, VA also does not assist veterans in moving out of medical foster homes as we do for veterans in other community residential care facilities under § 17.72(d)(2); however, VA will assist such veterans in locating an approved medical foster home when relocation is necessary.

(e) *Duties of Medical foster home caregivers.* The medical foster home caregiver, with assistance from relief caregivers, provides a safe environment, room and board, supervision, and personal assistance, as appropriate for each veteran.

(Authority: 38 U.S.C. 501, 1730)

§ 17.74 Standards applicable to medical foster homes.

(a) *General.* A medical foster home must:

(1) Meet all applicable state and local regulations, including construction, maintenance, and sanitation regulations.

(2) Have safe and functioning systems for heating, hot and cold water, electricity, plumbing, sewage, cooking, laundry, artificial and natural light, and ventilation. Ventilation for cook stoves is not required.

(3) Except as otherwise provided in this section, meet the applicable provisions of chapters 1 through 11 and 24, and section 33.7 of NFPA 101 (incorporated by reference, see § 17.1), and the other codes and chapters identified in this section, as applicable.

(b) *Community residential care facility standards applicable to medical foster homes.* Medical foster homes must comply with § 17.63(c), (d), (f), (h), (j) and (k).

(c) *Activities.* The facility must plan and facilitate appropriate recreational and leisure activities.

(d) *Residents' bedrooms.* Each veteran resident must have a bedroom:

(1) With a door that closes and latches;

(2) That contains a suitable bed and appropriate furniture; and

(3) That is single occupancy, unless the veteran agrees to a multi-occupant bedroom.

(e) *Windows.* VA may grant provisional approval for windows used as a secondary means of escape that do not meet the minimum size and dimensions required by chapter 24 of NFPA 101 (incorporated by reference, see § 17.1) if the windows are a minimum of 5.0 square feet (and at least 20 inches wide and at least 22 inches high). The secondary means of escape must be brought into compliance with chapter 24 no later than 60 days after a veteran resident is placed in the home.

(f) *Special locking devices.* Special locking devices that do not comply with section 7.2.1.5 of NFPA 101 (incorporated by reference, see § 17.1) are permitted where the clinical needs of the veteran resident require specialized security measures and with the written approval of:

(1) The responsible VA clinician; and

(2) The VA fire/safety specialist or the Director of the VA Medical Center of jurisdiction.

(g) *Smoke and carbon monoxide (CO) detectors and smoke and CO alarms.* Medical foster homes must comply with this paragraph (g) no later than 60 days after the first veteran is placed in the home. Prior to compliance, VA inspectors will provisionally approve a medical foster home for the duration of this 60-day period if the medical foster home mitigates risk through the use of battery-operated single station alarms, provided that the alarms are installed before any veteran is placed in the home.

(1) Smoke detectors or smoke alarms must be provided in accordance with sections 24.3.4.1 or 24.3.4.2 of NFPA 101 (incorporated by reference, see § 17.1); section 24.3.4.3 of NFPA 101 will not be used. In addition, smoke alarms must be interconnected so that the operation of any smoke alarm causes an alarm in all smoke alarms within the medical foster home. Smoke detectors or smoke alarms must not be installed in the kitchen or any other location subject to causing false alarms.

(2) CO detectors or CO alarms must be installed in any medical foster home with a fuel-burning appliance, fireplace,

or an attached garage, in accordance with NFPA 720 (incorporated by reference, see § 17.1).

(3) Combination CO/smoke detectors and combination CO/smoke alarms are permitted.

(4) Smoke detectors and smoke alarms must initiate a signal to a remote supervising station to notify emergency forces in the event of an alarm.

(5) Smoke and/or CO alarms and smoke and/or CO detectors, and all other elements of a fire alarm system, must be inspected, tested, and maintained in accordance with NFPA 72 (incorporated by reference, see § 17.1) and NFPA 720 (incorporated by reference, see § 17.1).

(h) *Sprinkler systems.* (1) If a sprinkler system is installed, it must be inspected, tested, and maintained in accordance with NFPA 25 (incorporated by reference, see § 17.1), unless the sprinkler system is installed in accordance with NFPA 13D (incorporated by reference, see § 17.1). If a sprinkler system is installed in accordance with NFPA 13D, it must be inspected annually by a competent person.

(2) If sprinkler flow or pressure switches are installed, they must activate notification appliances in the medical foster home, and must initiate a signal to the remote supervising station.

(i) *Fire extinguishers.* At least one 2–A:10–B:C rated fire extinguisher must be visible and readily accessible on each floor, including basements, and must be maintained in accordance with the manufacturer's instructions. Portable fire extinguishers must be inspected, tested, and maintained in accordance with NFPA 10 (incorporated by reference, see § 17.1).

(j) *Emergency lighting.* Each occupied floor must have at least one plug-in rechargeable flashlight, operable and readily accessible, or other approved emergency lighting. Such emergency lighting must be tested monthly and replaced if not functioning.

(k) *Fireplaces.* A non-combustible hearth, in addition to protective glass doors or metal mesh screens, is required for fireplaces. Hearths and protective devices must meet all applicable state and local fire codes.

(l) *Portable heaters.* Portable heaters may be used if they are maintained in good working condition and:

(1) The heating elements of such heaters do not exceed 212 degrees Fahrenheit (100 degrees Celsius);

(2) The heaters are labeled; and

(3) The heaters have tip-over protection.

(m) *Oxygen safety.* Any area where oxygen is used or stored must not be near an open flame and must have a posted ''No Smoking'' sign. Oxygen cylinders must be adequately secured or protected to prevent damage to cylinders. Whenever possible, transfilling of liquid oxygen must take place outside of the living areas of the home.

(n) *Smoking.* Smoking must be prohibited in all sleeping rooms, including sleeping rooms of non-veteran residents. Ashtrays must be made of noncombustible materials.

(o) *Special/other hazards.* (1) Extension cords must be three-pronged, grounded, sized properly, and not present a hazard due to inappropriate routing, pinching, damage to the cord, or risk of overloading an electrical panel circuit.

(2) Flammable or combustible liquids and other hazardous material must be safely and properly stored in either the original, labeled container or a safety can as defined by section 3.3.44 of NFPA 30 (incorporated by reference, see § 17.1).

(p) *Emergency egress and relocation drills.* Operating features of the medical foster home must comply with section 33.7 of NFPA 101 (incorporated by reference, see § 17.1), except that section 33.7.3.6 of NFPA 101 does not apply. Instead, VA will enforce the following requirements:

(1) Before placement in a medical foster home, the veteran will be clinically evaluated by VA to determine whether the veteran is able to participate in emergency egress and relocation drills. Within 24 hours after arrival, each veteran resident must be shown how to respond to a fire alarm and evacuate the medical foster home, unless the veteran resident is unable to participate.

(2) The medical foster home caregiver must demonstrate the ability to evacuate all occupants within three minutes to a point of safety outside of the medical foster home that has access to a public way, as defined in NFPA 101 (incorporated by reference, see § 17.1).

(3) If all occupants are not evacuated within three minutes or if a veteran resident is either permanently or temporarily unable to participate in drills, then the medical foster home will be given a 60-day provisional approval, after which time the home must have established one of the following remedial options or VA will terminate the approval in accordance with § 17.65.

(i) The home is protected throughout with an automatic sprinkler system in accordance with section 9.7 of NFPA 101 (incorporated by reference, see § 17.1) and whichever of the following apply: NFPA 13 (incorporated by reference, see § 17.1); NFPA 13R (incorporated by reference, see § 17.1); or NFPA 13D (incorporated by reference, see § 17.1).

(ii) Each veteran resident who is permanently or temporarily unable to participate in a drill or who fails to evacuate within three minutes must have a bedroom located at the ground level with direct access to the exterior of the home that does not require travel through any other portion of the residence, and access to the ground level must meet the requirements of the Americans with Disabilities Act. The medical foster home caregiver's bedroom must also be on ground level.

(4) The 60-day provisional approval under paragraph (p)(3) of this section may be contingent upon increased fire prevention measures, including but not limited to prohibiting smoking or use of a fireplace. However, each veteran resident who is temporarily unable to participate in a drill will be permitted to be excused from up to two drills within one 12-month period, provided that the two excused drills are not consecutive, and this will not be a cause for VA to not approve the home.

(5) For purposes of paragraph (p), the term *all occupants* means every person in the home at the time of the emergency egress and relocation drill, including non-residents.

(q) *Records of compliance with this section.* The medical foster home must comply with § 17.63(i) regarding facility records, and must document all inspection, testing, drills and maintenance activities required by this section. Such documentation must be maintained for 3 years or for the period specified by the applicable NFPA standard, whichever is longer. Documentation of emergency egress and relocation drills must include the date, time of day, length of time to evacuate the home, the name of each medical foster home caregiver who participated, the name of each resident, whether the resident participated, and whether the resident required assistance.

(r) *Local permits and emergency response.* Where applicable, a permit or license must be obtained for occupancy or business by the medical foster home caregiver from the local building or business authority. When there is a home occupant who is incapable of self-preservation, the local fire department or response agency must be notified by the medical foster home within 7 days of the beginning of the occupant's residency.

(s) *Equivalencies.* Any equivalencies to VA requirements must be in

accordance with section 1.4.3 of NFPA 101 (incorporated by reference, see § 17.1), and must be approved in writing by the appropriate Veterans Health Administration, Veterans Integrated Service Network (VISN) Director. A veteran living in a medical foster home when the equivalency is granted or who is placed there after it is granted must be notified in writing of the equivalencies and that he or she must be willing to accept such equivalencies. The notice must describe the exact nature of the equivalency, the requirements of this section with which the medical foster home is unable to comply, and explain why the VISN Director deemed the equivalency necessary. Only equivalencies that the VISN Director determines do not pose a risk to the health or safety of the veteran may be granted. Also, equivalencies may only be granted when technical requirements of this section cannot be complied with absent undue expense, there is no other nearby home which can serve as an adequate alternative, and the equivalency is in the best interest of the veteran.

(t) *Cost of medical foster homes.* (1) Payment for the charges to veterans for the cost of medical foster home care is not the responsibility of the United States Government.

(2) The resident or an authorized personal representative and a representative of the medical foster home facility must agree upon the charge and payment procedures for medical foster home care.

(3) The charges for medical foster home care must be comparable to prices charged by other assisted living and nursing home facilities in the area based on the veteran's changing care needs and local availability of medical foster homes. (The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0777.)

(Authority: 38 U.S.C. 501, 1730)

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R03–OAR–2011–0913; FRL–9625–5]

Approval and Promulgation of Air Quality Implementation Plans; District of Columbia; Regional Haze State Implementation Plan

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is approving the District of Columbia Regional Haze Plan, a revision to the District of Columbia State Implementation Plan (SIP) addressing Clean Air Act (CAA) requirements and EPA's rules for states to prevent and remedy future and existing anthropogenic impairment of visibility in mandatory Class I areas through a regional haze program. EPA is also approving this revision since it meets the infrastructure requirements relating to visibility protection for the 1997 8-hour ozone National Ambient Air Quality Standard (NAAQS) and the 1997 and 2006 fine particulate matter ($PM_{2.5}$) NAAQS.

DATES: *Effective Date:* This final rule is effective on March 5, 2012.

ADDRESSES: EPA has established a docket for this action under Docket ID Number EPA–R03–OAR–2011–0913. All documents in the docket are listed in the *www.regulations.gov* Web site. Although listed in the electronic docket, some information is not publicly available, *i.e.,* confidential business information (CBI) or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through *www.regulations.gov* or in hard copy for public inspection during normal business hours at the Air Protection Division, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103. Copies of the State submittal are available at the District Department of the Environment, 1200 First Street NE., Washington, DC 20002.

FOR FURTHER INFORMATION CONTACT: Jacqueline Lewis, (215) 814–2037, or by email at *lewis.jacqueline@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

Throughout this document, whenever ''we,'' ''us,'' or ''our'' is used, we mean EPA. On November 16, 2011 (76 FR 70929), EPA published a notice of proposed rulemaking (NPR) for the District of Columbia. The NPR proposed approval of the District of Columbia's regional haze plan for the first implementation period, through 2018. EPA proposed to approve this revision since it assures reasonable progress toward the national goal of achieving natural visibility conditions in Class I areas for the first implementation period. This revision also meets the infrastructure requirements of 110(a)(2)(D)(i)(II) and 110 (a)(2)(J), relating to visibility protection for the 1997 8-hour ozone NAAQS and the 1997 and 2006 $PM_{2.5}$ NAAQS.

II. Summary of SIP Revision

The revision includes a long term strategy with enforceable measures ensuring reasonable progress towards meeting the reasonable progress goals for the first planning period, through 2018. The District of Columbia's Regional Haze Plan contains the emission reductions needed to achieve the District of Columbia's share of emission reductions agreed upon through the regional planning process. Other specific requirements of the CAA and EPA's Regional Haze Rule and the rationale for EPA's proposed action are explained in the NPR and will not be restated here. No public comments were received on the NPR.

III. Final Action

EPA is approving a revision to the District of Columbia State Implementation Plan submitted by the District of Columbia, through the District Department of the Environment (DDOE), on October 27, 2011, that addresses regional haze for the first implementation period. EPA is making a determination that the District of Columbia Regional Haze SIP contains the emission reductions needed to achieve the District of Columbia's share of emission reductions agreed upon through the regional planning process. Furthermore, the District of Columbia's Regional Haze Plan ensures that emissions from the District will not interfere with the reasonable progress goals for neighboring states' Class I areas. In addition, EPA is approving this revision because it meets the applicable visibility related requirements of the CAA section 110(a)(2) including, but not limited to 110(a)(2)(D)(i)(II) and 110(a)(2)(J), relating to visibility protection for the 1997 8-hour ozone NAAQS and the 1997 and 2006 $PM_{2.5}$ NAAQS.

IV. Statutory and Executive Order Reviews

A. General Requirements

Under the CAA, the Administrator is required to approve a SIP submission that complies with the provisions of the CAA and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the CAA. Accordingly, this action merely approves state law as meeting