Introduction to Chapter 13: Life Safety

The standards in this chapter are based on Conditions of Participation (CoP) requirements from the Centers for Medicare & Medicaid Services (CMS) and the 2012 edition of the NFPA 101 *Life Safety Code*. Compliance with the Life Safety Code is based on the different occupancy chapters within the code. All hospitals must include healthcare occupancy designations; however hospitals may choose to include other occupancy designations if they comply with the respective occupancy chapter provisions.

The different occupancies may include, but are not limited to:
1. Healthcare Occupancy
2. Ambulatory Health Care Occupancy
3. Business Occupancy

Definition of Healthcare Occupancy:

An occupancy used to provide medical or other treatment or care simultaneously to four (4) or more patients on an inpatient basis, where such patients are mostly incapable of self-preservation due to age, physical or mental disability, or because of security measures not under the occupants’ control.

The health care facilities regulated by this occupancy chapter are those that provide sleeping accommodations for their occupants and are occupied by persons who are mostly incapable of self-preservation because of age, because of physical or mental disability, or because of security measures not under the occupants’ control.

The requirements established by this chapter do apply to all hospitals, nursing homes, and limited care facilities.

Examples of Healthcare Occupancies:
- Hospitals
- Psychiatric hospitals
- Specialty hospitals
- Inpatient hospices
- Nursing homes
- Skilled nursing facilities
- Long term care facilities
- Inpatient substance abuse facilities
Definition of Ambulatory Health Care Occupancy:

An occupancy used to provide services or treatment simultaneously to four (4) or more patients that provides, on an outpatient basis, one or more of the following:
(1) treatment for patients that renders the patients incapable of taking action for self-preservation under emergency conditions without the assistance of others;
(2) anesthesia that renders the patients incapable of taking action for self-preservation under emergency conditions without the assistance of others;
(3) emergency or urgent care for patients who, due to the nature of their injury or illness, are incapable of taking action for self-preservation under emergency conditions without the assistance of others.

Examples of Ambulatory Health Care Occupancies include:
- Physical rehab outpatient centers
- Ambulatory surgical centers
- Emergency departments
- Diagnostic centers

Definition of Business Occupancy:

An occupancy used for the transaction of business other than mercantile.

Examples of Business Occupancies include:
- Administrative offices
- Physician’s offices
- Support service centers (i.e. maintenance, laundry, sterile processing, boiler rooms, etc.)

For simplification purposes, this chapter will use the term ‘hospital’ and refer to all occupancies that are included within the facility that houses the healthcare occupancy. It is expected that the hospital be compliant with the Life Safety Code at all times. However, it is recognized there may be times during construction, repairs, or emergencies that compliance with the Life Safety Code is not possible. At those times, the organization needs to either immediately resolve the deficiency or assess the non-compliant issues for Alternative Life Safety Measures, based on the organization’s policy.
Waivers

Requests for waivers are permitted but only after the Life Safety Code deficiency has been cited during an HFAP survey. As part of the organization’s Plan of Correction, a waiver request may be presented to HFAP, who will consider the request and pass it on to the respective CMS Regional Office for approval. The waiver must explain the unreasonable hardship the healthcare organization has in meeting the Life Safety Code requirement and that it does not present a safety risk to the patient or staff.

When making a waiver request, the hospital should identify the deficiency, how the hospital deviates from the code, and steps taken by the hospital to ensure the equivalent level of safety. The hospital has the option of requesting a time-limited waiver if the intent is to ‘bridge’ a period of time until a feature of safety is installed or modified, such as the installation of sprinklers. Waivers approved by CMS are only valid until the next survey cycle. §482.41(b)(2)

Equivalencies

After consideration of survey findings, the CMS may approve a Fire Safety Evaluation System (FSES) equivalency request for specific provisions of the Life Safety Code, which if rigidly applied, would result in unreasonable hardship upon the hospital, but only if the equivalency does not adversely affect the health and safety of patients.

Submission of a FSES equivalency request may be made by the hospital after the deficiency has been cited during a survey. The organization’s Plan of Correction will identify that the hospital plans to submit a FSES equivalency request as the proposed correction for that particular deficiency.

The FSES equivalency request will be submitted to HFAP after the Plan of Correction has been submitted to the HFAP central office. Once received, HFAP will review the FSES equivalency request and may forward it with a recommendation to the CMS Regional Office for consideration and action. Only the Regional Office of CMS may approve FSES equivalency requests for Medicare or Medicaid-participating hospitals.

When making a FSES equivalency request, the hospital should follow the provisions of NFPA 101A Guide on Alternative Approaches to Life Safety, 2010 edition. FSES equivalencies approved by CMS are valid until the next survey, or until major renovation or remodeling is conducted in the area where the deficiency is identified, whichever comes first.

The main difference between a waiver request and an equivalency request is a waiver is seeking permission to not have to comply with a particular Life Safety Code requirement, without any engineering analysis to support that claim. However, an equivalency request is based on an engineering analysis that demonstrates the hospital has an acceptable level of safety based on other features of fire safety, even though the hospital has not resolved the Life Safety Code deficiency.
Instructions for Submitting a Waiver or Equivalency Request

Instructions on how to submit a waiver or equivalency request are found on the HFAP website at www.hfap.org, under the ‘Resources’ tab.

Definition of New Construction vs. Existing Conditions

New construction is defined as those areas whose construction documents were approved by state and local governmental agencies after July 5, 2016. Existing conditions is defined as those areas whose construction documents were approved on or before July 5, 2016.

Features of Life Safety installed under new construction requirements, must be maintained to those new construction requirements even after they later qualify as existing conditions.

Definition of Time

Please be aware that HFAP standard 13.00.06 defines the intervals between testing and inspection activities identified in this chapter. Since NFPA standards and codes are written by different technical committees, often they do not agree on the definition of what a period of time means, such as ‘quarterly’ or ‘annually’. HFAP has reviewed all of the NFPA standards and developed a standard that everyone can follow, and still meet the intent of the respective NFPA technical committee.

For instance, where one technical committee may consider an ‘annual’ activity to occur anytime during a calendar year, another technical committee may want the activity to occur close to the anniversary date of the last activity. Therefore, HFAP has decided to change some of the definitions of time to no longer allow a period of time that goes beyond the intent of the NFPA technical committee. As an example, for activities that are required ‘every 12 months’ or ‘annually’, the HFAP standard now says the completion of the activity is performed during the 12th month of the annual period, but not beyond.

Documentation Requirements

HFAP standard 13.00.07 has specific requirements concerning documentation of evidence of compliance for standards in this chapter. Please be fully aware of these requirements as they apply to all testing and inspection documents, whether the hospital creates their own documents or relies on those provided by contractors.
Facility Demographic Report

A Facility Demographic Report (FDR) is a document that requests basic information concerning the facility and is required to be maintained at all times, and updated annually. The FDR form is found at the end of this chapter, and it will be reviewed during a survey.

Since the FDR is a document that requests specific, detailed, engineering data about the facility, it must be completed by an individual who has a working knowledge of the applicable NFPA codes and standards, and has experience with the facility. This individual may be one who is employed by the hospital, or it may be one who is contracted by the hospital to complete the document. Failing to properly answer each question on the FDR will result in a citation.
Table of Contents of Chapter 13: Life Safety Code

General Requirements
Life Safety Code Compliance ................................................................. 13.00.01
Alternative Life Safety Measures – Policy ............................................. 13.00.02
Alternative Life Safety Measures – Implementation .............................. 13.00.03
Notification of Emergency Forces ......................................................... 13.00.04
Facility Demographic Report ................................................................. 13.00.05
Testing & Inspection – Definition of Time ............................................. 13.00.06
Testing & Inspection – Documentation ............................................... 13.00.07
Interior Finish ...................................................................................... 13.00.08
Fire Watch ......................................................................................... 13.00.09

Means of Egress
Doors ................................................................................................. 13.01.01
Door Locks ....................................................................................... 13.01.02
Corridor Clutter .................................................................................. 13.01.03
Suites ................................................................................................. 13.01.04
Signage .............................................................................................. 13.01.05
Exit Discharge ................................................................................... 13.01.06
Corridor ............................................................................................. 13.01.07
Path of Egress Obstruction ................................................................. 13.01.08
Travel Distance to Exits ...................................................................... 13.01.09
Exit Enclosure .................................................................................... 13.01.10

Fire Alarm Systems
Fire Alarm System – Installation and Maintenance .............................. 13.02.01
Fire Alarm System – Testing ................................................................ 13.02.02
Fire Alarm System – Transmitting Signal .............................................. 13.02.03
Fire Alarm System – Technician qualification ...................................... 13.02.04
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fire Suppression Systems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water Based Fire Suppression System – Installation &amp; Maintenance</td>
<td></td>
<td>13.03.01</td>
<td></td>
</tr>
<tr>
<td>Water Based Fire Suppression System – Testing &amp; Inspection</td>
<td></td>
<td>13.03.02</td>
<td></td>
</tr>
<tr>
<td>Water Based Fire Protection – Control Valves, Piping and Hangers</td>
<td></td>
<td>13.03.03</td>
<td></td>
</tr>
<tr>
<td>Fire Pumps – Monthly Test</td>
<td></td>
<td>13.03.04</td>
<td></td>
</tr>
<tr>
<td>Fire Pump – Annual Test</td>
<td></td>
<td>13.03.05</td>
<td></td>
</tr>
<tr>
<td>Alternative Fire Suppression System – Installation &amp; Testing</td>
<td></td>
<td>13.03.06</td>
<td></td>
</tr>
<tr>
<td>Water Based Standpipe &amp; Hoses – Inspection &amp; Test</td>
<td></td>
<td>13.03.07</td>
<td></td>
</tr>
<tr>
<td>Water Based Fire Department Connections</td>
<td></td>
<td>13.03.08</td>
<td></td>
</tr>
<tr>
<td>Portable Fire Extinguishers – Installation, Inspection &amp; Maintenance</td>
<td></td>
<td>13.03.09</td>
<td></td>
</tr>
<tr>
<td>Fire Hose Valves</td>
<td></td>
<td>13.03.10</td>
<td></td>
</tr>
<tr>
<td>Internal Inspection of Piping</td>
<td></td>
<td>13.03.11</td>
<td></td>
</tr>
<tr>
<td>Cooking Hood Fire suppression</td>
<td></td>
<td>13.03.12</td>
<td></td>
</tr>
<tr>
<td><strong>Fire Safety Systems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire Rated Barriers</td>
<td></td>
<td>13.04.01</td>
<td></td>
</tr>
<tr>
<td>Smoke Barriers</td>
<td></td>
<td>13.04.02</td>
<td></td>
</tr>
<tr>
<td>Fire &amp; Smoke Dampers</td>
<td></td>
<td>13.04.03</td>
<td></td>
</tr>
<tr>
<td>Overhead Rolling/Horizontal Sliding Fire Doors</td>
<td></td>
<td>13.04.04</td>
<td></td>
</tr>
<tr>
<td>Construction Type</td>
<td></td>
<td>13.04.05</td>
<td></td>
</tr>
<tr>
<td>Separated Occupancies</td>
<td></td>
<td>13.04.06</td>
<td></td>
</tr>
<tr>
<td>Fire Rated Door Assemblies</td>
<td></td>
<td>13.04.07</td>
<td></td>
</tr>
<tr>
<td>Hazardous Areas</td>
<td></td>
<td>13.04.08</td>
<td></td>
</tr>
<tr>
<td>Ceilings</td>
<td></td>
<td>13.04.09</td>
<td></td>
</tr>
<tr>
<td>Corridor Walls</td>
<td></td>
<td>13.04.10</td>
<td></td>
</tr>
<tr>
<td><strong>Building Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fireplaces</td>
<td></td>
<td>13.05.01</td>
<td></td>
</tr>
<tr>
<td>Elevator Recall</td>
<td></td>
<td>13.05.02</td>
<td></td>
</tr>
<tr>
<td>Trash &amp; Linen Chutes</td>
<td></td>
<td>13.05.03</td>
<td></td>
</tr>
<tr>
<td>Generator Inspection</td>
<td></td>
<td>13.05.04</td>
<td></td>
</tr>
<tr>
<td>Generator Monthly Load Test</td>
<td></td>
<td>13.05.05</td>
<td></td>
</tr>
<tr>
<td>STANDARD / ELEMENT</td>
<td>EXPLANATION</td>
<td>SCORING PROCEDURE</td>
<td>SCORE</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------</td>
<td>--------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Generator 3-year Load Test</td>
<td>..........................</td>
<td>13.05.06</td>
<td></td>
</tr>
<tr>
<td>Automatic Transfer Switch Test</td>
<td>..........................</td>
<td>13.05.07</td>
<td></td>
</tr>
<tr>
<td>Medical Gas Shutoff Valves</td>
<td>..........................</td>
<td>13.05.08</td>
<td></td>
</tr>
<tr>
<td>Utility systems</td>
<td>..........................</td>
<td>13.05.09</td>
<td></td>
</tr>
<tr>
<td>Medical Gas Systems &amp; Equipment – Maintenance</td>
<td>..........................</td>
<td>13.05.10</td>
<td></td>
</tr>
<tr>
<td>Cooking Hoods Cleaning</td>
<td>..........................</td>
<td>13.05.11</td>
<td></td>
</tr>
<tr>
<td>Health Care Facilities Code</td>
<td>..........................</td>
<td>13.05.12</td>
<td></td>
</tr>
</tbody>
</table>

### Operating Features

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decorations</td>
<td>..........................</td>
<td>13.06.01</td>
<td></td>
</tr>
<tr>
<td>Trash Receptacles</td>
<td>..........................</td>
<td>13.06.02</td>
<td></td>
</tr>
<tr>
<td>Portable Heaters</td>
<td>..........................</td>
<td>13.06.03</td>
<td></td>
</tr>
<tr>
<td>Life Safety Drawings</td>
<td>..........................</td>
<td>13.06.04</td>
<td></td>
</tr>
<tr>
<td>Alcohol Based Hand – Rub Dispensers</td>
<td>..........................</td>
<td>13.06.05</td>
<td></td>
</tr>
</tbody>
</table>
General Requirements.

13.00.01  Life Safety Code Compliance.

Except as otherwise provided in this section —

The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served. §482.41(b)(1)(i)

Notwithstanding paragraph (b)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors. §482.41(b)(1)(ii)

The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately

All hospitals, regardless of size or number of beds, must comply with the NFPA 101 Life Safety Code (2012 edition) requirements for all locations. All buildings and spaces owned, leased or rented which is used for hospital business must comply with the Life Safety Code.

The organization is responsible for developing a systematic process for assessing the compliance with the Life Safety Code of each building under its control.

While HFAP does not specify what process to Life Safety compliance the organization should use, the results must show that the facilities are in full compliance with the Life Safety Code, and other applicable standards.

Roller latches may not be used on corridor doors, with the exception of corridor doors that are not required to latch, such as doors to toilet rooms, bathrooms, shower rooms, sink closets and similar spaces that do not contain flammable or combustible materials.

DOCUMENT REVIEW AND OBSERVATION

Determine that buildings are in compliance with the applicable occupancy chapters of the Life Safety Code, by direct observation.

1 = Compliant

2 = Not Compliant

Comment:
13.00.02 Alternative Life Safety Measures — Policy
The hospital must have a written policy on Alternative Life Safety Measures (ALSM) whenever situations where a deficiency to the Life Safety Code cannot be immediately resolved. All deficiencies to features of Life Safety must be assessed and documented for additional measures the same day they are discovered. The need to implement compensation measures for the life safety deficiency is based on the criteria in the hospital’s ALSM policy.

The ALSM policy must identify when a particular compensating measure is required to be implemented and to what extent that measure is implemented.

It is understood that features of life safety may be compromised or impaired during periods of construction, maintenance or emergency repairs. During these periods, the hospital must perform a documented risk assessment of the deficiency, and implement compensating measures based on the criteria of their ALSM policy.

Not all deficiencies to Life Safety may require compensation, but the ALSM policy must clearly distinguish when and to what extent such measures are implemented.

**DOCUMENT REVIEW**
- Review the hospital’s ALSM policy. The policy must clearly identify that it applies to all conditions when impairments to features of Life Safety exists, including during periods of construction, maintenance, and emergency repairs.
- The ALSM policy must clearly identify what compensating measures will be taken when certain deficiencies are discovered.

Comment:
13.00.03 Alternative Life Safety Measures – Implementation.

When a Life Safety Code deficiency cannot be corrected the same day it is discovered, the hospital conducts an assessment and implements appropriate measures to compensate for impairments to the Life Safety Code, based on their ALSM policy.

When conditions exist that compromises a feature of life safety, the organization must conduct an assessment to determine what ALSM, if any, to implement, based on their ALSM policy. When alternative measures are implemented, they must be continued until such time the deficiency is resolved.

The assessment is documented.

13.00.04 Notification of Emergency Response Forces.

The hospital notifies the local emergency response force (fire department) when a fire alarm system, or parts thereof, is out of service more than four (4) hours in a 24-hour period, and either evacuates the building or portions of the building affected by the outage or implements a fire watch in all affected areas.

The organization must take appropriate action when the fire alarm system (or parts thereof) is out of service for more than four (4) hours in a 24-hour period, and when the automatic sprinkler system (or parts thereof) is out of service for more than ten (10) hours in a 24-hour period. The phrase ‘or parts thereof’ refers to circuits or branches of the systems, not a single device.

Refer to 13.00.09 on the proper method and procedure to conduct a fire watch.
The fire watch and the notification of the local emergency response force are documented.

§482.41(b)(8)
§482.41(b)(8)(i)
§482.41(b)(8)(ii)

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.00.05 Facility Demographic Report (FDR).</td>
<td>The organization must designate an individual to be responsible for the assessment of the facility’s compliance with the Life Safety Code. This individual is responsible to complete and maintain the Facilities Demographic Report (FDR) report. HFAP does not set qualifications for the designated individual; however since the FDR is technical in manner, a person with technical knowledge must be designated. The hospital must complete the HFAP Facility Demographic Report on at least an annual basis, or more often as needed, for each facility identified as a healthcare occupancy or as an ambulatory healthcare occupancy, and maintain the accuracy of the information. Business occupancies are not required to have a FDR completed. Individual healthcare occupancies or ambulatory healthcare occupancies must have individual FDRs completed for each facility.</td>
<td>OBSERVATION AND DOCUMENTATION</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Review the documentation in the FDR that designates the responsible individual, and assess the qualifications listed. • Review the FDR to determine if it has been updated within the past 12 months, and is current and maintained. • Review the FDR to ensure the organization completed the assessment and maintains the accuracy of the information. Determine if each question was answered accurately.</td>
<td></td>
<td>1 = Compliant 2 = Not Compliant</td>
</tr>
</tbody>
</table>
Testing and inspection activity cannot exceed the allowable amount of time permitted by the applicable standard or regulation.

The completion of the weekly and monthly activities is to be performed during the designated calendar period.

The completion of the quarterly, semi-annually, annually, 3-year, 5-year, and 6-year activities is to be performed during the last calendar month of that period.

Testing and inspection activity cannot exceed the allowable amount of time permitted by the applicable standard or regulation.

The completion of the weekly and monthly activities is to be performed during the designated calendar period.

The completion of the quarterly, semi-annually, annually, 3-year, 5-year, and 6-year activities is to be performed during the last calendar month of that period.

**DOCUMENTATION**
- When reviewing documentation, make sure testing, inspection or maintenance activity is performed within the limits of this standard.
- If the testing/inspection activity was not conducted within the specified time-frame then score non-compliance with the respective standard that requires the testing/inspection activity.

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.00.06 Testing &amp; Inspection—Definition of Time.</td>
<td>Testing and inspection activity cannot exceed the allowable amount of time permitted by the applicable standard or regulation. The completion of the weekly and monthly activities is to be performed during the designated calendar period. The completion of the quarterly, semi-annually, annually, 3-year, 5-year, and 6-year activities is to be performed during the last calendar month of that period.</td>
<td></td>
<td>Not Score Under This Standard</td>
</tr>
</tbody>
</table>

**Weekly or ‘every 7 days’**:  
- **The completion of the activity is performed anytime during the calendar week.**

**Monthly or ‘every 30 days’**:  
- **The completion of the activity is performed anytime during the calendar month.**

**Quarterly or ‘every 3 months’**:  
- **The completion of the activity is performed quarterly, during the third month of the quarterly period.**

**Semi-annually or ‘every 6 months’**:  
- **The completion of the activity is performed semi-annually, during the 6th month of the semi-annual period.**

**Annually or ‘every 12 months’**:  
- **The completion of the activity is performed annually, during the 12th month of the annual period.**
### 13.00.07 Testing & Inspection - Documentation

Unless otherwise stated, testing, inspection and maintenance documentation must include, at a minimum, the following information:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Name of individual performing the activity</td>
</tr>
<tr>
<td>2.</td>
<td>Affiliation of the individual performing the activity</td>
</tr>
</tbody>
</table>

All documentation of testing, inspection and maintenance activities must include this basic information.

If a component of safety is found to fail its test, then the component must be repaired or replaced immediately or alternative life safety measures must be implemented according to the organization’s policy. (See 13.00.03)

This standard requirement on documentation does not apply to the inspection and maintenance tags located on portable fire extinguishers. The date the

---

**DOCUMENTATION**

- When reviewing documentation, make sure testing, inspection or maintenance results are documented in accordance with this standard.
- If the testing/inspection documentation does not meet the requirements of this standard, then score a finding under the respective standard that required the test or inspection.

---

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-Years:</td>
<td>The completion of the activity is performed once every 3 years, during the 36th month of the 3-year period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-Years:</td>
<td>The completion of the activity is performed once every 5 years, during the 60th month of the 5-year period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-Years:</td>
<td>The completion of the activity is performed once every 6 years, during the 72nd month of the 6-year period.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Not Scored Under This Standard**

---

**Healthcare Facilities Accreditation Program (HFAP)**

*Accreditation Requirements for Acute Care Hospitals*
### LIFE SAFETY

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. The signature of the individual performing the activity</td>
<td>inspection or maintenance activity was performed and the initials of the person performing the activity must be recorded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Activity name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Date(s) (month/day/year) that activity was performed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. The frequency that is required of the activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. The NFPA code or standard which requires the activity to be performed, as applicable.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. The results of the activity, such as ‘Pass’ or ‘Fail’</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***OBSERVATION & DOCUMENTATION***

- Review the flame spread rating of selected interior finishes to determine if it meets the proper classification rating.
- Plywood used as interior finish in utility or equipment rooms would be permitted provided it met the required flame spread for that classification.

13.00.08 Interior Finish.
The interior finish on existing walls and ceilings must be Class A or Class B, except rooms protected with sprinklers are permitted to be Class C provided the room is separated from the exit access corridor.

The interior finish on new construction walls and ceilings must be Class A or Class B, except rooms having a capacity not exceeding four persons are permitted to be Class C; and interior finish on new

Class A interior wall and ceiling finishes have a flame spread rating of 0 – 25, and a smoke development rating of 0 - 450.

Class B interior wall and ceiling finishes have a flame spread rating of 26 - 75, and a smoke development rating of 0 - 450.

Class C interior wall and ceiling finishes have a flame spread rating of 76 - 200, and a smoke development rating of 0 - 450.

---

2017 - Prepublication

Healthcare Facilities Accreditation Program (HFAP)

Accreditation Requirements for Acute Care Hospitals

13-15
construction corridor walls not exceeding 4 feet in height that is restricted to the lower half of the wall is permitted to have Class A, Class B, or Class C finish.

13.00.09 Fire Watch. A fire watch consists of dedicated, trained individual(s) with no other duties constantly circulating throughout the portion of the facility affected by the deficiency or impairment looking for a fire, fire hazards, or hazardous conditions that may affect the fire safety of the facility.

‘Constantly circulating’ the affected areas of the facility means continuous, without interruption. If breaks are desired, then a replacement individual is needed.

Only individuals with fire-response training may conduct a fire watch, and may not perform any other duty during the fire watch. They are to ensure there is no fire, and confirming that other fire protection features of the building, such as egress routes, suppression systems, and alarm systems are available and functioning. The individuals must have ready access to fire extinguishers, and the ability to promptly notify the fire department in the event of a fire.

If it requires one individual more than 30 minutes to complete one round of the affected area, then additional individuals must be assigned to fire watch duty.

Fire watches must be documented indicating the start date and time, and the end date and time. The documentation must record all individuals who conduct the fire watch, with their individual start and end times.

**OBSERVATION AND DOCUMENTATION**

- Ask to see the documentation of the fire watch.
- Check to see that fire watches are performed continuously, without interruption.
- Determine if the individual(s) performing the fire watch have received fire-response training.

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.00.09 Fire Watch</td>
<td>A fire watch consists of dedicated, trained individual(s) with no other duties constantly circulating throughout the portion of the facility affected by the deficiency or impairment looking for a fire, fire hazards, or hazardous conditions that may affect the fire safety of the facility.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Constantly circulating’ the affected areas of the facility means continuous, without interruption. If breaks are desired, then a replacement individual is needed. Only individuals with fire-response training may conduct a fire watch, and may not perform any other duty during the fire watch. They are to ensure there is no fire, and confirming that other fire protection features of the building, such as egress routes, suppression systems, and alarm systems are available and functioning. The individuals must have ready access to fire extinguishers, and the ability to promptly notify the fire department in the event of a fire. If it requires one individual more than 30 minutes to complete one round of the affected area, then additional individuals must be assigned to fire watch duty. Fire watches must be documented indicating the start date and time, and the end date and time. The documentation must record all individuals who conduct the fire watch, with their individual start and end times.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD / ELEMENT</td>
<td>EXPLANATION</td>
<td>SCORING PROCEDURE</td>
<td>SCORE</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------</td>
<td>--------------------</td>
<td>-------</td>
</tr>
</tbody>
</table>

Means of Egress.

13.01.01  Doors.
Corridor doors and doors to hazardous rooms shall be provided with positive latching hardware.

Roller latches are not permitted on corridor doors that are required to latch.

Corridor doors shall be capable of resisting the passage of smoke.

Doors in the path of egress must be side-hinged or pivot-swing type.

§482.41(b)(1)(ii)

Latching devices are necessary to keep patient room doors securely closed in the event of the fire. Positive latching devices are required on all corridor doors.

The use of roller latches will not be allowed on corridor doors in hospitals where corridor doors are required to latch (see 13.00.01).

Corridor doors cannot be restrained in such a way to prevent the door from closing.

Doors in the path of egress are required to be side-hinged or pivoted-swinging type, and are required to swing in the direction of egress when serving a room or area with an occupant load of 50 or more persons.

Doors must open to a minimum of 90 degrees from its closed position, and extend no more than seven (7) inches into the corridor when opened to its fullest extent.

Horizontal sliding doors are required to be side-hinged and capable of ‘breaking away’, unless the door serves a room with an occupant load less than 10, and complies with all of the provisions in 19.2.2.2.10.2 of the 2012 Life Safety Code.

A level landing surface is required and shall be maintained on each side of the door threshold. The depth of the landing is to be at least equal to the width of the widest door leaf.

DOCUMENT REVIEW AND OBSERVATION
Examine corridor doors during building tour for compliance.

- During the building tour, examine corridor doors to ensure they can close and latch. NOTE: Self-closing is not required.
- Examine horizontal sliding doors: Ensure they are also side-hinged and capable of ‘breaking away’ and swing from the side hinges unless the door serves a room with an occupant load of less than 10 persons.
- Ensure doors in the path of egress open to at least 90 degrees, and extend no more than seven (7) inches into the corridor when fully opened.

1 = Compliant  2 = Not Compliant

Comment:
13.01.02 Door Locks
Doors in the means of egress must be operable with not more than one releasing operation.

Doors within the means of egress must not be equipped with a latch or lock that requires the use of a tool or key from the egress side, with the exception where the clinical needs of the patients require specialized security measures for their safety.

Doors in the means of egress are permitted to be equipped with delayed egress locks provided the entire facility is protected with automatic sprinklers, or fully detected with smoke detectors.

Doors in the means of egress are permitted to be equipped with access-control locks.

Doors separating elevator lobbies from exit access corridors are permitted to be locked with electrical locks provided all of the provisions of 7.2.1.6.3 of the 2012 Life Safety Code are met.

Doors in the means of egress are permitted to be equipped with locks where the patient’s special needs

Occupants accessing doors in the path of egress are not permitted to operate more than one device to open the door.

A door is not permitted to have a lock separate from the latching mechanism (such as a dead-bolt lock) which would require the occupant to operate two devices to open the door. (NOTE: Pulling on a handle or pushing on the door is not considered an operation.)

However, two releasing operations are permitted for existing hardware on a door leaf serving an area having an occupant load not exceeding three, provided that releasing does not require simultaneous operations.

Normally, doors in the path of egress in a healthcare occupancy are not permitted to be locked. However, the Life Safety Code permits five (5) types of locks on doors in the path of egress.

1. Clinical needs locks are those used in psychiatric and behavioral health units, however staff must be able to unlock the doors at all times (see 18/19.2.2.2.5.1 of the 2012 edition of the Life Safety Code).

2. Clinical needs locks are not permitted to be used for infant or pediatric security. However, door locking arrangement are permitted where patient special needs require specialized protective measures for their safety, provided that all of the provisions of 18/19.2.2.2.5.2 are met.

• During the building tour, observe how doors are locked and if they comply with the provisions listed.

• Observe delayed egress locks to ensure that they are only installed in fully sprinklered or fully detected buildings.

• Observe access-control locks to determine they have motion sensors mounted on the egress side to automatically unlock the door when someone approaches; and a ‘Push To Exit’ button mounted on the egress side within five (5) feet of the door, that unlocks the door when depressed.

• Observe Clinical Needs locks and ensure they are only installed in Psychiatric, Alzheimer’s, dementia, and substance abuse units.

• Observe elevator lobby locks and ensure the elevator lobby is smoke detected and the entire building is sprinklered.

• Observe special arrangement locks where the needs of the patient require special protective measure locks (i.e. nurseries, mother/baby units, ICUs, ERs), to ensure the entire locked area is smoke detected and the entire building is sprinklered.

DOCUMENT REVIEW AND OBSERVATION

1 = Compliant
2 = Not Compliant

Comment:
require specialized protective measures for their safety, in accordance with section 18/19.2.2.2.5.2 of the 2012 Life Safety Code.

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.01.03 Corridor Clutter</td>
<td>The exit access corridor must be maintained to the full required width.</td>
<td>Minimum width of exit access corridors for new construction in an acute-care hospital is eight (8) feet. Minimum width of exit access corridors for new construction in a psychiatric care hospital is six (6) feet. Minimum width of exit access corridors for new construction in adjunct areas not intended for use by inpatients is forty-four (44) inches. Minimum width of exit access corridors for existing construction is four (4) feet. Minimum width of exit access corridors in adjunct areas not intended for use by inpatients is forty-four (44) inches.</td>
<td>[ ] 1 = Compliant [ ] 2 = Not Compliant</td>
</tr>
</tbody>
</table>

3. Delayed egress locks must comply with section 7.2.1.6.1 of the 2012 edition of the Life Safety Code and access-control locks must comply with section 7.2.1.6.2 of the same document.

4. Elevator lobbies are permitted to be locked provided they meet all of the requirements in 7.2.1.6.3 of the 2012 Life Safety Code.

5. Doors in the means of egress from Nurseries, Mother/Baby units, ICUs, and ERs are permitted to be locked provided they are equipped with locks in accordance with section 18/19.2.2.2.5.2 of the 2012 Life Safety Code.

**Observation**

- During the building tour, observe corridors for clutter and unattended items left more than 30 minutes. Ask staff how long carts and equipment are left in corridors.
- Observe if the corridor width in existing conditions has been reduced to less than what is required for new construction.
- Review the organization’s plan to remove the authorized carts and equipment from the corridor during a fire emergency.
Alterations of the existing width of corridors cannot be reduced to less than that which is required for new construction.

Items left unattended in the exit access corridors for more than 30 minutes are not permitted, with the exception of emergency crash carts, and patient isolation supply carts, provided the carts are mounted on wheels, and the organization has a plan to remove the carts from the corridor during a fire emergency.

Projections into the required width of the corridor are permitted for certain wheeled equipment, such as equipment in use; medical emergency equipment not in use; and patient lift and transport equipment, provided it meets the provisions of 18/19.2.3.4(4) of the 2012 Life Safety Code.

Projections into the required width of the corridor are permitted for fixed furniture provided it meets the provisions of 18/19.2.3.4(5) of the 2012 Life Safety Code.

### 13.01.04 Suites

Suites containing patient sleeping rooms are limited in area to the following:
- 5,000 square feet in non-sprinklered buildings;
- 7,500 square feet in smoke compartments protected with standard response sprinklers and

Sleeping room suites exceeding 1,000 square feet are required to have two exit access doors, one of which may be to an exit stairwell, direct exit, horizontal exit, or directly to an adjoining suite, provided the separation between the suites complies with the corridor requirements.

Non-sleeping room suites exceeding 2,500 square feet are required to have two exit access doors, one of which may be to an exit stairwell, direct exit,

### OBSERVATION

- During the building tour, observe the size of the suites to determine if they are within the limits listed.
- Check suite entrance doors to ensure they positively latch.
- Check sleeping suites to ensure they are staffed continuously.

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.01.04 Suites</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comment:</th>
<th>1 = Compliant</th>
<th>2 = Not Compliant</th>
<th>N/A</th>
</tr>
</thead>
</table>

2017 - Prepublication

Healthcare Facilities Accreditation Program (HFAP)
Accreditation Requirements for Acute Care Hospitals
### Standard / Element

<table>
<thead>
<tr>
<th>Explanation</th>
<th>SCORING PROCEDURE</th>
<th>Score</th>
</tr>
</thead>
</table>

| Smoke detectors, or in smoke compartments protected with quick response sprinklers; | Check sleeping suite to ensure they have direct supervision of patients from a normally attended location, or the entire suite must be protected with smoke detectors. |  |

- **10,000 square feet where direct supervision of the patient sleeping rooms is arranged from a normally attended location in the suite, the suite is fully smoke detected, and the suite is fully protected with quick response sprinklers.**

Suites containing non-sleeping room suites are limited to 10,000 square feet.

#### 13.01.05  **Signage.**
Exits shall be marked by an approved sign readily visible from any direction of exit access and be illuminated. Illuminated signs must be legible in both the normal and emergency lighting mode.

Access to exits shall be marked by approved signs in all cases where the way to reach the exit is not readily apparent to the occupants.

All exits must be marked with an approved ‘Exit’ sign, with the exception of exterior exit doors which clearly are identifiable as exits.

This standard does not necessarily require an ‘Exit’ sign to be visible at every location in an exit access corridor.

If the path of egress is apparent, then an ‘Exit’ sign is not required.

Monthly inspections of ‘Exit’ signs are required to insure they are still illuminated.

---

**DOCUMENT REVIEW AND OBSERVATION**

- During the building tour, observe all ‘Exit’ signs to insure they are properly illuminated.

- If the path of egress is not marked, and the way to the exit is not readily apparent, then the organization is not compliant with this standard.

- During the document review session, review the monthly ‘Exit’ sign inspection log to insure all ‘Exit’ signs were inspected.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exit signs shall be visually inspected monthly for operation of the illumination sources.</td>
<td>Doors that do not lead to exits but could be confused as an exit must have a sign that reads “NO EXIT”, with the word “NO” two inches tall, and the word “EXIT” one inch tall. Enclosed stairwell identification signage is required to be provided in compliance with section 7.2.2.5.4 of the 2012 Life Safety Code for new stairways serving three or more stories and existing stairways serving five or more stories. The exit discharge is the portion of means of egress from the exit door to the public way. The walking surface must be level and free of cracks and abrupt changes in elevation exceeding ¼ inch. Note that steps are permitted. Exit discharge must be maintained free from ice and snow. An exit discharge across an unimproved area, such as a lawn, is not considered to be in compliance with this standard due to the uneven walking surface. Illumination of exit discharge must be by lighting fixtures with more than one lamp, or multiple lighting fixtures to ensure path is illuminated if one lamp fails.</td>
<td>OBSERVATION</td>
<td></td>
</tr>
</tbody>
</table>

- During the building tour, observe all exit discharges to ensure they have level walking surfaces and illumination all the way to the public way.

1 = Compliant

2 = Not Compliant

Comment: |
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
</table>

**13.01.07 Corridor.**

Items attached to the wall of the corridor cannot project more than four (4) inches into the corridor, **may not exceed 36 inches in length**; are separated from other wall-mounted projections by at least 48 inches; and are located at least 40 inches above the floor.

Corridors must provide access to two (2) approved exits without passing through intervening rooms or spaces, other than other corridors or lobbies.

Dead-end corridors are limited to 30 feet. Existing dead-end corridors are permitted to remain if determined to be impractical and unfeasible to alter them to allow two paths of egress.

Wall mounted items in the corridor are not permitted to project more than **four (4)** inches into the corridor. This includes drinking fountains, flip-down desks for wall charting stations, evacuation chairs, **hand-rub dispensers**, and any other item attached to the wall surface.

This applies to new and existing conditions, regardless how long they have been installed.

The path of egress is not permitted from a corridor into a room or suite to reach an exit.

Dead-end corridors are created by doors that are locked in the path of egress.

**OBSERVATION**

- During the building tour, examine wall-mounted items in the corridor to ensure they do not project more than 6 inches.
- During the building tour, observe dead-end corridors, remembering locked doors in the path of egress may create an unexpected dead-end corridor. Do they exceed 30 feet in length?
- If more than 30 feet, are dead-end corridors existing? If existing, would it be impractical or unfeasible to resolve?

**13.01.08 Path of Egress Obstructions.**

The path of egress must be free and clear of all obstructions or impediments all the way to the public way.

This standard applies to items and objects that would impede travel along the path of egress, including stairwells, passageways and exit discharges, all the way to the public way.

For corridor clutter, see standard 13.01.03.

**OBSERVATION**

- During the building tour, examine each path of egress all the way to the public way to ensure there are no objects that would impede access.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.01.09 Travel Distance to Exits.</td>
<td>The travel distance to an exit is measured along the normal walking path, around objects in rooms, and no closer than 12 inches to corridor walls. The travel distance between any point in a healthcare sleeping room (other than suites) and the exit access door in that room must not exceed 50 feet. For buildings that are fully protected with automatic sprinklers, the maximum travel distance from any point in a room to an exit is 200 feet.</td>
<td>OBSERVATION • During the building tour, examine selected travel distances to exits to ensure they are within the allowable amount.</td>
<td>1 = Compliant 2 = Not Compliant</td>
</tr>
<tr>
<td>13.01.10 Exit Enclosures.</td>
<td>Openings in exit enclosures are limited to those necessary for access from normally occupied spaces and corridors. Existing openings to mechanical equipment spaces protected by fire rated door assemblies are permitted, provided: • The space is used solely for non-fuel-fired mechanical equipment; • The space contains no storage of combustibles materials; • The building is protected throughout by an automatic sprinkler system. Penetrations into and openings through an exit enclosure are limited to existing penetrations that are protected with fire-rated materials. New construction exit enclosures are prohibited from penetrations, with the exception of:</td>
<td>OBSERVATION • During the building tour, examine exit enclosures to ensure they do not have openings to unoccupied rooms. • If existing mechanical spaces open directly to exit enclosure, ensure the space is not used for fuel-fired equipment, the space contains no storage of combustibles, and the building is fully sprinklered. • While stairwells are not to be used as general storage areas, it is permissible to store safety-related items (i.e. evacuation chairs) in stairwells where they will not interfere with the use as an exit.</td>
<td>1 = Compliant 2 = Not Compliant</td>
</tr>
</tbody>
</table>

OBSERVATION

- During the building tour, examine selected travel distances to exits to ensure they are within the allowable amount.

Comment:
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
</table>

- Electrical conduit serving the exit enclosure;
- Required exit doors;
- Ductwork and equipment necessary for independent stair pressurization;
- Water or steam piping necessary for heating or cooling of the exit enclosure;
- Sprinkler piping;
- Standpipes;
- Penetrations for fire alarm circuits where the circuits are installed in metal conduit.

Items are not permitted to be stored in exit enclosures that have the potential to interfere with its use as an exit.

Minimum headroom in exit enclosures must be at least 7 foot 6 inches, unless existing conditions which is permitted 7 foot 0 inches.

Stairs and ramps that continue more than ½ story beyond the level of exit discharge must be provided with an interruption gate to prevent occupants from traveling past the level of exit discharge during building evacuation.
Fire Detection Systems.

13.02.01 Fire Alarm System - Installation & Maintenance.
A fire alarm system required for life safety shall be installed and maintained in accordance with sections 18/19.3.4 of the Life Safety Code (2012 edition), and in accordance with NFPA 72, 2010 edition.

Basic installation requirements are defined in section 18/19.3.4 in the Life Safety Code (2012 edition).

Specific installation details of the fire alarm system components are defined in NFPA 72 (2010 edition) National Fire Alarm Code.

Once installed, fire alarm systems must be maintained to the original installation requirements.

13.02.02 Fire Alarm System - Testing.
Fire alarm systems, and all their components, shall be tested according to NFPA 72 National Fire Alarm Code (2010 edition), Table 14.4.2.2 Test Methods, and Table 14.4.5 Testing Frequencies.

All testing results are documented.

Reliability of the hospital's fire alarm system is critical for the safety of the facilities occupants.

This standard does not require the hospital to have all of the components identified in NFPA 72 (2010 edition), Tables 14.4.2.2 and 14.4.5, but if installed, they must be maintained and tested according to the methods and frequencies identified.

The over-all fire alarm system consists of multiple connected and inter-connected components and systems that together create a detection and notification system.

Basic components include power supplies, control panels, initiating devices, notification devices and interface devices, which require specific testing procedures at specified frequencies.

OBSERVATION
- During the building tour, observe if components of the fire alarm system are installed according to the codes and standards identified.
- During the building tour, observe the fire alarm system to determine if it is maintained in accordance with the original installation requirements.

DOCUMENT REVIEW
- Documentation demonstrating compliance with NFPA 72 (2010 edition) Tables 14.4.2.2 and 14.4.5 must be maintained for a minimum of three (3) years.
- Documentation must demonstrate that each and every device connected to the fire alarm system is inventoried and accounted for and passed (or failed) its test.
- Verify that the fire alarm test report fully complies with the frequencies identified in Table 14.4.5 of NFPA 72 (2010 edition). Each individual fire alarm device that is tested must be identified as to its location, and whether or not it passed or failed its test.

1 = Compliant
2 = Not Compliant

Comment:
Secondary components that are controlled by the fire alarm system such as air-handlers, smoke dampers, smoke or fire doors held open, and access-control, or delayed egress locks must be tested through their normal range of control when activated (or deactivated) by the fire alarm system.

- During the document review session, make sure the hospital annually tests the interface devices (relays) between the fire alarm systems and the locks used on the delayed egress and access-control locks.

- Interview staff to determine if the test methods used on the fire alarm system components are consistent with Table 14.4.2.2 of NFPA 72 (2010 edition).

**13.02.03 Fire Alarm Systems - Transmitting Signal.**

The fire alarm system shall transmit an appropriate signal to an offsite monitoring station, or directly to the emergency response force.

This signal shall be tested annually from the alarm panel in the protected premise, to the emergency response force.

All results of the tests are documented.

This standard does not require the fire alarm system to transmit all three signals, but when the fire alarm system activates an alarm signal, supervisory signal, or a trouble signal, it must be transmitted to an approved location, such as an Auxiliary Fire Alarm System, a Central Station, a Proprietary System, or a Remote Supervising Station.

**Manual reporting systems and methods are not permitted.**

Annually, the off-premises monitoring transmission equipment must be tested to ensure the local fire-responding agency received an alarm signal, even if the transmission of that signal is through a third-party entity.

NFPA 72 (2010 edition) Table 14.4.2.2 (18) (a) through (e), and Table 14.4.5 (22) describes in detail the methods and procedures to follow for each type of system.

**DOCUMENT REVIEW**

- Review hospital records to determine whether the fire alarm system signal is transmitted annually from the fire alarm panel to the emergency response force.

Comment:

1 = Compliant
2 = Not Compliant
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.02.04 Fire Alarm System- Technician Qualifications.</td>
<td>Fire alarm inspection, testing and maintenance personnel shall be qualified and experienced in the testing of fire alarm systems. Documentation identifying the qualification of the individual(s) performing testing, inspecting and maintenance activities on the fire alarm system must be available for review.</td>
<td><strong>DOCUMENTATION</strong>&lt;br&gt;- Documentation for the individual(s) performing testing, inspection or maintenance of fire alarm system, and their components, must be on file for reviewed.&lt;br&gt;- Review documentation that demonstrates compliance with this standard.</td>
<td>□ 1 = Compliant&lt;br&gt;□ 2 = Not Compliant&lt;br&gt;Comment:</td>
</tr>
</tbody>
</table>

Technicians performing inspections, testing and maintenance on fire alarm systems must have proper certification, license, and/or training to do so. Examples of qualified personnel shall be permitted to include, but not limited to individuals with the following qualifications:
- Factory trained and certified
- National Institute for Certification in Engineering Technologies (NICET) fire alarm certified
- International Municipal Signal Association (IMSA) fire alarm certified
- Certified by a state or local authority
- Trained and qualified personnel employed by an organization listed by a national testing laboratory for the servicing of fire alarm system.

The requirement to maintain documentation on the individual providing inspection, testing or maintenance activities on the fire alarm system apply to contracted services as well hospital staff.
Fire Suppression Systems.

13.03.01 Water-Based Fire Protection System: Installation & Maintenance.
A water-based fire protection system must be installed and maintained in accordance with section 18.3.5 of the Life Safety Code (2012 edition) in all new construction, remodeled and renovated areas.

A water-based fire protection system must be installed and maintained in accordance with section 19.3.5 of the Life Safety Code (2012 edition) where required in existing construction, or renovated areas.

This standard requires the installation of sprinklers in new construction since the adoption of the 1991 edition of the Life Safety Code.

This standard does not require the installation of sprinklers in existing construction prior to the adoption of the 1991 edition of the Life Safety Code, unless the Construction Type dictates it, or the sprinklers are a measure of equivalency.

All sprinkler systems installed must comply with NFPA 13 Standard for the Installation of Sprinkler Systems, (2010 edition), regardless if the sprinkler systems are required or not.

Once installed, sprinkler systems must be maintained to the original installation requirements.

Water-based sprinkler systems, including pre-action and dry-pipe systems, are included in this standard.

This standard does not require a hospital to have automatic sprinkler systems or their components installed, but if they do, the sprinkler systems must be tested, inspected and maintained according to NFPA 25 Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 edition.

Water-based fire protection systems and components, include but are not limited to:

- Documentation demonstrating compliance with NFPA 25 (2011 edition) must be maintained for a minimum of three (3) years. Documentation must demonstrate that each and every device connected to the water-based fire protection system is accounted for and passed or failed its test.

- Verify that the water-based fire protection system documentation fully complies with the frequencies identified in NFPA 25 (2011 edition).
### LIFE SAFETY

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sprinklers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Piping and hangers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control valves, valve components and trim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water-flow devices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standpipe and hoses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dry-pipe, deluge and pre-action valves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service mains</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Storage tanks</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Control valves are required to be visually inspected monthly to confirm they are still in their designated position. This inspection must be documented.

### 13.03.03 Water-Based Fire Protection System: Control Valves, Piping and Hangers.

If provided, control valves used in water-based fire protection systems must be electronically supervised with tamper switches and connected to the building fire alarm system. Tamper switches must be tested at intervals according to 13.02.02.

Sprinkler piping and hangers shall be free of all material, including wire, cable, conduit, HVAC duct, or any other objects, and shall not be used to support any other item or system.

All sprinkler control valves must have tamper switches installed and connected to the building fire alarm system to send electronic supervisory signals. Chains and locks on control valves, while permitted, do not demonstrate compliance with this standard.

Nothing is permitted to be attached to sprinkler piping and hangers, including wire and cable.

**OBSERVATION**
- During the building tour, observe sprinkler control valves to ensure they are electronically monitored.
- Examine sprinkler piping and hangers to ensure nothing is suspended or attached to them.

Comment: 1 = Compliant, 2 = Not Compliant, N/A
### STANDARD / ELEMENT

<table>
<thead>
<tr>
<th>13.03.04</th>
<th>Fire Pumps: Monthly Test.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explanation</strong></td>
<td>This standard does not require the installation of fire pumps in the facility.</td>
</tr>
<tr>
<td><strong>Explaination</strong></td>
<td>If so equipped, electric-motor driven fire pumps must be tested <strong>monthly</strong> at no-flow conditions in accordance with NFPA 25 <em>Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 edition</em>.</td>
</tr>
<tr>
<td><strong>Score</strong></td>
<td>201</td>
</tr>
<tr>
<td><strong>Documentation</strong></td>
<td>During the document review session, review documentation to ensure fire pump is tested in accordance with NFPA 25.</td>
</tr>
<tr>
<td><strong>Comment</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>

If so equipped, **engine-driven fire pumps** must be tested **weekly** at no-flow conditions in accordance with NFPA 25, 2011 edition.

The results of all testing activities are documented.

### 13.03.05 Fire Pumps: Annual Test.

| **Explanation** | This standard does not require a hospital to have a fire pump installed, but if they do, the fire pump must be tested according to NFPA 25 *Standard for the Testing, Inspection and Maintenance of Water-Based Fire Protection Systems* (2011 edition). |
| **Explaination** | An annual water-flow test is required for all fire pumps, which consists of: |
| **Score** | 201 |
| **Documentation** | During the document review session, review documentation to ensure fire pump is tested annually in accordance with NFPA 25 (2011 edition) and this standard. |
| **Comment** | N/A |

1. A **churn test**

2. The pump operated at design flow (100% nameplate capacity)

3. The pump operated at peak flow (150% nameplate capacity)}
4. During peak flow, a power failure is simulated on electric motor driven pumps equipped with automatic transfer switches to ensure emergency power supply is connected, and confirmation of peak flow continues.

5. After peak flow has been confirmed and documented, normal power is restored to ensure circuit protection devices have not opened.

Additional readings and measurements are required during this annual flow test. If peak flow is not attainable due to limitations in water supply, that shall not constitute an unsuccessful test.

13.03.06 **Alternative Fire Suppression Systems: Installation & Testing.**
Approved fire suppression systems that are installed, tested and maintained to their respective NFPA standard, are permitted to be an alternative to water-based fire protection systems without the facility being classified as non-sprinklered.

All such alternative fire suppression systems shall be connected to the building fire alarm system and initiate an alarm when activated.

The results of all testing activities are documented.

This standard does not require the installation of alternative fire suppression system.

If so equipped, alternative fire suppression systems must be installed, tested and maintained in accordance with their respective NFPA standard.

Examples of alternative fire suppression systems are:
- Halon systems
- FM-200 systems
- Inergen systems
- CO2 systems

**INTERVIEW AND DOCUMENTATION**
- Interview facility manager to determine what areas contain alternative fire suppression systems.
- Review documentation to determine if appropriate testing and inspection frequencies are achieved.

[1 = Compliant]
[2 = Not Compliant]
[N/A]  

Comment:
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
</tr>
</thead>
</table>
| **13.03.07 Water-Based Standpipes & Hoses: Inspection & Test.** | This standard does not require the installation of standpipes or occupant-use fire hoses. If so equipped, water-based automatic (wet) standpipes, must be tested once every 5-years at flow conditions equal to original acceptance requirements at the hydraulically most remote location. If so equipped, manual (dry) standpipes must be hydrostatic tested at not less than 200 psi pressure for 2 hours, or at 50 psi in excess of the maximum pressure, whichever is greater, at least once every 5-years. If so equipped, occupant-use fire hoses must be un-racked annually, inspecting for abnormal wear conditions. Occupant-use fire hoses must be hydraulically pressure tested in accordance with NFPA 1962, Standard for the Inspection, Care and Use of Fire Hose, Couplings, and Nozzles and the Service Testing of Fire Hose, (2008 edition) 5-years after initial installation and every 3 years thereafter. The results of all testing and inspection activities are documented. | **DOCUMENTATION**
- Review documentation to ensure wet standpipe systems are water-flow tested at least once every 5 years in accordance with NFPA 25.
- Review documentation to ensure dry standpipe systems, including the piping for the fire department connections, are hydrostatic tested at least once every 5 years in accordance with NFPA 25.
- Review documentation of annual fire hose inspection and when it was last pressure tested or replaced.
- Review the documentation from the local or state authority having jurisdiction (AHJ) granting permission to remove occupant-use fire hoses from the facility.

<table>
<thead>
<tr>
<th>SCORE</th>
<th>1 = Compliant</th>
<th>2 = Not Compliant</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD / ELEMENT</td>
<td>EXPLANATION</td>
<td>SCORING PROCEDURE</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------</td>
<td>-------------------</td>
<td></td>
</tr>
</tbody>
</table>
| 13.03.08 Water-Based Fire Department Connections. | The hospital must inspect the Fire Department Connections (also called Siamese connections) once per quarter. It is important to point out that this standard includes those connections where a fire department would hook-up and pump water into the buildings. | **DOCUMENTATION**
- Review documentation to ensure fire department connections are inspected at least once per quarter in accordance with NFPA 25, 2011 edition.
- Review documentation of quarterly fire department connections.
- Physically observe Fire Department Connections to determine they are not obscured and they are visible from the street.

Fire Department Connections must be properly maintained for immediate use, and not be obstructed by vehicles, vegetation or anything else preventing its view from the street. | 13.03.09 Portable Fire Extinguishers- Installation, Inspection and Maintenance. | Portable fire extinguishers are not permitted to sit on the floor, but are required to be mounted on brackets or placed in cabinets, at least four (4) inches above the floor and no higher than 60 inches above the floor. | **DOCUMENTATION AND OBSERVATION**
- Review monthly inspection documentation for portable fire extinguisher during building tour.
- During the building tour, observe the extinguisher installation to ensure it is at least four (4) inches above the floor and the handle is no more than 60 inches above the floor.

Fire extinguishers shall be inspected monthly and maintained annually. | The results of all inspection activities are documented. | The results of all inspection and maintenance activities are documented. | 1 = Compliant
2 = Not Compliant
N/A

Comment:
The travel distance required to get to a fire extinguisher is based on the level of the hazard and the capacity and type of the extinguisher, as identified in NFPA 10.

The monthly inspection documentation must identify the date (month/day/year) and signature (or initials) of individual performing the inspection. Electronic documentation is acceptable provided it contains all required data and is retrievable at the time of survey.

### 13.03.10 Fire Hose Valves

All fire hose valves must be inspected quarterly.

Class I and Class III standpipe hose valves (2½ inch hose valves) must be tested annually.

Hose valves on hose stations attached to sprinkler systems, and Class II standpipe hose valves (1½ inch hose valves) must be tested once every 3-years.

Inspections and tests are documented.

If so equipped, fire hose valves must be inspected on a quarterly basis. The inspection ensures the following:

- Hose caps are in place and not damaged.
- Hose threads are not damaged.
- Valve handles are present and not damaged.
- Gaskets are inspected for damage or deterioration.
- Hose valves are not leaking.
- Ensure there are no obstructions to hose valves.
- If required, ensure restricting devices are present.

### DOCUMENTATION AND OBSERVATION

- Review quarterly inspection documentation to ensure all fire hose valves are inventoried and their location is documented and whether they passed or failed their inspection.
- Review annual test of 2½ hose valves and 3-year test of Class II and 1½ hose valves to ensure the valve was opened.
- Check test and inspection records to determine if any damaged equipment or failed test/inspection was followed up with appropriate repairs.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I and Class III (2½ inch) hose valves must be tested annually by opening and closing the valve. NOTE: Full flow of water is not required.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class II and 1½ inch hose valves must be tested once every 3 years by opening and closing the valve. NOTE: Full flow of water is not required.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**13.03.11 Internal Inspection of Piping**  
An internal inspection of water-based fire protection system piping and branch line conditions must be conducted once every 5 years.

- The internal inspection must be conducted by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign material.
- Tubercules or slime, if found, must be tested for indications of Microbiological Influenced Corrosion (MIC).
- Non-metallic pipe is not required to be inspected internally.

**DOCUMENTATION AND OBSERVATION**

- Review inspection documentation to ensure the internal inspection was conducted on the sprinkler piping.
- If slime was found, check the documentation for the testing of MIC.
- If MIC was determined to be present, check the documentation of corrective actions to eliminate MIC.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>These inspections and maintenance activities are documented.</td>
<td>The following items need to be verified:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where cooking hoods are protected in accordance with NFPA 96, <em>Standard</em></td>
<td>• The extinguishing system is in its proper location.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The manual actuators are unobstructed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The tamper indicators and seals are intact.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DOCUMENTATION AND OBSERVATION**

- Review the documentation for the monthly inspection to verify all requirements were met.
- Review the documentation for the semi-annual maintenance to ensure all requirements are met.
- During the building tour, ensure that kitchens are separated from corridor by
**for Ventilation Control and Fire Protection of Commercial Cooking Operations**, 2011 edition, cooking equipment will not cause the room or space housing the cooking equipment to be classified as a hazardous area.

- The maintenance tag or certificate is in place.
- No obvious physical damage or condition exists that might prevent operation.
- The pressure gauge(s), if provided, shall be inspected physically or electronically to ensure it is in the operable range.
- The nozzle blowoff caps, where provided, are intact and undamaged.
- Neither the protected equipment nor the hazard has not been replaced, modified, or relocated.

At least semiannually, maintenance shall be conducted on all cooking hood fire suppression systems in accordance with the manufacturer’s listed installation and maintenance manual.

Maintenance shall include the following:
- A check to see that the hazard has not changed
- An examination of all detectors, the expellant gas container(s), the agent container(s), releasing devices, piping, hose assemblies, nozzles, signals, all auxiliary equipment, and the liquid level of all non-pressurized wet chemical containers
- Verification that the agent distribution piping is not obstructed
- During the building tour, examine the kitchen storage rooms to determine compliance with hazardous area requirements.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Kitchens that have cooking hoods that are equipped with listed, approved fire suppression systems will allow the kitchen to not be considered a hazardous area, even though the kitchen contains heat producing appliances. However, storage rooms greater than 50 square feet containing combustible supplies are still considered hazardous areas and must be protected as such.</td>
</tr>
<tr>
<td>STANDARD / ELEMENT</td>
<td>EXPLANATION</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Fire Safety Systems.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>13.04.01 Fire Rated Barriers.</strong></td>
<td>The hospital shall assure that fire rated barriers are properly rated, appropriate for their purpose, be free from unsealed penetrations, and have the appropriate fire-rated opening protectives.</td>
</tr>
<tr>
<td></td>
<td>Not all fire rated barriers are rated the same.</td>
</tr>
<tr>
<td></td>
<td>Opening protectives are fire rated door assemblies and fire dampers. Not all fire rated barriers are required to have fire dampers.</td>
</tr>
<tr>
<td></td>
<td>Fire rated barriers are permitted to be combined with smoke compartment barriers, provided all the requirements from each barrier are implemented.</td>
</tr>
<tr>
<td><strong>13.04.02 Smoke Barriers.</strong></td>
<td>The hospital shall assure that smoke compartments are separated by smoke barrier walls, and are properly rated; properly constructed for their purpose; be free from unsealed penetrations, and have the required opening protectives.</td>
</tr>
<tr>
<td></td>
<td>The 2012 edition of the Life Safety Code specifies where barriers for smoke compartments are required.</td>
</tr>
<tr>
<td></td>
<td>Opening protectives are smoke barrier door assemblies and smoke dampers. Not all smoke barriers are required to have smoke dampers. Smoke barrier doors are not required to be fire-rated or positive latching, however they must self-close.</td>
</tr>
<tr>
<td></td>
<td>Although smoke barrier walls are required to have a fire rating, they are not fire rated barriers. If the smoke barrier does have fire-rated doors, then the fire rated door assemblies must be maintained properly, including self-closing and positive latching.</td>
</tr>
<tr>
<td></td>
<td>Smoke compartment barriers are permitted to be combined with fire rated barriers, provided all the requirements from each barrier are implemented.</td>
</tr>
</tbody>
</table>
Fire and smoke dampers must be fully tested and operated one (1) year after installation and once every six (6) years thereafter in all healthcare facilities classified as hospitals.

In healthcare facilities not classified as hospitals, fire and smoke dampers must be fully tested and operated one (1) year after installation, and once every four (4) years thereafter.

The results of all inspection activities are documented.

Fire dampers are required to be installed, maintained and tested in accordance with NFPA 80 Standard for Fire Doors and Other Opening Protectives (2010 edition) and smoke dampers are required to be installed, maintained and tested in accordance with NFPA 105 Standard for Smoke Door Assemblies and Other Opening Protectives (2010 edition).

Dampers installed in the facility must be documented identifying the following:
- Type of damper
- Location of damper (i.e. Building, Floor, Unit, Room, Area, etc.)
- Orientation of damper (i.e. Horizontal or Vertical)
- Date of installation (if known)
- Last test date and results (Pass/Fail)

NOTE: There are no provisions in the NFPA codes or standards that permit inaccessible dampers to remain inaccessible and untested.

Documentation and observation:
- Documentation demonstrating compliance with NFPA 80 (2010 edition) and NFPA 105 (2010 edition) must be maintained for a minimum of six (6) years.
- Verify that each fire and smoke damper is documented, and identified as to its location, and whether or not the damper passed or failed its test.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>13.04.04</strong> <em>Overhead Rolling / Horizontal Sliding Fire Doors.</em></td>
<td>This standard does not require hospitals to have overhead rolling or horizontal sliding fire doors, but if they do, the doors must be installed, maintained and tested in accordance with NFPA 80 <em>Standard for Fire Doors and Fire Windows</em> (2010 edition) to ensure proper operation. The test of the fire door assembly must be initiated by all devices associated with the control of the door, such as smoke detector and interface, thermal link, etc. Overhead rolling and horizontal sliding fire doors must be tested annually.</td>
<td><strong>DOCUMENTATION AND OBSERVATION</strong>&lt;br&gt;- Documentation demonstrating compliance with NFPA 80 (2010 edition) must be maintained for a minimum of three (3) years. 1 = Compliant 2 = Not Compliant N/A&lt;br&gt;- Verify that each overhead rolling or horizontal sliding fire door was tested at least annually, and that the test was initiated by the safety device which controls the door.</td>
<td></td>
</tr>
</tbody>
</table>

| **13.04.05** *Construction Type.* | Construction Type is determined by the number of stories in the building, as defined in sections 18/19.1.6, of the 2012 Life Safety Code. Construction type must be identified in accordance with NFPA 220, 2012 edition. Construction Type must be correctly identified in the HFAP Facility Demographic Report, using NFPA 220 nomenclature. Floor assemblies are designed and maintained in accordance with the required fire resistive rating for the facility’s Construction Type. | **BUILDING TOUR**<br>- Examine the Facility Demographic Report to find the facility’s Construction Type. 1 = Compliant 2 = Not Compliant<br>- During building tour, observe number of stories and sprinkler installation to determine if the Construction Type listed is correct. 1 = Compliant 2 = Not Compliant<br>- During the building tour, observe the fire-proofing material applied to the structural steel to ensure it is installed and maintained correctly. |  |
13.04.06  Separated Occupancies.
When different occupancies are claimed to be separated in the facility, 2-hour fire rated barriers separate healthcare occupancies from all other occupancies, and 1-hour fire rated barriers separate non-healthcare occupancies.

If the organization claims to have separated occupancies in the same building as the healthcare occupancy, then 2-hour fire rated barriers must separate the occupancies.

Note that a 2-hour fire rated floor assembly does not qualify as an appropriate barrier for occupancy separation, but does not qualify as an appropriate building (i.e., construction type) separation.

13.04.07  Fire Rated Door Assemblies.

All fire rated doors assemblies, whether they are located in a fire rated barrier or not, must be tested and inspected on an annual basis according to NFPA 80, 2010 edition.

The test and inspection is documented.

Doors in fire rated door assemblies must have a legible label that identifies its fire rating. Frames in fire rated door assemblies must have a legible label that identifies it as a fire rated frame. Note that frames are not required to be labeled with an hourly rating, unless the assembly rating is for 3 or more hours.

Fire rated door assemblies must have self-closing devices, positive latching hardware, gaps between meeting edges of door pairs are no more than 1/8 inch, and the space between the bottom of the door and the floor is no more than 3/4 inch.

All after-market hardware installed on fire rated door assemblies must be listed for use on fire rated door assemblies.

All fire rated door assemblies throughout the facility must be inventoried, then tested and inspected on an annual basis, including those fire rated door assemblies that are not located in a fire rated barrier.

BUILDING TOUR
- During the building tour, refer to the Life Safety Drawings to identify barriers that separate occupancies.
- Examine fire rated barriers to determine if they are free from unsealed penetrations, and have appropriately-rated doors assemblies.

BUILDING TOUR
- During the building tour, examine fire door labels to ensure the door is properly rated for the fire barrier designation. If the label is not legible, then the door is not compliant.
- Measure the gap between meeting edges of door pairs and the undercut of the door to ensure they are within limits.
- Examine after-market hardware installed on fire rated doors (astragals, coordinators, closers, etc.) to ensure they are listed for use on fire rated door assemblies.
- Review the documentation that demonstrates that each individual fire-rated door assembly is tested and inspected on an annual basis.
### HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

#### ACCREDITATION REQUIREMENTS FOR ACUTE CARE HOSPITALS

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.04.08 <strong>Hazardous Areas.</strong></td>
<td>Hazardous areas, as defined in 18/19.3.2 of the 2012 edition of the Life Safety Code, must be protected with the following:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Hazardous areas must** be identified on the organization’s Life Safety Drawings. The type of barrier for a hazardous area is dependent on whether the area is new or existing construction, and whether or not the area is sprinklered. | **BUILDING TOUR**  
- During the building tour, examine the Life Safety Drawings for hazardous areas. Once found, observe the hazardous area to determine if it meets the requirements listed. | 1 = Compliant  
2 = Not Compliant | |
| - For new construction and existing areas that are remodeled or renovated, all hazardous areas must be protected with 1-hour fire rated barriers that extend from the floor to the deck, and be equipped with ¾ hour fire rated door assemblies that self-close and positively latch. The hazardous area must be protected with automatic sprinklers. | | | |
| - For existing construction, hazardous areas must be protected with 1-hour fire rated barriers that extend from the floor to the deck and ¾ hour fire rated door assemblies that self-close and positively latch if the area is not protected with automatic sprinklers, OR be protected with non-rated smoke resistant barriers that extend from the floor to the ceiling (provided the ceiling also resists the passage of smoke) and equipped with doors that are smoke resistant and self-close if there are certain exceptions to the requirement that spaces in existing conditions that are repurposed for the storage of combustible supplies have to meet new construction requirements. Under certain conditions, the space may be able to meet hazardous area requirements for existing conditions. | | | |
| Review the list of hazardous areas found in sections 18/9.3.2 of the 2012 edition of the Life Safety Code. | **Comment:** | | |
| Refer to Chapter 43 in the 2012 Life Safety Code for details. | | | |
13.04.09 **Ceilings.**

Ceilings which are required to limit the passage of smoke, such as ceilings containing smoke or heat detectors, and sprinklers, and used in conjunction with corridors and hazardous rooms that have smoke resistant barriers, are free from cracks, holes or missing tiles. Where ceilings are expected to resist the passage of smoke, they cannot have any missing tiles, or cracks or holes. Gaps or cracks exceeding 1/8 inch constitutes non-compliance with this standard. Suspended grid and acoustical tile type of ceiling, when properly installed and maintained, can limit the passage of smoke.

**BUILDING TOUR**

- During the building tour, observe ceilings for missing tiles, cracks or holes. Especially look for missing escutcheon plates around sprinklers, and communication wires penetrating the ceiling.

13.04.10 **Corridor Walls.**

In new construction, corridor walls are permitted to be non-rated and are required to resist the passage of smoke, and are permitted to extend from the floor to the ceiling, provided the ceiling also resists the passage of smoke.

30-minute fire rated wall is defined by NFPA as 3½ inch steel studs with one layer of 5/8 inch gypsum board on one side.

In existing construction, corridor walls are required to be 30-minute fire rated, and extend from the floor to the deck, with all penetrations properly sealed in non-sprinklered smoke compartments, and door openings are not required to be fire rated.

In existing construction, corridor walls in fully sprinklered smoke compartments to determine if corridor walls extend to the deck and are free from unsealed penetrations.

**BUILDING TOUR**

- During the building tour, examine above the ceilings in corridors in non-sprinklered smoke compartments to determine if corridor walls extend to the deck and are free from unsealed penetrations.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
</table>

Compartments are permitted to be non-rated and are required to resist the passage of smoke, and are permitted to extend from the floor to the ceiling, provided the ceiling also resists the passage of smoke.
Building Services.
13.05.01 Fireplaces.
Direct-vent gas fireplaces are permitted inside smoke compartments containing patient sleeping areas, but not in patient sleeping rooms.

Direct-vent gas fireplaces are permitted inside smoke compartment containing patient sleeping areas, provided the following are met:
- All such devices are properly maintained;
- No such device is located in a patient sleeping room;
- The smoke compartment is fully protected with quick response sprinklers;
- The direct-vent fireplace is equipped with a sealed glass front with a wire mesh panel or screen;
- The controls for the direct-vent gas fireplace must be locked or located in a restricted location;
- Electrically supervised carbon monoxide detection must be provided in the room where the fireplace is located.

BUILDING TOUR AND DOCUMENT REVIEW
- During the building tour, if a fireplace is observed, determine that it is not located in a patient sleeping room.

2017 - Prepublication
Healthcare Facilities Accreditation Program (HFAP)
Accreditation Requirements for Acute Care Hospitals
### 13.05.02 Elevator Recall

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.05.02 Elevator Recall</td>
<td>All elevators, new or existing, that have a travel distance 25 feet or more above or below the level that best serves the needs of the local emergency fire response force must be equipped with elevator recall, also known as Firefighter’s Service, Phase 1. Elevator recall is designed to capture the control of the car, and return it to a previously designated floor, and open its door when a smoke detector located in the elevator lobby, elevator shaft, or elevator mechanical room is in alarm. Elevator recall is required to be tested monthly in accordance with the Life Safety Code, regardless what the Elevator Safety Code requires.</td>
<td>DOCUMENT REVIEW</td>
<td>1 = Compliant &lt;br&gt; 2 = Not Compliant &lt;br&gt; N/A</td>
</tr>
</tbody>
</table>

Elevator recall is tested and operated monthly. All results of the test are documented.

### 13.05.03 Trash & Linen Chutes

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.05.03 Trash &amp; Linen Chutes</td>
<td>All trash and linen chute inlet and discharge door assemblies are properly fire rated, are self-closing, and positive latching. Chute door assemblies have not been modified in the field. Trash chutes discharge into a collection room that is not used for any other purpose. An approved automatic sprinkler system is installed inside the chute at the top and at the lowest service level, and on alternating floors levels. Trash and linen discharge rooms are separated from the corridor and other areas with 1-hour fire rated barriers. Trash and linen chutes must be maintained with fire rated doors at each inlet and discharge opening. Field modifications to the doors are not permitted. Sprinklers inside the chutes must be inspected and maintained at the same frequency as other building sprinklers.</td>
<td>BUILDING TOUR</td>
<td>1 = Compliant &lt;br&gt; 2 = Not Compliant &lt;br&gt; N/A</td>
</tr>
</tbody>
</table>

- During the building tour, examine chute doors for field modification, such as welded repairs, after-market latching devices, and add-on locks. If any observed, then chute doors are not compliant with this standard.
- Examine sprinklers inside the chute for dust and dirt accumulation.
- Examine trash chute discharge room to determine if it used for any other purpose or storage.
- Examine trash and linen discharge room to determine if it meets the 1-hour fire separation requirement.
**LIFE SAFETY**

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
</table>
| **13.05.04 Generator Inspection.** Emergency power generators and all appurtenant components must be inspected weekly. | Routine inspection must be accomplished in accordance with NFPA 110 (2010 edition). | **INTERVIEW AND OBSERVATION**  
- Confirm generators located indoors are separated with 2-hour fire rated barriers, and no other items are stored in the room.  
- Review weekly inspection log and confirm battery electrolyte specific gravity readings or conductive readings are recorded.  
- Review annual fuel quality test to ensure it has been conducted. | □ 1 = Compliant  
□ 2 = Not Compliant |

Generators located indoors must be separated from the rest of the facility with 2-hour fire rated barriers.

Batteries used in connection with the generator shall be inspected weekly and maintained in full compliance with the manufacturers’ recommendations, and electrolyte specific gravity levels on lead-acid batteries shall be recorded.

Sealed lead-acid batteries must have an electrical conductive test performed.

Results of inspection shall be documented.

For all emergency power generators (regardless when they were installed) located inside the building, the generator must be installed within a separate room with a minimum of 2-hour fire rated barriers.

If located outside the building, the generator shall be located in an enclosure capable of resisting the entrance of snow and rain.

No other equipment except that which serves the space is permitted to be stored in these rooms.

Where sealed lead-acid batteries are utilized, electrolyte specific gravity levels are not required to be recorded; however conductance testing will be required, with the results documented.

A fuel quality test shall be performed at least annually using tests approved by ASTM standards.

A remote manual stop station must be located outside the room housing the generator, or elsewhere on the premises when the generator is located outside the building.

Comment:
13.05.05 Generator Monthly Load Test.
Emotional power generators shall be tested twelve (12) times a year with a dynamic load of at least 30% of nameplate rating, with testing intervals not less than 20 days and not more than 40 days, for a minimum of 30 minutes.

In lieu of meeting 30% nameplate rating during each monthly load test, generator may be operated to meet the manufacturers' recommended prime mover's exhaust gas temperature.

If the hospital cannot meet the 30% nameplate rating or the exhaust gas temperature for any of the monthly load tests, then a supplemental annual load test must be conducted with connected loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 90 continuous minutes. The monthly load tests must still be conducted at the appropriate intervals even if they do not meet the load requirements.

Results of tests shall be documented.

Emergency power generator sets shall be tested in accordance with NFPA 110, (2010 edition).

**DOCUMENT REVIEW**
- Request records to verify that testing is performed as required. Check monthly test dates to ensure no tests are accomplished sooner than 20 days and no later than 40 days from previous test.
- If applicable, examine annual load tests to ensure designated loads are met and test was for at least 90 continuous minutes.

1 = Compliant
2 = Not Compliant

Comment:
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
</table>
| **13.05.06 Generator 3-Year Load Test.** | Emergency power generator 3-year load test shall be tested in accordance with NFPA 110 (2010 edition). | **DOCUMENT REVIEW**  
- Request records to verify that testing is performed as required. |  
|  |  | [ ] 1 = Compliant  
[ ] 2 = Not Compliant |  
|  | Results of tests shall be documented. | **Comment:** |  
| **13.05.07 Automatic Transfer Switch Test.** | All automatic transfer switches must be tested monthly, operating the transfer switch from the standard position to the alternate position and then return to the standard position. Tests shall be in accordance with NFPA 110 (2010 edition). | **DOCUMENT REVIEW**  
- Request records to verify that testing is performed as required. |  
|  |  | [ ] 1 = Compliant  
[ ] 2 = Not Compliant |  
|  | Results of tests shall be documented. | **Comment:** |  
| **13.05.08 Medical Gas Shutoff Valves.** | Medical gas shutoff valves must be accessible and properly labeled to assist in proper routine adjustment of systems and also during emergencies. | **OBSERVATION**  
- Determine if medical gas shutoff valves are accessible and labeled.  
- Determine if medical gas shutoff valves are located in the corridor on the same story as the area served. |  
|  |  | [ ] 1 = Compliant  
[ ] 2 = Not Compliant |  
|  | Medical gas shutoff valves must be accessible from a standing position in the corridor on the floor served by the | **Comment:** |
shut-off valves, and not located behind doors or other building appurtenances.

Medical gas shutoff valves must be placed such that a wall intervenes between the valve and the outlets/inlets that it controls.

The medical gas shutoff valve must not be located in a room with a station outlet/inlet that it controls.

Access to medical gas shutoff valves must not be obstructed.

13.05.09 Utility Systems. Utility systems are properly installed and maintained to a fire-safe condition.

Utility systems must be installed and maintained to a fire-safe condition.

Access to electrical control panels must not be obstructed.

Circuits in electrical control panels must be properly labeled as to their use.

Electrical junction box covers must be properly installed.

Electrical wires and cables are not permitted to be tied to conduits.

- Determine if medical gas shutoff valves are located outside of the room with outlets/inlets that it controls.

- Determine if electrical control panels have proper clearance, and all circuits labeled.

- Determine if electrical junction boxes are properly covered.

- Determine if electrical conduits are free of attached wires and cables.

OBSERVATION

1 = Compliant

2 = Not Compliant

Comment:
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
</table>
| 13.05.10 Medical Gas Systems & Equipment: Maintenance. | Storage of compressed medical gas cylinders is limited as follows:  
- **Up to 300 cubic feet per smoke compartment is permitted to be stored outside of a designated room provided the cylinders are properly secured.**  
- **For quantities over 300 cubic feet but less than 3,000 cubic feet per smoke compartment, cylinders must be stored outside the facility or within an interior room with limited combustible construction with a door that can be secured against unauthorized entry.**  
- **Oxidizing gases must be separated from combustibles a minimum of 20 feet in non-sprinklered areas; or five (5) feet in sprinklered areas; or in an enclosed cabinet of non-combustible construction having a minimum fire protection rating of ½ hour.**  
- **For rooms containing gas manifold systems, or storage rooms of compressed gas cylinders in total quantities of 3,000 cubic feet or greater, the room must meet the following conditions:**  
  o **Walls having a minimum of 1-hour fire resistive rating;**  
  o **Door assemblies having a minimum of 1-hour fire resistive rating;**  
  o **Doors must be self-closing, positive latching and be secured;** | **OBSERVATION AND DOCUMENT REVIEW**  
- **Observe hospital’s storage areas of compressed medical gas cylinders during building tour.**  
- **Review hospital’s policy on inspection, testing and maintenance on medical gas systems, including alarm panels.**  
- **Examine testing and inspection records for evidence of routine inspections and documentation of the hospital’s monitoring and maintenance program.** | 1 = Compliant  
2 = Not Compliant |

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>o All electrical devices must be protected from physical damage, or located a minimum of 60 inches above the floor;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o If heated, must be by indirect means;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Racks and chains or other fastening devices must be present to secure all cylinders;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o A constant mechanical ventilation system with its inlet no more than 12 inches above the floor; or where natural ventilation is used in lieu of mechanical ventilation, it must consist of two louvered openings, each having a minimum free area of 72 square inches, with one located within 12 inches above the floor and the other located within 12 inches of the ceiling.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Mechanical ventilation must be at the rate of 1 cfm/5 cubic feet of designed stored gas, but no less than 50 cfm and no more than 500 cfm.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Flammable liquids, gases and vapors are not permitted to be stored with oxidizing gases.

- Rooms containing gas manifold systems are not permitted to be used for any other purpose.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The gas content of medical piping systems must be readily identifiable with appropriate labeling with the name of the gas contained. Labels must appear on piping at intervals of not more than 20 feet, and at least once in each room and each story traversed by the piping system.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical gas systems, including master alarm panels and branch alarm panels must be inspected, tested and maintained according to the hospital’s policy, which is consistent with NFPA 99 (2012 edition) chapter 5. For inspection and testing frequency intervals greater than 1 year, a risk assessment must demonstrate no adverse implications based on historical evidence.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13.05.11 **Cooking Hoods Cleaning.** Kitchen cooking exhaust hoods and associated equipment are inspected and cleaned on a semi-annual basis. Kitchen cooking hoods are designed to capture airborne grease from the foods that are prepared underneath the canopies. The filters, traps, hoods, exhaust duct, and exhaust fans are required to be inspected and cleaned in accordance with NFPA 96 (2011 edition).

Fusible links must be removed and replaced with new fusible links during every semi-annual cleaning. Used fusible links must be destroyed so they cannot be used again.

**OBSERVATION**
- Review documentation to ensure the organization inspected and cleaned their cooking hood exhaust system(s) on a semi-annual basis.

1 = Compliant
2 = Not Compliant

Comment:
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.05.12 Health Care Facilities Code</td>
<td>Listed hoods containing mechanical or fire-actuated dampers, internal washing components, or other mechanically operated devices shall be inspected and tested by properly trained, qualified, and certified persons every 6 months or at frequencies recommended by the manufacturer in accordance with their listings.</td>
<td>OBSERVATION</td>
<td>□ 1 = Compliant □ 2 = Not Compliant</td>
</tr>
</tbody>
</table>

**13.05.12 Health Care Facilities Code.** Except as otherwise provided in this section, the hospital must meet the applicable provision and must proceed in accordance with the Health Care Facilities Code (NFPA 99-2012 edition, and Tentative Interim Amendments TIA-12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6).

Chapters 7, 8, 12 and 13 of the adopted Health Care Facilities Code do not apply to a hospital.

If application of the Health Care Facilities Code required under this section would result in an unreasonable hardship for the hospital, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of the patients.

13.05.12.10 Health Care Facilities Code. | NFPA 99 2012 edition, has standards that apply design and operating conditions for a variety of health care mechanical systems, such as medical gas systems, electrical systems, HVAC systems, electrical equipment, gas equipment, hyperbaric facilities, and additional information useful for the operation of a healthcare facility. | INCORPORATION | □ 1 = Compliant □ 2 = Not Compliant |

NFPA 99 does apply to all health care facilities, with the exception of home care. Construction and equipment requirements referenced in NFPA 99 do apply to new construction and new equipment, unless otherwise stated in the individual chapters.

Only the altered, renovated, or modernized portion of an existing system or individual component shall be required to meet the installation and equipment requirements stated in NFPA 99.

An existing system that is not in strict compliance with NFPA 99 shall be permitted to be continued in use, unless the authority having jurisdiction (i.e. CMS, or HFAP) has determined that such use constitutes a distinct hazard to life.

- HFAP has specific standards regarding medical gas equipment, medical gas systems, utility systems, and emergency power generators that are also referenced in NFPA 99. Deficiencies with those specific systems and equipment should be scored under those explicit HFAP standards.

- Other deficiencies observed pertaining to NFPA 99 issues may be scored under this standard.

- Confirm the organization has conducted the necessary Risk Assessments on the building services listed, to determine the Category designation of the risk of that system to the patient and caregiver.

- Confirm the organization’s Safety Committee has reviewed and approved the Category designations for the listed building services.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
</tr>
</thead>
</table>
| Certain building systems in health care facilities must be designed to meet Category 1 through Category 4 requirements as detailed in Chapter 4 of NFPA 99-2012. Each system must be evaluated for its potential impact on both the patients and the caregivers if the system should fail. Based on worst-outcome scenario of a failure’s impact, the system is assigned a category. The chapter on that particular building system then describes the requirements for the selected category. The four levels of system categories as defined by Chapter 4 of NFPA 99-2012 are based on the risks to patients and caregivers in the facility. Therefore, a Risk Assessment is required for certain building systems that the organization has, based on a documented defined procedure. HFAP does not prescribe what format the Risk Assessment must follow, but NFPA 99-2012 recommends the following documents:  
- ISO/IEC 31010 *Risk Management – Risk Assessment Techniques*  
- NFPA 551 *Guide for the Evaluation of Fire Risk Assessments*  
- SEMI S10-0307E *Safety Guidelines for Risk Assessment and Risk Evaluation Process*  
- Other formal process  
The results of the Risk Assessment procedure must be documented and the records reviewed and approved by the organization’s Safety Committee. All Risk Assessments must be available for review during a survey. |  |
LIFE SAFETY

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
</table>

Only the following building systems are required to be evaluated for categories in a Risk Assessment:

- Gas & Vacuum Systems
- Electrical Systems
- HVAC Systems
- Electrical Equipment
- Gas Equipment
### Operating Features.

<table>
<thead>
<tr>
<th>Standard / Element</th>
<th>Explanation</th>
<th>Scoring Procedure</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.06.01 Decorations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Combustible decorations consist of any material that could support flame, and if they are not flame retardant, then they are not permitted unless they meet the provisions of this standard.

**Decorations**

1. They are flame-retardant or are treated with approved fire-retardant coating;


3. The decorations, such as photographs, paintings, and other art, are attached directly to the walls and ceiling (but not to the doors) in accordance with the following:
   a. The decorations do not interfere with the operation of any exit or exit access openings;
   b. The decorations do not exceed 20 percent of the wall and ceiling area inside any room or space of a smoke compartment.

**BUILDING TOUR**

- During the building tour, observe areas for combustible decorations. If hospital claims they are fire retardant, they must have documentation to demonstrate compliance.

- For combustible decorations that are attached directly to the walls and ceiling, calculate the amount of surface covered by the decorations and compare to the total surface of the wall and ceiling in that area or room.

**Comment:**

1 = Compliant

2 = Not Compliant
### LIFE SAFETY

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>compartment that is not protected throughout by automatic sprinklers;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. The decorations do not exceed 30 percent of the wall and ceiling area inside any room or space of a smoke compartment that is protected throughout by automatic sprinklers;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Decorations do not exceed 50 percent of the wall and ceiling area inside patient sleeping rooms having a capacity not exceeding four (4) persons in a smoke compartment that is protected throughout by automatic sprinklers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The decorations are photographs or paintings in such limited quantities that a hazard of fire development or spread is not present.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Exit access doors and exit doors are free from hangings, mirrors, decorations or curtains that could obscure or confuse the direction of exit.
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>13.06.02</strong> Trash Receptacles.</td>
<td>Trash receptacles and soiled linen hoppers exceeding 32 gallons capacity must be stored in an approved hazardous room.</td>
<td><strong>BUILDING TOUR</strong>&lt;br&gt;• During the building tour, observe if any trash receptacles that exceed 32 gallons are not stored in a hazardous room.&lt;br&gt;• Where multiple trash receptacles that are less than 32 gallons each are accumulated, determine if they exceed 32 gallons capacity in a given 64 square foot area.&lt;br&gt;• For containers containing clean waste or patient records awaiting destruction, confirm the capacity of the container does not exceed 96 gallons, and is labeled as meeting FM Approval 6921, or equal.</td>
</tr>
<tr>
<td><strong>Score</strong></td>
<td>2017</td>
<td>7</td>
</tr>
</tbody>
</table>

An accumulative total capacity of trash receptacles shall not exceed 32 gallons in any 64 square foot area, outside of a hazardous room.

**Containers used solely for recycling clean waste or for patient records awaiting destruction are excluded from meeting this standard provided all of the following are met:**

- Each container is limited to a maximum capacity of 96 gallons;
- Containers must be labeled and listed as meeting FM Approval standard 6921 or equal.
- Containers with capacities greater than 96 gallons must be located in a room protected as a hazardous area when not attended.

| **13.06.03** Portable Heaters. | Portable heaters with elements that exceed 212°F are not permitted inside a healthcare occupancy. | **BUILDING TOUR**<br>• During the building tour, observe under work stations, in storage rooms, and patient rooms for portable space heaters. | ![1 = Compliant](1) ![2 = Not Compliant](2) Comment: |
| Portable electric heaters with elements that do not exceed 212°F are not permitted in a smoke compartments containing patient sleeping or treatment areas. | Self-explanatory. | | |

2017 - Prepublication

Healthcare Facilities Accreditation Program (HFAP)

Accreditation Requirements for Acute Care Hospitals

13-61
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>13.06.04</strong> Life Safety Drawings.</td>
<td>Basic drawings of the facility indicating the following features are required:</td>
<td><strong>BUILDING TOUR</strong> Examine the Life Safety drawings before starting the building tour. The hospital's representatives must be able to interpret the drawings and be able to answer questions that may arise.</td>
</tr>
<tr>
<td></td>
<td>• Rated walls and barriers, including their fire rating</td>
<td>□ 1 = Compliant □ 2 = Not Compliant</td>
</tr>
<tr>
<td></td>
<td>• Exit, exit enclosure, horizontal exit, and exit discharge</td>
<td>Comment:</td>
</tr>
<tr>
<td></td>
<td>• Suite-of-rooms, their boundaries and total area</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hazardous rooms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Smoke barriers <strong>separating smoke compartments</strong>, the total area of each smoke compartment, and the farthest travel distance to the closest smoke barrier door</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The farthest travel distance to the closest exit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Areas of the facility that are and are not protected with sprinklers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Smoke partitions</td>
<td></td>
</tr>
</tbody>
</table>

Basic Life Safety Drawings are critical to the maintenance of life safety features in the hospital. Life Safety Drawings must include the basic information identified in the standard and may include additional information that is pertinent to the life safety features. However, background clutter such as column lines, furniture and cabinets are not desirable.

Hospital staff must be able to answer all questions concerning the Life Safety Drawings.

Smoke partitions are barriers that are required to resist the passage of smoke but are not necessarily required to have a fire resistive rating.

Examples where smoke partitions are located, are:

- Corridor walls and suite enclosure walls in fully sprinklered smoke compartments;
- Hazardous room barriers in existing conditions where the hazardous room is protected with sprinklers.
13.06.05 Alcohol Based Hand-Rub Dispensers.
Alcohol based hand-rub (ABHR) dispensers are permitted to be installed in exit access corridors of healthcare occupancies, and ambulatory health care occupancies.

§482.41(b)(7)

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.06.05 Alcohol Based Hand-Rub Dispensers.</td>
<td>The restrictions for ABHR dispenser in healthcare occupancy corridors, are:</td>
<td>BUILDING TOUR</td>
<td>□ 1 = Compliant □ 2 = Not Compliant</td>
</tr>
<tr>
<td>Alcohol based hand-rub (ABHR) dispensers are permitted to be installed in exit access corridors of healthcare occupancies, and ambulatory health care occupancies.</td>
<td>• The corridor must be at least 6 feet wide</td>
<td>• During the building tour, observe ABHR dispenser locations for compliance.</td>
<td>Comment:</td>
</tr>
<tr>
<td>§482.41(b)(7)</td>
<td>• Maximum dispenser quantity is 1.2 liters in rooms, corridors and areas open to corridors</td>
<td>• Ask facility representative if they know if they have no more than 10 gallons of ABHR solution in dispensers per smoke compartment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Maximum dispenser quantity is 2.0 liters in suites of rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ABHR dispensers must be separated by at least 4 feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No more than 10 gallons aggregate total of ABHR solution in use per smoke compartment. <strong>NOTE:</strong> One ABHR dispenser per room or suite is not included in the aggregate total quantity per smoke compartment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No more than five (5) gallons of ABHR solution per smoke compartment is allowed to be stored outside of a cabinet which meets NFPA 30</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ABHR dispensers shall not be installed over or within one (1) inch (side-to-side) to an ignition source</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• In corridors of at least six (6) feet in width,</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### LIFE SAFETY

<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
<th>SCORING PROCEDURE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>maximum corridor projection is four (4) inches.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.06.06 Not Applicable.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.07.01 Not Applicable.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.07.02 Not Applicable.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CMS Resources:**

482.41(e) 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 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](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.


(ii) 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.
(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.
(x) TIA 12-3 to NFPA 101, issued October 22, 2013.
(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.