

Healthcare Interpretations Task Force – Interpretations Issued
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1. Fire damper testing exemption

Background Information: Effective 1993, NFPA 90A requires maintenance of fire and smoke dampers, once every 4 years. In conducting these tests and maintenance several fire dampers were discovered totally inaccessible due to added utilities.

Question: Is it acceptable to exempt a fire damper from the four-year maintenance and test requirement where the physical limitations cause the damper to be inaccessible?

Answer: Yes, NFPA 90A – 1999 Edition: 1-3.2 and NFPA 101(2000 ed): 4.6.3 both contain provisions to allow alternative methods to be considered. As an example of this, the HITF notes the following text that is found in the 2000 edition of NFPA 101.

4.6.3 Modification of Requirements for Existing Buildings. Where it is evident that a reasonable degree of safety is provided, the requirements for existing buildings shall be permitted to be modified if their application would be impractical in the judgment of the authority having jurisdiction.

Interpretation from May 16, 2000 HITF Meeting

2. Locking doors in the means of egress of health care facilities

Background Information: Prior to the 1988 edition of the *Life Safety Code*, the code only permitted doors in the required means of egress of a health care facility to be locked with time delay type locks or in mental health facilities with keys. The more recent editions of the code now refer to the clinical needs of the patient and do not limit key locking to just mental health facilities.

For example, today's nursing homes have Alzheimer's units or wings. Alzheimer's is not a mental health condition and was not identified prior to the mid 1980's other than through vague terminology such as "senility" or "dementia".

AHJ's using editions of the *Life Safety Code* prior to 1988 are not permitting nursing homes to lock Alzheimer's units other than with time delay locks (special locks) because they are not mental health facilities. Time delay locks are totally inadequate for Alzheimer's patients. Alzheimer's patients have no idea that their pressing on the panic bar is the cause for the alarm and the locks eventually open without staff interceding. The constant alarming only causes the staff to disconnect the systems.

QUESTION: Was it the intent of the Life Safety Code prior to the 1988 Edition to permit doors in the means of egress of health care facilities to be locked where the clinical needs of the patients required specialized security, provided staff can unlock the doors at all times?

ANSWER: YES. Locking of these doors is acceptable provided: The clinical needs of the patients require specialized security measures for their safety; and Staff can readily unlock such doors at all times.

Interpretation from September 10, 1998 HITF Meeting

3. Undercut of non-rated corridor doors

QUESTION:

Is it the intent of 12-3.6.2.1 and 13-3.6.3.1 to require conformance with NFPA 80, *Fire Doors and Windows* for non-rated corridor doors?

Would a non-rated corridor door, provided with an average 1 inch undercut, be an acceptable arrangement?

NOTE: While this interpretation is rendered based upon the 1997 edition of the Life Safety Code – NFPA 101, it should be noted that this interpretation is also applicable to the 1985, 1981, 1973 and 1967 editions of the code.

ANSWER: NO and YES

Interpretation from September 10, 1998 HITF Meeting

4. Fire Watch – use of normal clinical staff

QUESTION: Can the normal clinical staff in an area affected by a fire alarm impairment or a sprinkler system impairment be used to satisfy the requirements for a fire watch? (NFPA 101, 1997 Edition)

ANSWER: YES. Clinical staff may fulfill this role provided, as determined by the authority having jurisdiction, there is an adequate staffing level to continuously patrol the affected area and that they have the means to make proper notification to other occupants in the event of a fire.

Interpretation from September 10, 1998 HITF Meeting

5. Fire Drills – are 50% required to be unannounced?

Interpretation 98-4 NFPA 101, 1997 Edition¹. Section 1-7.5

Background Information:

This section of the Life Safety Code does not specifically address what percentage, if any, of fire drills must be announced or unannounced. This section expects fire drills to be held at both expected and unexpected times but does not specifically require more unannounced drills than announced fire drills. Recently, JCAHO stated that at least 50% of the fire drills must be unannounced although this requirement is not part of their EC standards. (See Healthcare Fire Protection Newsletter, October 1998, Volume 4, No. 10, page 11 as quoted by Janet McIntyre, spokesperson for the JCAHO). This is their interpretation of section 1-7.5.

Question:

Does Section 1-7.5 require that 50% or more of the fire drills conducted be of the unannounced type?

Answer:

NO. Each authority having jurisdiction may establish a percentage of unannounced drills as appropriate for the circumstances. For example, JCAHO has recently indicated that at least half of the fire exit drills should be conducted as unannounced drills. Regardless of this, no drill should ever jeopardize the welfare of the patient receiving care.

Interpretation from November 17, 1998 HITF Meeting

6. Charting areas open to the corridor

Interpretation 98-5 NFPA 101, 1997 Edition. Section 12-3.6.1/13-3.6.1

Background Information:

In many health care settings, charting areas for use by nurses are provided in corridors. These spaces are open to the corridor and are not enclosed. They are in addition to and often not visible from nursing stations. They range in size from a small desk in an alcove to large rooms and sometimes have several racks/shelves of paper records and/or x-ray film. Generally, they are not occupied at all times. Sections 12/13-3.6.1 requires corridors to be separated from all other areas but allows several exceptions such as nursing stations to be open to the corridor. The 1997 edition of the Life Safety Code Handbook states in the explanatory commentary that..."Areas used for charting and communications by doctors and nurses are permitted to be open to the corridor." Some AHJs are confused whether this statement in the LSC HB is universally applied.

Question:

Is it acceptable to have charting areas that are not part of a nursing station open to a corridor in a health care occupancy in accordance with 12/13-3.6.1, Exception No. 3?

Answer:

NO. However, if such spaces can be protected using any of the options in:

101: 12-3.6.1, Exception No. 1; or

101: 13-3.6.1, Exception No. 1; or

101: 13-3.6.1, Exception No. 6

¹ NOTE: While this interpretation is rendered based upon the 1997 edition of the Life Safety Code, it should be noted that this interpretation is also applicable to the 1994 Edition of the code.

such spaces can be open to the corridor.

Interpretation from November 17, 1998 HITF Meeting

7. Positive latching requirements for corridor doors to hazardous areas

Interpretation 98-6 NFPA 101, 1997 Edition. Section 13-3.6.3.2

Background Information :

Some AHJs require that doors to hazardous areas off of a corridor in existing health care occupancies be provided with positive latching. Section 13-3.6.3.2 of the Life Safety Code requires doors to be provided with means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. It does not state that latching is specifically required. The means used must be capable of keeping the door fully closed if a force of 5 lbf is applied at the latch edge of the door. The appendix note to 13-3.6.3.2 states that a number of options exist for patient sleeping room doors such as ...”Doors protecting openings to patient sleeping rooms or treatment rooms, or spaces having a similar combustible loading might be held closed using a closer exerting a minimum closing force of 5 lbf on the door latch stile.” Although the appendix note does not address doors to hazardous areas off corridors, some AHJs permit a self-closing device to serve as the means for keeping the door closed. For sprinkler protected hazardous areas in existing health care occupancies, Section 13-3.2.1 requires doors be equipped with self or automatic closers.

Question:

Is positive latching required for corridor doors to hazardous areas that are sprinkler protected in existing health care occupancies?

Answer:

NO. Provided that a self-closing or automatic closing device is installed on the door and that such device can meet the 5 pounds (force) criteria of 101: 13-3.6.3.2.

Interpretation from November 17, 1998 HITF Meeting

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38. Two exit signs visible in an exit corridor

4Interpretation 98-7 NFPA 101, 1997 Edition. Section 5-10.1.4

Background Information :

Section 5-10.1.4 requires that access to exits be marked by approved readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. It further states that sign placement shall be such that no point in the exit access corridor is more than 100 feet from the nearest sign, with an exception for existing buildings. Some AHJ’s interpret this to require two exit signs to be visible from any location in an exit access corridor, even in existing buildings.

Question:

Must two exit signs always be visible from any location in an exit access corridor per Section 5-10.1.4?

Answer:

NO

Interpretation from November 17, 1998 HITF Meeting

9. Floor plans showing evacuation routes

NFPA 101, 1985 and Subsequent Editions.

Background Information: Many Authorities having Jurisdiction (AHJ’s) require floor plans showing evacuation routes to be posted on each floor of a healthcare facility. The AHJ’s often cite Sections 31-4.1.1 and 31-4.2.2 of the 1985 edition of NFPA 101 and similar sections in other editions of the Life Safety Code. For example, HCFA’s Fire Safety Report for the 1985 Code in K48 states “ A simple floor plan showing the evacuation routes is posted in prominent locations on all floors. 31-4.1.1, 31-4.2.2”; however, the referenced Code section does not specifically require these evacuation plans.

Question: Does the Life Safety Code require that floor plans showing evacuation routes be posted on all or any floors of a healthcare facility?

Answer: NO

Interpretation from November 16, 1999 HITF Meeting

10. Fire watch in unoccupied areas under construction

NFPA 101, 1997 Edition; Sections 7-6.1.8 and 7-7.6

Background Information: None

Question 1 : Is it the intent that the referenced code sections require a fire watch in unoccupied areas of a healthcare occupancy under construction for the duration of the shutdown?

Answer 1: **YES**

Question 2 : If the answer to question 1 is yes, is the fire watch requirement applicable 24 hours a day for the duration of the shutdown?

Answer 2: **YES**

Interpretation from November 16, 1999 HITF Meeting

11. Marking the location of portable fire extinguishers

NFPA 10, 1998 Edition; Section 1-6.2

Background Information: Some AHJ's (inspectors) require signs marking the location of portable fire extinguishers to be mounted perpendicular to the wall in which the extinguisher cabinet is mounted. They also require this same type of signage when extinguishers are surface mounted on a wall.

The referenced code section requires only that "extinguishers mounted in cabinets or wall recesses...be marked conspicuously."

Question 1 : Is it the intent of NFPA10 to require signs marking the location of wall mounted portable fire extinguishers when not in cabinets or recesses?

Answer 1: **NO**

Question 2 : Where signs are installed to meet the marking requirements of the referenced code, must they be mounted perpendicular to the wall in which the extinguisher cabinet is mounted?

Answer 2: **NO**

Question 3 : If the answer to question 2 is no, does a conspicuous sign, including those mounted parallel to the wall, meet the intent of this section?

Answer 3: **YES.** NFPA 10, Section D-2-2.2 provides guidance to support this position.

Interpretation from November 17, 1998 HITF Meeting

12. Linen chutes – four foot extension

NFPA 101, 1997 Edition; Section 13-5.4.1; NFPA 82, 1994 Edition; Section 3-2.2.4.

Background: One state agency has been mandating the four foot extension on linen chutes that is required in NFPA 82, Section 3-2.2.4, be provided for existing chutes. NFPA 101, Section 13-5.4.1 requires compliance with NFPA 82 for any new chutes that may be installed in existing healthcare facilities.

Question: Is it the intent of NFPA 101, Section 13-5.4.1 to require existing chutes, that are not otherwise being altered or replaced, to comply with the four foot extension rule that is contained in NFPA 82, Section 3-2.2.4?

Answer: **NO.** The language of NFPA 101 is very clear that it only requires compliance with NFPA 82 (via the reference to NFPA 101, Section 7-5) for new chutes. In addition, NFPA 82, Sections 1-3.1 and 1-3.2 apply the standard to new construction and allows existing chutes to remain without be altered. NFPA 101, Sections 1-3.4, 1-3.8 and 7-5.2, exception, support this conclusion as does the general statement (specifically the last sentence) contained in NFPA 101, Section 33-1. This last statement describes the intended use of the referenced documents contained in NFPA 101.

Interpretation from November 17, 1998 HITF Meeting

13. Sprinkler/Wardrobe Issue

This item had been discussed at previous meetings, yet no formal action had ever been requested. NFPA received three letters that asked if the HITF could take a look at these items and, if appropriate, provide an interpretation. A written response from HCFA was passed out. In all three cases, since it appeared that the basis for these questions centered on HCFA enforcement of the rule, a detailed and thoughtful response from HCFA was prepared. Two primary issues were raised, the first one being that individuals should contact the regional HCFA inspectors if they are unclear on the HCFA policy on this issue. Number 2, HCFA does have a detailed policy and fix for the need, or lack of need, for sprinklers in select wardrobe units. This policy has been widely distributed to HCFA inspectors and has been used on countless occasions to remedy the sprinkler/wardrobe problem. The HITF believe that the current HCFA policy addresses this issue. If individuals believe that NFPA 13, *Standard for the Installation of Sprinkler Systems* should be changed or modified to further address this issue, then it is appropriate for proposals to be submitted for the next revision cycle of NFPA 13. In addition, it is noted that the 2000 edition of NFPA 101: 3.3.33 now defines contents and furnishings. This should help to separate furniture objects from building objects in terms of automatic sprinkler coverage. NFPA will send a response to this effect to the individuals who have raised this issue and refer them to HCFA Interpretative Guide of 30 August 1993.

Interpretation from May 16, 2000 HITF Meeting

14. Inspection of Inaccessible Fire Dampers:

This item as submitted by the Department of Veterans Affairs. NFPA 90A provides a requirement for periodic inspection of fire dampers. In some cases, modifications to building system equipment and components result in access to certain dampers being physically impossible. While any code or standard can not contemplate all future modifications or changes to a building or structure that may alter access to select equipment or component parts, both NFPA 90a as well as NFPA 101 contain language that allow these unique circumstances to be considered on a case by case basis. Based on this discussion, the HITF voting members agreed with a 4-0 vote to issue the following interpretation:

Document to be interpreted: NFPA 90A, section 3-4.7

Edition: Year : 99

Background Information: Effective 1993, NFPA 90A requires maintenance of fire and smoke dampers, once every 4 years. In conducting these tests and maintenance several fire dampers were discovered totally inaccessible due to added utilities.

Question: Is it acceptable to exempt a fire damper from the four-year maintenance and test requirement where the physical limitations cause the damper to be inaccessible?

Answer: Yes, NFPA 90A: 1-3.2 and NFPA 101(2000 ed): 4.6.3 both contain provisions to allow alternative methods to be considered. As an example of this, the HITF notes the following text that is found in the 2000 edition of NFPA 101.

4.6.3 Modification of Requirements for Existing Buildings. Where it is evident that a reasonable degree of safety is provided, the requirements for existing buildings shall be permitted to be modified if their application would be impractical in the judgment of the authority having jurisdiction.

Interpretation from May 16, 2000 HITF Meeting

15. Non-required dampers – abandon in place

Document to be interpreted: NFPA101, Section 1-3.13.2

Edition Year: 1997

Background Information: Section 1-3.13.2 of the 1997 Code states that existing life safety features, such as, but not limited to, automatic sprinkler, fire alarm, and standpipe systems, and horizontal exits, if not required by the code, either shall be maintained or removed. Section

4.6.12.2 of the 2000 Code now refers to existing life features 'obvious to the public', if not required by the Code, shall be either maintained or removed.

Question: Must non-required smoke dampers, fire dampers, or combination fire/smoke dampers, that are not obvious to the public, be maintained or removed?

Answer: **NO.**

Interpretation from November 14, 2000 HITF Meeting

16. Patient provided upholstered furniture or mattresses

Document to be interpreted: NFPA101, Section 19.7.5

Edition Year: 2000

Background Information: With the increased use of the 2000 edition of the Life Safety Code we are seeing different interpretations of the Exceptions to Sections 19.7.5.2 and 19.7.5.3 of the 2000 edition. As background, these exceptions were added to the Code in the 1997 edition because Medicare/Medicaid Regulations require nursing homes to allow patients to bring in their own furniture and mattresses to allow for as much of a residential environment as possible. With out these exceptions, the Regulations would be in conflict with the Life Safety Code in nonsprinklered facilities, thus the additional requirement for the smoke detector.

Many AHJ's are interpreting that the smoke detector is required even in sprinklered buildings, which we disagree. Admittedly the language in the exceptions might be better if it stated the exception only applies to nonsprinklered rooms, but it doesn't need to state that.

The appropriate Sections in Chapter 10 clearly state that upholstered furniture and mattresses are not required to be regulated if they are located in rooms or spaces protected by sprinklers. Likewise if you look at the requirements for new health care occupancies you will note there are no requirements for furniture or mattresses provided by the patient. The reason being that sprinklers are mandated in new health care facilities.

In existing sprinklered buildings it would make no sense that if the facility provided unregulated mattresses or furniture there would be no requirement for the smoke detector, but if the patient provided the mattresses or furniture there would be a requirement for the smoke detector.

Question: Is a smoke detector required to be installed in a patient sleeping room protected by an approved automatic sprinkler system when either upholstered furniture or mattresses are provided by the patient per the Exceptions to Sections 19.7.5.2 and 19.7.5.3?

Answer: **NO.** The provisions of 19.7.5.2 and 19.7.5.3 intend to refer to the criteria of Chapter 10. Sections 10.3.2, 10.3.3 and 10.3.4 do not specify or set any regulations for mattresses and upholstered furniture in existing healthcare occupancies that are protected with automatic sprinklers.

Interpretation from May 20, 2003 HITF Meeting

17. Locking of doors in a healthcare facility

Document to be interpreted: NFPA 101, Section 18- 2 and 19- 2

Edition year: 2000

Background Information: The Life Safety Code (LSC) is being interpreted and enforced through Medicare & Medicaid Regulations and State enforcing authorities in a very inconsistent manner. It is clearly understood that some states have requirements that are more restrictive and different than Section 18- 2 & 19- 2 of the LSC, but the differing interpretations are occurring in states that have no requirements for locking of doors that are more restrictive than the LSC. The differing interpretations are also coming from the Federal level where to the best of my knowledge there are no requirements other than those contained in the LSC.

The Technical Committee on Health Care Occupancies in the 1988 edition of the LSC made major changes to the Code relative to the locking of doors in health care facilities. These changes were necessary to recognize how health care services were being provided in today's facilities and the need to lock doors to prevent the very real hazard of elopement by patients.

I personally submitted the proposal to expand the permissiveness to lock doors beyond psychiatric hospitals and certain areas in acute care hospitals. My substantiation for these changes

was for the LSC to recognize the need to lock doors in nursing homes due to the significant increase in the population of Alzheimer and dementia patients. The Technical Committee wisely chose to expand my proposal and use the term "clinical needs of the patient and not restrict locking to only psychiatric facilities. The Committee also wisely chose not to "laundry list those illnesses that might require locking of doors and chose the words clinical needs." It is my understanding that the Technical Committee did not restrict the types of locks that could be used, the number of locks in a means of egress ' unless time delay locks were used, or require a minimum number of patients whose clinical needs required locking before doors could be locked.

It is clear that many AHJs are not comfortable or are opposed to the permissiveness of the newer editions of the LSC relative to the locking of doors when the clinical needs of the patient requires locking to prevent elopement or escape. With the adoption of the 2000 LSC for Medicare Medicaid, many AHJs are putting up roadblocks to try to prevent the locking of doors or to limit the number of doors that can be locked. Although not specifically a LSC issue, AHJs are even prohibiting the locking of doors using the requirement that a facility must maintain compliance with the requirements of the building code the facility was required to comply with when built, which did not permit the locking of doors. This borders on absurdity because when these older facilities were built, they did not even house patients whose clinical needs required locking to prevent elopement. Even if they did house these types of patients, the facilities weren't heavily fined for elopement by the very same agencies that restrict or prohibit the locking of doors to prevent elopement.

Psychiatric hospitals, which have a lower staff/patient ratio than acute care hospitals and nursing homes, have key locked doors for more than 100 years. When the Technical Committee changed the requirements in the Code for the locking of doors in the 1988 Edition, there were no incidents brought to their attention that the key locking of doors in psychiatric hospitals had resulted in the injury or death of patients due to a fire or other emergency incident. It would be nice and neat if the only hazard a health care facility had to face was fire, but in the real world, this is not the case. Health care facilities must be given the tools to address such hazards as elopement, infection, etc.

I am requesting the following interpretations of Sections 18- 2 and 19- 2 of the 2000 Life Safety Code:

Question #1: Is it the intent of the Code to require a minimum number of patients whose clinical needs require the locking of doors be housed in a healthcare facility in order to permit the doors to be locked? **No**

Question #2: Is it the intent of the Code that patients whose clinical needs require the locking of doors be housed in the same smoke compartment or on the same floor? **No**

Question #3: If the answer to Questions #2 is no, can the patients whose clinical needs require the locking of doors be distributed throughout the facility based on the health care program of the facility? **Yes**

Question #4: Is it the intent of the Code that the clinical needs of patients relative to the need to require doors to be locked be determined by the appropriate and qualified staff of the health care facility? **Yes**

Question #5: Is it the intent of the Code to restrict the type of locking device to time delay locks? **No**

Question #6: If the answer to Questions #5 is no, can key locks, cipher locks, magnetic locks and similar locks be used as long as they can readily be unlocked by staff present when the doors are locked? **Yes**

Question #7: Are locks, other than time delay locks, and locks used on doors for stairway re-entry, required to automatically unlock upon operation of the fire alarm system or power failure?
No

Question #8: Are the number of locked doors in the means of egress limited other than for doors using time delay locks? **No**
Interpretation from January 23, 2004 HITF Ballot

18. 18” clearance below sprinkler heads

Document to be interpreted: NFPA 13, Section 5- 13.10
Edition year: 1999

Background Information: Section 5-5.6 states that the clearance between the sprinkler deflector and the top of storage shall be 18 in. (457 mm) or greater. Section 5-13.10 provides guidance on sprinkler protection of library stacks. This guidance allows floor to ceiling bookshelves and requires sprinklers to be installed in every aisle with a distance between sprinklers along aisles not to exceed 12 ft (3.6 m).

Question: Is it acceptable to apply the principles of NFPA 13, 5-13.10 to the storage of Medical Records on fixed open bookshelves, thereby allowing the tops of the bookshelves used for this purpose to come within less than 18 inches of the horizontal plane of the sprinkler deflector with sprinklers installed in every aisle?

Answer: YES
NFPA Formal Interpretation – Effective January 23, 2002

19. Clips required for suspended-grid ceilings

Document to be interpreted: NFPA 101
Edition year: 2000

Code Language: 19.3.6.2.3* In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.3, a corridor shall be permitted to be separated from all other areas by non-fire-rated partitions and shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke.

A.19.3.6.2.3 An architectural, exposed, suspended-grid acoustical tile ceiling with penetrating items such as sprinkler piping and sprinklers; ducted HVAC supply and return-air diffusers; speakers; and recessed lighting fixtures is capable of limiting the transfer of smoke.

Question: Is it the intent of the LSC to require the architectural suspended-grid ceiling to have the acoustical ceiling tiles clipped in place or of a specific weight (e.g. one pound per square foot) to meet the requirements of paragraph 19.3.6.2.3?

Answer: NO
Interpretation from the June 7, 2005 HITF Meeting

20. Delayed egress doors unlock with the manual fire alarm

Document to be interpreted: NFPA 101
Edition: 2000

Code Language: 7.2.1.6.1 Delayed-Egress Locks.

Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an

approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.

18.2.2.2.4

Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.

Exception No. 2:* Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.

19.2.2.2.4

Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.

Exception No. 2:* Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.

Question: Do Sections 18 & 19.2.2.2.4 Exception No. 2 or Section 7.2.1.6.1 of the 2000 Life Safety Code require delayed-egress locks installed on doors in the means of egress to automatically unlock upon manual activation of the fire alarm system?

Answer: **NO**

Interpretation from the June 7, 2005 HITF Meeting

21. Top of the wall blocking to protect the cavity in corridor walls.

Document to be interpreted: NFPA 101

Edition: 2000

Background Information: Regarding barrier construction, some healthcare facilities would like to create corridor walls with open tops (drywall on two sides, no blocking to close the cavity of the smoke partition). In sprinklered buildings some healthcare facilities would like to create corridor walls that limit the transfer of smoke with drywall on two sides below the lay in ceiling, and either a) run one side to the deck above or b) stop both sides just above the ceiling, thus creating an opening on the occupied side, with no blocking to close the cavity of the corridor wall. Both of these design features could allow the products of combustion to enter the barrier cavity, compromising the integrity of the construction.

Question 1a: In a fully sprinklered new healthcare occupancy (18.3.6.2) with non-rated corridor walls is it acceptable to have the wall constructed of noncombustible material that limits the transfer of smoke on both sides up to the lay-in ceiling or extend only one side to the deck above?

Answer 1a: **BOTH** arrangements are permissible.

Question 1b: In a fully sprinklered new healthcare occupancy (18.3.6.2) with non-rated corridor walls, does a corridor wall constructed as mentioned in a) above need to be blocked at the top of the cavity to prevent products of combustion from entering the assembly?

Answer 1b: **NO.** This is not a required element.

Question 2a: In a fully sprinklered existing healthcare occupancy (19.3.6.2.1, Exceptions 1, 2 & 3) with non-rated corridor walls, is it acceptable to have the wall constructed of noncombustible material that limits the transfer of smoke on both sides up to the lay-in ceiling or extend only one side to the deck above?

Answer 2a: **BOTH** arrangements are permissible.

Question 2b: Does a corridor wall constructed as mentioned in 2a above need to be blocked at the top of the cavity to prevent products of combustion from entering the assembly?

Answer 2b: **NO.** This is not a required element.

Question 3: Are penetrations such as waste lines, electrical back boxes, recessed equipment such as charting stations that enter the corridor side of the wall, required to be wrapped or blocked to prevent smoke from entering the corridor wall cavity?

Answer 3: **NO.** There is no requirement to wrap or block such components but they must be trimmed to limit the transfer of smoke.

Interpretation No. 1 from HITF June 2006

22. Chute terminal door and collection room access door

Document to be interpreted: NFPA 82

Edition: 1999

Subject/Background: A typical design in health care is for linen and waste chutes to terminate in a collection room. NFPA 82-1999 3-2.4 addresses chute loading doors (those doors on the upper floors where staff loads the chute). NFPA 82-1999 3-2.6 requires the chute to terminate in a rated room equivalent to the rating of the chute. The terminus room is to have automatic or self closing 1 ½ hour fire doors. The drawings in the code (Figure 3-2.5.1 Gravity Chute) indicate the need for a bottom terminal door that is self-closing and fire rated, although this is not stated in the body of the text.

Question 1: 1. Are both the chute terminal door at the bottom of the chute and the collection room access door required to be automatic or self closing 1 ½ hour fire doors?

Answer 1: **YES**

Question 2: If the collection room access door is an automatic or self closing 1 ½ hour fire door, will this suffice for protecting not only the chute but the collection room? If not, what is the philosophy and code reference for requiring both of these doors?

Answer: **NO.** Protection of the chute terminus room (collection room) requires that protection be provided between the room itself and the shaft (hence the requirement for the rated chute door) and between the chute terminus room and surrounding or adjacent spaces (hence the requirement for the rated door at the opening). See NFPA 82, 1992 Edition, Sections 3-2.2.9 and 3-2.4.3 (NFPA 82, 2004 Edition, Sections 5.2.3.2 and 5.2.5.3.2).

Interpretation No. 2 from HITF June 2006

23. Fire drills

Document to be interpreted: NFPA 101

Editions: 2000 and 2006 Editions

Subject/Background: HITF addressed a very similar question in May 15, 2001 Disneyland Hotel from NFPA staff, "NFPA Request - Frequency of fire drills at SNF". It apparently concerned a State agency and drill requirements at a SNF attached to a hospital. The HITF did not make a formal interpretation and the minutes went on to say, "Unless the state regulatory agency made some determination with respect to licensing that the SNF and healthcare facility were one in the same, the drills must be completed independent of each other."

A new situation is emerging where fire alarm systems, with their amazing micro processing capabilities, are designed to limit where the alarm is sounded. These options are taken in coordination with the fire plan.

For example, a large 7-story healthcare facility is separated by 2-hour fire barriers into three buildings, Russell, Hamblet, and Stevens. Where buildings are attached and the option is taken to sound an alarm signal only in the Hamblet building, what effect would that have on the fire drill requirement? For the facility, did we just go from 12 drills per year to 36? The telephone operator still makes the Code Red announcement heard in all three buildings and selected staff respond from all three buildings according to the fire plan, to the fire area.

NFPA 101 A.19.7.1.4 states, "the purpose of a fire drill is to test and evaluate the efficiency, knowledge, and response of institutional personnel in implementing the facility fire emergency plan." . . . "Fire drills should be scheduled on a random basis to ensure the personnel in health care facilities are drilled not less than once in a 3-month period."

JCAHO EC.5.30 (2006) states, "The organization conducts fire drills regularly." EP 1. "Fire drills are conducted quarterly on all shifts in each building defined by the LSC as the following: Ambulatory Health care occupancy, Health care occupancy, Residential occupancy." EP # 5 "Staff in all areas of every building where individuals are housed or treated participate in drills to the extent called for in the facility's fire plan." EP # 7 "The effectiveness of fire response training according to the fire plan is evaluated at least annually."

Specific example # 1: A health care facility consists of two buildings that abut each other but are separated by a 2-hour fire barrier. The fire plan calls for selected staff in building A to respond to the fire zone in building B. The fire alarm system activates only in Building B and a "Code Red" announcement is transmitted to both buildings according to the fire plan.

Are a total of 12 drills per year sufficient, randomly conducted among the two buildings? I believe YES.

Specific example # 2: Given the same situation as example # 1 except the fire plan does not call for staff in "Building A" to take action for an alarm in Building B, the fire plan does NOT call for staff response from one "building" to another. The phone operator "Code Red" announcement is still transmitted to both buildings. Does the drill in building B count as a fire drill only for building B? I believe YES. Now 24 drills are required for the facility? I believe YES.

Specific example # 3: Given a situation where a medical center is divided into several distinctly separated buildings, such as a mental health campus facility consisting of nine buildings connected by tunnels. The fire plan is specific to the building in alarm with the plan stating that available personnel from the neighboring two buildings respond to assist. The fire alarm system gives an automatic voice Code Red announcement throughout all nine buildings. Would 12 drills per year be sufficient for each group of three buildings? I believe YES. Campus wide would 36 drills per year meet the Code intent, 12 drills for each group of three? I believe YES.

Question: Is it the intent of the Code that twelve drills, once per quarter per shift, be conducted according to the extent of participation called for in the fire plan regardless of the configuration of the building?

Answer: **YES.** The intent of conducting the drills is to expose staff in each building to the protocol. Drills should be initiated and rotated in different locations of each building to ensure broad participation in the drill, knowledge of the protocols to be followed and to verify that the staff members are adequately trained.

Interpretation No. 3 from HITF June 2006

24. Allowable gaps in certain corridor doors.

Document to be interpreted: NFPA 101

Edition: 2000

Subject/Background: Allowable gaps in certain corridor doors.

The following questions apply to requirements in the 2000 Life Safety Code for corridor doors other than those in required enclosures of vertical openings, exits, or hazardous areas, and other than those in smoke barriers.

Question 1: Does the Life Safety Code limit the gap between the edge of a corridor door and the door frame to 1/8-inch?

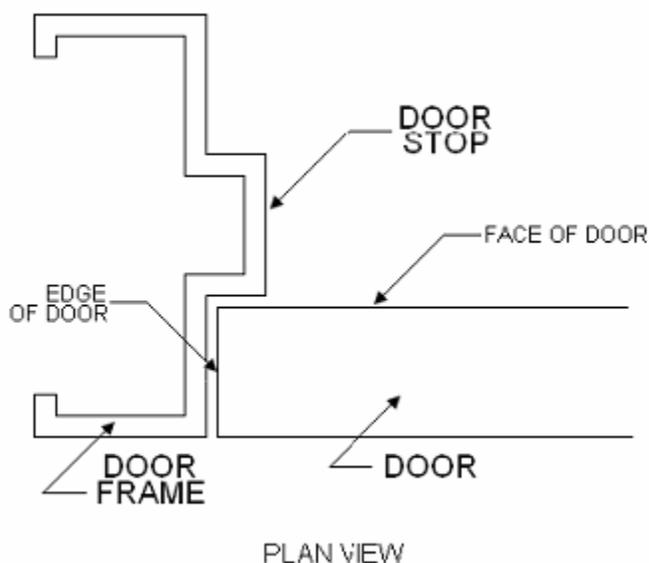
Answer 1: **NO.** However, because the door stop functions as an astragal, the gap between the edge of a corridor door and the door frame shall not be greater than the depth of the door stop.

Question 2: Does the Life Safety Code limit the gap between the face of a corridor door and the door stop to 1/8-inch?

Answer 2: **NO.** The Code does not specify a maximum gap dimension and specifically states that corridor doors are not required to comply with NFPA 80, Standard for Fire Doors and Fire Windows. The Code goes on to state that corridor doors should be relatively smoke tight. Due to the lack of specific dimensions for door gaps and the subjective language in the Code, the following guidance is deemed appropriate. In a smoke compartment that is not fully sprinklered, a gap not exceeding 1/4-inch between the face of a corridor door and the door stop should be permitted, provided that the door latch mechanism is functioning. In a smoke compartment that is fully sprinklered, a gap not exceeding 1/2-inch between the face of a corridor door and the door stop should be permitted, provided that the door latch mechanism is functioning. In a smoke compartment that is not fully sprinklered, to achieve a better fit the thickness of a 1 3/4-inch thick corridor door should be permitted to be reduced by removing not more than 1/4-inch from the face of the door. In a smoke compartment that is fully sprinklered, the Code does not impose construction requirements on a corridor door, provided that it resists the passage of smoke.

Question 3: Does the Life Safety Code limit the gap between the meeting edges of the leaves of a two-leaf corridor door to 1/8-inch?

Answer 3: **NO.** The gap is permitted to exceed 1/8-inch provided that the meeting edges of the leaves are equipped with an astragal, a rabbet, or a bevel.
HITF



Interpretation No. 1 from HITF December 2006

25. Smoking policies / Smoking areas

Document to be interpreted: NFPA 101

Edition: 2000

Subject/Background: Smoking Policies.

Many nursing homes are establishing no smoking policies. This results in both staff and patients who want to smoke to smoke outside. Life safety surveyors are now requiring that the outside smoking areas comply with Sections 18 & 19.7.4 of the 2000 *Life Safety Code*. Specifically, the surveyors are requiring that the outside smoking areas be provided with noncombustible ashtrays of safe design and that metal containers with self closing covers be readily available to each outside smoking area.

Question 1: Do the requirements of Sections 18 & 19.7.4 apply to designated smoking areas outside the building? Answer: **YES**

Question 2: If the answer to Question #1 is yes, is there a distance away from the building in which the requirements of Sections 18 & 19.7.4 would not apply?

Answer 2: **NO.**

Interpretation No. 2 from HITF December 2006

26. Staff drills

Document to be interpreted: NFPA 101

Edition: 2000

Subject/background: Staff Drills.

Life safety surveyors are now requiring that every staff member of a nursing home participate in a minimum of 4 fire drills per year and provide written documentation to verify that each staff member has participated in 4 drills. Although this may sound like a simple and reasonable requirement, not all staff members are present when their shift has a drill. Staff members may be on vacation, sick, in training outside the facility, etc. It is not practical to conduct 2 to 3 drills per quarter per shift to insure that every staff member participates in 4 drills per year. The alternative is to have staff, which missed a drill on their shift, to participate in a drill on another shift. This would require paying overtime to these staff members. It is sometimes very difficult to get staff to come in during other shifts, particularly if they have second jobs or dependent children and I haven't even looked into the union issues it might create.

Question: Does the 2000 *Life Safety Code* require in Sections 18 & 19.7.1.2 that all staff members of a health care facility participate in 4 quarterly fire drills per year?

Answer: **NO**

Interpretation No. 3 from HITF December 2006

27. Minimum corridor width within suites

Document to be interpreted: NFPA 101 (2000) 19.2.5, 19.2.3.3 exception # 2

NFPA 101 (2006) 19.2.5.6, 19.2.3.4(4)

Edition: 2000 and 2006

Background Information: Recently several surveyors have cited medical centers for not maintaining 6 and 8 feet corridor widths within suites, usually within emergency department suites.

The 2000 Code was quite clear on this issue where, under the corridor width requirements Section 19.2.3.3 had an exception stating "*Exception # 2 Exit access within a room or suite of rooms complying with the requirements of 19.2.5*". We had the understanding that corridor width requirements do not apply within a suite. We would then default to Chapter 7 Section 7.3 and 7.3.4, which specifies a minimum width of 36 inches as the general rule and allows exceptions down to 28 inches. The 2006 Code has the same requirements.

Question: Within a space meeting the requirements for a suite, do the requirements for minimum corridor width apply? Answer: **NO**

Interpretation No. 1 from HITF June 2006

28. Portable devices/equipment in corridors

Document to be interpreted: NFPA 101 (2000)

Edition: 2000

Background Information :

Healthcare occupancies are prone to having more and different types of equipment in them. While NFPA 101: Sections 18.2.3.4. and 19.2.3.4 work to address the importance of maintaining minimum corridor widths, portable devices / equipment invariably find their way into these corridor spaces. Computers on wheels (C.O.W.s) are a particular concern.

NOTE: Because the size, geometry, and combustibility of mattresses and bed furnishings can vary to a great degree, and the possibility of other items being “stored” on the mattress surface, beds should not be considered portable devices / equipment for the purposes of this interpretation.

Questions:

Q1. How long should portable devices / equipment on wheels (such as COWs, portable x-ray machines (i.e. C-arms), EKG / EEG or other diagnostic equipment or other equipment with electrical connections) located in a corridor be permitted to be inactive before they are considered to be in storage? In this context, inactive is the amount of time that passes between users accessing the equipment.

A1. Although the code does not address a specific time limit (See NFPA 101:A.18.2.3.4/A.19.2.3.4), recent interpretations by the Joint Commission and Centers for Medicare/Medicaid Services have established a time of **30 minutes** as a maximum limit on the amount of time that portable devices/equipment on wheels can be considered to be in use. The HITF agrees that this is a reasonable time frame for an AHJ to consider.

Note: This limitation should not be applied to crash carts or isolation carts.

Q2. Based on the answer to Q1, if the portable devices / equipment on wheels do not compromise the required egress width, can they be stored in the egress corridors, i.e. alcoves or spaces?

A2. YES. Alcoves or spaces being used for such purposes are not considered to be hazardous areas as defined by NFPA 101:18.3.2.1/19.3.2.1, nor should they be subject to the requirements for areas open to the corridor (See NFPA 101:18.3.6.1/19.3.6.1).

Q3. If the answer to Q2 is yes, can the portable devices / equipment on wheels be charging in these acceptable locations or while in use?

A3. YES, provided that the battery and charging systems meet the following design requirements to ensure safe operation:

- Sealed Lead-Acid Batteries:
- Absorbed Glass Mat design and
- Sealed Case (Sealed Lead-Acid)
- All Battery Systems (SLA, NiMH, Li+ Ion, Li+ Ion Polymer):
- Smart Charging system with overcharge protection and
- Shorted cell protection that shuts down upon detecting a shorted cell

HITF interpretation Number 1, December 2007

29. Cooking operations in health care facilities

Document to be interpreted: NFPA 96 (1998) 1.3.5 , NFPA 96 (2008) 1.1.4

Edition: 1998 and 2008

Background Information:

Typical to the past, the evolution of long term care facilities is ahead of the codes and standards. One real world significant change is what is referred to as the “greenhouse project”. Small (10-12 beds), long term care facilities are being built in a campus like setting. The proponents of the smaller facilities feel this provides a more residential environment for the patients and improves the program of care for patients.

As you know, the codes and standards define a health care occupancy if it has four or more beds and the requirements remain the same whether there are 4 beds or 400 beds. An example where this is problematic is that each of these small facilities has a kitchen. Only residential appliances are used in the kitchen. Kitchens may be used to cook or warm meals for patients or they may be for personal use by staff or patients. The real issue is that the cooking appliances are residential

type appliances. Most states are requiring the facilities to install commercial range hood and duct systems in compliance with the 1998 NFPA 96.

Currently, residential cooking equipment used for occupational therapy and in nourishment centers in health care facilities are generally not required to comply with NFPA 96.

Although both the 1998 and 2008 editions of NFPA 96 state that the standard applies to all cooking operations, except in single family homes, the 2008 NFPA 96 states in Section 1-1.4 the following:

Section 1-1.4 This Standard does not apply to facilities where all the following are met:

- (1) Only residential equipment is being used.
- (2) Fire extinguishers are located in all kitchen areas in accordance with *NFPA 10, Standard for Portable Fire Extinguishers*.
- (3) Facility is not assembly occupancy
- (4) The Authority Having Jurisdiction has approved the installation.

Question: Does the 1998 NFPA 96 require cooking operations in health care facilities that comply with the intent of Section 1-1.4 of the 2008 NFPA 96?

Answer:

The Authority Having Jurisdiction (AHJ) always has the option of invoking the equivalency clause contained in NFPA 96: 1-3.5 (1998 Edition). This could certainly include the AHJ reviewing and taking into account any provision contained in a more recent edition of NFPA 96 - such as the 2008 edition and the scoping limits of Section 1.1.4. While it is likely that future editions of NFPA 101 will have special requirements for these future concept nursing home designs, AHJs may have to rely on certain equivalency provisions and application of “concept” ideas until any future regulations are finalized.

HITF interpretation No. 2 December 2007

30. Previously approved emergency generators diesel drivers

Document to be interpreted: NFPA 101 (2000) 9.1.3, 19.5.1

Edition: 2000

Background Information (optional):

Many nursing homes have emergency generators that were approved and installed prior to the development of the first edition of NFPA 110 in 1985 and long before the 1998 edition of NFPA 110 became an applicable standard with the adoption of the 2000 LSC by CMS in 2003. The issue is that nursing homes are being told that they must bring their diesel engines into compliance with the 1998 edition of NFPA 110. For example, many of these older generators do not have remote annunciators or the ability to connect to an annunciator.

Question: Does the *2000 Life Safety Code* require previously approved diesel drivers to comply with the 1998 edition of NFPA 110?

Answer: No. NFPA 101: 19.5.1 does not require full compliance with NFPA 110. NFPA 101: 9.1.3 does require the testing and maintenance of the generator to be done in compliance with NFPA 110 (1998 Edition).

It is noted, however, that an Authority Having Jurisdiction does have the prerogative to require compliance with the retroactive provisions (Section 1.3 of NFPA 110) if they judge or otherwise make a determination that the system presents a distinct hazard to life.

HITF Interpretation No. 3 December 2007

31. Documentation for inspection of portable fire extinguishers

Document to be interpreted: NFPA 10 (2002) 6.2.1 NFPA 10 (2007)

Edition: 2002 and 2007

Background Information: If taken literally, the text in section 7.2.1.2 of the 2007 edition requires that inspections must be performed at an interval not less than 30 days apart. This would allow

the inspections to be performed at an interval greater than “approximately 30-day intervals” as was previously required in the 2002 edition. NFPA Committees were instructed to remove unenforceable language, such as the word “approximately.” We believe that the removal of the word “approximately” was for that reason because there was no technical justification identified for the change and the proposal did not explicitly show the word to be struck out. (see NFPA 10 ROP, 10-54A, Log #CP-4). Some AHJs are now requiring that inspection tags include the day of the month so that the 30-day interval can be measured. However, sections 7.2.4.3 and 7.2.4.5 in the 2007 edition seem to indicate that the committee intended for 12 inspections to be conducted, one per month, without requiring a 30-day interval.

Question: Is it permissible to document fire extinguisher inspections by indicating the month and year (without the day of the month)?

Answer: The dates may not necessarily be absolute. The HITF is aware that some NFPA technical committees are starting to look into their time based criteria. In addition, the Joint Commission previously developed their own guidance/tolerances on these sorts of time criteria in the February 2006 issue of EC News.

HITF Interpretation No. 1 June 2008

32. Existing fire alarm systems, maximum time delay 10 seconds

Document to be interpreted: NFPA 72 (1999) 1-2.3

Edition: 1999

Background Information: **Issue:** Facilities are being cited for deficiencies because their existing fire alarm systems do not comply with the maximum time delay of 10 seconds required after January 1, 2000. It is our position that previously approved fire alarm systems installed prior to the adoption of the 2000 Life Safety Code and 1999 NFPA 72 are not required to comply with the 10 second delay requirement after January 1, 2002. Our opinion is based the language in Section 1-2.3 of 1999 NFPA 72, Section 2-1 of 2000 NFPA 101 and good common sense.

Question: Are existing fire alarm systems approved and installed prior to the adoption of the 2000 Life Safety Code (NFPA 101) and 1999 National Fire Alarm Code (NFPA 72) required to comply with the 10 second delay requirement effective January 1, 2002?

Answer: NO. The effective date in NFPA 72 is for new installations installed after the effective date – January 1, 2002. The AHJ has the ability to invoke certain criteria from NFPA 72 on a retroactive basis (See NFPA 72: 1-2.3, 1999 Edition – Exception) if they have determined that a distinct hazard to life or property exists.

HITF Interpretation No. 2 June 2008

33. Storage rooms 50 square feet or less

Document to be interpreted: NFPA 101 (2000) 18/19.3.6

Edition: 2000

Background Information: The 2000 Life Safety Code does not classify storage rooms 50 ft² or less in area storing combustible material as a hazardous area in new health care facilities. The language for existing health care facilities is different in that for existing health care facilities, rooms or spaces 50 ft² (4.6 m²) or less in area, including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction. The difference between new and existing health care facilities is that the 50 sq. ft. rule applies to both repair shops and storage rooms in existing buildings. The 2000 Life Safety Code allows all spaces to open to the corridor, if properly protected, except for patient treatment rooms, patient sleeping rooms and hazardous areas (see Sections 18/19.3.6).

Question 1: Could a room or space 50 square feet or less and that is storing combustible material, be considered a hazardous area?

Answer 1: Yes. The presence of stored combustible materials in a room or space 50 square feet or less does not necessarily result in the room or space being classified as a hazardous area. In some circumstances, the amount and type of combustibles may result in the room or space being classified as a hazardous area by the AHJ

HITF Interpretation No. 3 June 2008

34. Operation of doors

Document to be interpreted: NFPA 101 (2000) 7.2.1.5.4, 18/19.2.2.2.2, 18/19.2.2.2.4, 18/19.2.2.2.5 NFPA 101 (2006) 7.2.1.5.9.2, 18/19.2.2.2.2, 18/19.2.2.2.4, 18/19.2.2.2.5, 18/19.2.2.2.5.2

Edition: 2000 and 2006

Background Information: Chapter 7 requires that where locks or latches are provided, the releasing mechanism shall open the door with not more than one releasing operation. However, Chapters 18 and 19 allow doors in the means of egress to be locked where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. Note that the use of a key carried by staff frequently will require two operations to open the door (one operation to unlock the door using the key and one operation to unlatch the door using the door handle, see Figure 1 below). Often times, equipment such as wander alert systems, which require multiple operations to open a door, are used based on the clinical needs of the patients. Such systems are widely accepted for use in dementia units for the safety of the patients.

Question 1: Where the provisions in Chapters 18 and 19 of the Life Safety Code permit locking of doors in the direction of egress travel based on the clinical needs of the patients, is it permitted to have more than one operation to open the door?

Answer 1: Yes. Specifically, one of the operations is to release the lock and the second operation is to release the latch to allow the door to be pulled or pushed open. 6

See Figure 1. Door Requiring Two Operations (door with key deadbolt lock)

Question 2: Special Hardware: Where the clinical needs of the patients require special hardware (releasing mechanism) to unlatch the door, is it permitted to have more than one operation to open the door?

Answer 2: Yes. It is generally understood that the restriction concerning the releasing operation does not include the opening of the door once the lock is released and the latch is released.

HITF Interpretation No. 4 June 2008

35. Section of a health care facility – classification of another occupancy

Document to be interpreted: NFPA 101(2000) 18/19.1.2.1

Edition: 2000

Background Information : Sections 18/19.1.2.1 establish provisions under which a section of a health care facility may be classified as another occupancy. We have seen these sections of the Code interpreted differently by different authorities having jurisdiction, particularly with regard to clinical laboratory areas. We would like to clarify how this provision is intended to be enforced, especially with respect to lab spaces.

Case: In an existing fully sprinklered health care building of Type II (222) construction a clinical laboratory area will be renovated. The clinical lab area will be separated from the health care occupancy by 2-hour walls and by 2-hour floor construction. There are health care occupancies located above and below the clinical labs, so the lab spaces will be sub-divided into multiple smoke compartments. The clinical labs will not serve health care occupants for purposes of housing, treatment, or customary access. Occupants of the clinical labs will have access to exits without having to enter the health care area. Likewise, health care occupants have access to multiple exits without entering the clinical labs. The clinical lab spaces will contain minimal

quantities of hazardous materials and would be classified as Class D lab units under NFPA 45. Under that standard, the labs would be allowed to be unlimited in area. They would not be classified as severe hazard spaces per Sections 18/19.3.2.2.

Question 1: Is it the intent of Sections 18/19.1.2.1 to require that the 2-hour wall run vertically through the height of the building?

Answer 1: NO

Question 2: Is it the intent of Sections 18/19.1.2.1 to preclude the clinical labs in this example from being located immediately above or below a health care occupancy?

Answer 2: NO

Question 3: May the clinical labs in this example be classified as a business use and be permitted to comply with Chapter 38 for New Business Occupancies?

Answer 3: YES

Question 4: Are the clinical labs in this example required to comply with the 10,000 square foot suite limitations of Chapter 18?

Answer 4: NO

Question 5: Other than subdivision to comply with the provisions of Section 18.3.7 are the clinical labs in this example required to comply with any other provisions of Chapter 18?

Answer 5: YES. Where any requirements in Chapter 18 apply to the whole building (e.g. building construction types, automatic sprinklers, and shared egress components).

Question 6: Would the clinical labs in this example be required to comply with NFPA 99?

Answer 6: NO. Since the labs are not a part of the healthcare occupancy.

HITF interpretation no. 1 December 2008

36. Recessed wardrobes in an alcove

Document to be interpreted: NFPA 13 (1999) 5.13.9.2 and A5.13.9.2

Edition: 1999

Background Information : We have a major AHJ who has determined that recessed wardrobes in an alcove are not “freestanding” Wardrobes per Sections 5.13.9.2 & A5.13.9.2 of the 1999 NFPA 13 and are required to have sprinklers installed inside the wardrobes. The nursing home industry has 1000’s of resident sleeping rooms with recessed wardrobes and to the best of my knowledge these wardrobes have never been cited for not having sprinklers inside the wardrobes. I suspect that many hospitals also have recessed wardrobes that do not have sprinklers inside the wardrobes. Please see the following attachments:

1. My letter to NFPA for a staff interpretation.
2. Letter from Jim Lake, NFPA staff liaison to NFPA 13 responding to my letter.
3. Pictures of a typical installation that has been cited for the lack of sprinklers.

Question: Do recessed wardrobes (attached or freestanding) in an alcove that is fully sheathed with sheetrock qualify as freestanding wardrobes per Sections 5.13.9.2 & A.5.13.9.2 of the 1999 edition of NFPA 13 and therefore are not required to be sprinklered?

Answer: YES. Provided that the sprinkler protection of the room includes the floor space of the alcove.

HITF interpretation no. 2 December 2008

37. Regulate eye washes located in the general areas of nursing homes

Document to be interpreted: NFPA 99 (1999) 10-6

Edition: 1999

Background Information: AHJ’s are using Section 10-6 of the 1999 NFPA 99 to regulate eye washes located in the general areas of nursing homes. We do not believe that Section 10-6 is intended to apply to eye washes other than in laboratories. Please Attachment “Extracts from 1999 NFPA 99.”

Question: Do the requirements of Section 10-6 of the 1999 edition of NFPA 99 apply to eye washes in health care facilities other than in laboratories?

Answer: NO.

38. Combination to key pad locks be posted at each key pad

Document to be interpreted: NFPA 101 (2000) 18.2.2.2.4; 19.2.2.2.4 – Exception No. 1

Edition: 2000

Background Information:

We are having AHJ's requiring that the combination to key pad locks be posted at each key pad so that anyone approaching the door can unlock the door. These doors are being locked for the safety of patients/ residents who have the clinical needs for the doors to be locked due to the hazard of elopement. We recognize that the Code requires staff to be present to unlock the doors anytime the doors are locked. We disagree that the Code requires that the combination to the key pads have to be posted. To post the combinations would allow the very patients/residents whose clinical needs require the doors to be lock to unlock the doors.

Question: Does the combination to a keypad that unlocks doors in the means of egress in accordance with NFPA 101, Sections 18 & 19.2.2.2.4, Exception No. 1 have to be posted at the keypad?

Answer: NO.

HITF interpretation No. 4 December 2008

39. Exit discharge; paved, distance

Document to be interpreted: NFPA 101, 2000 edition, 19.2.7. ; 7.7.1

Edition: 2000

Background Information: Issue: Many existing health care facilities have exits that discharge to surfaces in accordance with the provisions of Chapter 19.2.7 and 7.7.1 such as grass lawns, or dirt and gravel yards. Authorities Having Jurisdiction are now determining these exits to be deficient and are requiring that all existing exits discharge to a paved hard surface sidewalk to a public way. Some of these existing health care facilities are rural and located far distances from a public way so that it would be impracticable to extend the exit discharge all the way "to a public way".

Background Information:

In Reference to Question 1, Exit Discharge Obstructions:

Many AHJs are using paragraph 7.1.10 to not accept a discharge of grass, dirt or gravel because they assert that when it rains, these surfaces become wet and therefore may become an obstruction to egress. It is easy to understand how snow or ice may become a barrier to the exit discharge and must be removed, but A.7.7.1 clearly indicates many "...walking surfaces within the exit discharge are not required to be paved and often are provided by grass or similar surfaces". Still, because there is the presence of a grass lawn, the AHJs assert a wheelchair cannot be pushed through a grass lawn and require a paved surface from every exit discharge. The paving of these existing exit discharges is very costly and provides no measurable additional benefit to the safety of the patients or residents if they are properly maintained.

In Reference to Question 2, Exit Discharge Extension: Although there is no definitive distance an exit discharge must extend when there is no public way in proximity to the building, there are some paragraphs in the Annex material of Chapter 7 that may give some indication how far it should extend. The primary purpose of exterior egress route is for the occupants to be able to move to a public way or a distance *considered safe* from the building, whichever is closest. Often some AHJs use 50 ft. as a safe distance away from the building. The 50 ft. distance comes from Sections 22 & 23.2.7.1 for detention and correctional facilities. Others use 30 feet and still others 40 feet. How far does the Interpretations Task Force think a person must move away from the building to be at a distance "considered safe"?

Question 1: In a healthcare occupancy, are sidewalks required between the exit door and the public way in order to qualify as an exit discharge as stated in Section 7.7.1?

Answer 1: NO.

See NFPA 101: Annex Section A.7.7.1.

Question 2: If the answer to Question 1 is NO, when is “grass or similar surfaces” not acceptable as a means of exit discharge?

Answer 2: See NFPA 101: Annex Section A.7.7.1 that provides guidance on the appropriate conditions to utilize a non-paved surface.

HITF interpretation No.1 June 2009

40. Requirements for utility penetration protection in corridor walls and smoke barriers in existing buildings.

Document to be interpreted: NFPA 101, Sections 19.3.6.2.1, 19.3.6.2.2, A19.3.6.2.2, 18 & 19.3.7.3, 8.3.6.1 and 8.3.6.2

Edition: 2000

Background Information: Various AHJ’s are interpreting the 2000 Life Safety Code as to the requirements for the protection of penetrations of corridor walls and smoke barriers differently. Some require fire stopping materials and others require materials that are capable of maintaining smoke resistance. We believe it is the intent of the Code that utility penetrations of corridor walls and smoke barriers only require materials that resist the passage of smoke and do not require fire stopping materials. Please see Sections A19.3.6.2.2, 8.3.6.1 and 8.3.6.2

Question 1: Can utility penetrations of corridor walls in existing buildings be filled with materials that are not listed fire stop material provided that the materials resist the passage of smoke?

Answer 1: YES – Provided that the materials are limited combustible or non-combustible.

Question 2: Can utility penetrations of smoke barriers in new buildings be filled with materials that will resist the passage of smoke and need not be fire stop material?

Answer 2: NO.

New smoke barriers are required to be constructed with walls that have a rating of 1 hour thus use of a listed fire stop material/system is required.

Question 3: Can utility penetrations of smoke barriers rated less than 1 hour in existing buildings be filled with a limited combustible or non-combustible material that will resist the passage of smoke but that is not listed as a fire stop material?

Answer 3: YES – Provided that the materials are limited combustible or non-combustible.

HITF interpretation No. 2 June 2009

41. Requirements for the lighting of the exterior exit discharges.

Document to be Interpreted: NFPA 101, Sections 19.2.8, 19.2.9, 7.8.1.1, 7.9.1.1, A7.8.1.1 and A7.9.1.1

Edition: 2000

Background Information: Many AHJ’s require that the illumination and the emergency lighting of the exterior exit discharge pathway be illuminated to the public way. Many nursing homes are located in rural areas where the public way can be 100’s to 1000’s of feet away from the building. As a result, the nursing home industry has spent \$100’s of thousands of dollars to extend both normal illumination and emergency lighting to the public way. We often point out the language in Sections A7.8.1.1 and A7.9.1.1, (see below) but are told that Annex material doesn’t apply, disregarding the guidance given by the Technical Committee. Whether the language in Sections A7.8.11 and A7.9.11 should be in the body of the Code or in the Annex is clearly a subject for debate, but we do believe that it was the intent of the Technical Committee on Means of Egress that the lighting for both need only extend to the public way or area safely away from the building, whichever is closest

Question 1: If approved by the AHJ, for a healthcare facility can the exterior exit discharge, and the illumination and emergency lighting of the exterior exit discharge, extend to an area that is closer to the building than the public way if the area is a safe distance away from the building?

Answer 1: YES

HITF interpretation No. 3 June 2009

42. Whether NFPA 99 and/or NFPA 110 requires a back up on-site fuel supply when the essential electrical system fuel supply is an off-site fuel supply such as natural gas.

Document to be Interpreted: NFPA 101, NFPA 99 and NFPA 110

Edition: 101 (2000) 99 and 110 (1999)

Background Information: With in the last year or so, AHJ's have been requiring that essential electrical systems that are supplied by an off-site fuel supply, such as natural gas, install an on-site, back up fuel supply. Many of these existing emergency electrical systems have been in place for many years with no record of failure due to the interruption of the off-site fuel supply. Even with recent natural disasters, particularly in the Gulf States, we are not aware of failures of essential electrical systems due to the interruption of off-site fuel supplies. The requirement for the back up on-site fuel supply is applied to both nursing facilities with and without life support systems or equipment or whether the facilities have a Level 1, 2 or 3 essential electrical system. Some AHJ's claim that the off-site fuel supplies are unreliable, without providing any loss experience or reliability data. Other AHJ's claim that NFPA 99 and NFPA 110 requires that essential electrical systems must be located "on-site" and that includes the fuel system, even when it is clear that NFPA 110's list of approved fuels includes fuels that are normally supplied from off-site sources.

Question 1: Do all off-site fuel supplies to essential electrical systems require on-site back up fuel supplies?

Answer 1: NO.

New installations in accordance with NFPA 99, 1999 Edition only require an alternate fuel source for Level 1 or Level 2 systems if there is a high probability of interruption of the source.

Question 2: Do new nursing homes that have life support equipment require a Level 1 Emergency Power System?

Answer 2: YES.

See NFPA 99, 1999 Edition, Section 16-3.3.2.

Question 3: If the answer to Question 2 is NO, what type of essential electrical system does a nursing home require for life support?

Answer 3: N/A

HITF interpretation No. 4 June 2009

43. Patient lift equipment sprinkler obstruction

Document to be interpreted: NFPA 101, (2009) 18.3.5.1/19.3.5.1; NFPA 13, (2007)

Edition: 101-2009; 13-2007

Background Information: Sections 18/19.3.5.1 require sprinkler systems to be installed in accordance with the NFPA 13, Installation of Sprinkler Systems. NFPA 13 does not specifically address spacing of sprinklers relative to moving rails that are used for patient lift devices. Ceiling mounted patient lift equipment has been installed in fully sprinkler protected health care facilities. The patient lift equipment is typically two rails fixed to the structure mounted parallel to each other at a distance of 8 feet apart with a moving rail mounted perpendicular to the fixed rails. This rail moves along the fixed rails such that patients can be lifted and moved throughout the patient room depending on the location of the rails.

At any given time, the movable rail will be "parked" when it is not being utilized to make a patient move or when there is no patient in the room. There is no apparent section in NFPA 13 that covers sprinkler placement relative to these moving rails.

A photo of a typical installation is provided below along with an informal interpretation from NFPA staff on this issue. (Letter to and from NFPA and picture available at Webb sites)

Question 1: Is it the intent that the obstruction requirements of NFPA 13 apply to the fixed rails of the patient lifting system?

Answer: YES.

Question 2: Is it the intent that the obstruction requirements of NFPA 13 apply to the movable rail of the patient lifting system when the rail is “parked” in any position?

Answer: NO

HITF interpretation No. 5 June 2009

44. Fire alarm system out of service

Document to be interpreted: NFPA 101, (2009) Section 9.6.1.6/A.9.6.1.6

NFPA 101, (2000) Section 9.6.1.8/A.9.6.1.8

Edition: 2009 and 2000

Background Information: While the 2000 edition of the Life Safety Code provides no direction as to what is meant by “out of service”, the 2009 edition provides some guidance in the second paragraph of A.9.6.1.6.

Question 1: Does a single non-operating initiating device or a single non-operating notification appliance result in a fire alarm system being “out of service”?

Answer: NO.

Based on application of the 2009 edition of NFPA 101, a single non-operational device (initiating a notification) does not necessarily result in a system being out of service. See NFPA 101 (2009) – Section A. 9.6.1.6. Other measures, such as posting of a fire watch will have to be considered. The HITF notes that The Joint Commission, June 2009 Edition of Perspectives (See P. 3-4) contains information on actions that can be taken including interim life safety measures and conducting a fire watch when a system or portion of a system is out service.

HITF interpretation No. 6 June 2009