Healthcare 2024 ideas – 3/25/2020

Healthcare - Group A to 2024

Quesetions/Items to address in next cycle group A

- Regular wood roofs on group I-2
    - Joe Holland suggests putting the class A roof requirement in chapter 15 table.

1) Notes 3-25-2020: Fire - last cycle proposal to Chapter 6

- LOCK UPS

2) Notes 3-25-2020:General – seclusion; psychiatric; clinical-needs; assisted living/group homes; residential treatment; assembly(cafeteria)

- Mixed and separated occupies, accessory uses and non healthcare suites.
    - o What is a hospital? When I Group I-2 more stringent that other occupancies? What is an acceptable level of incidental(accessory)

3) Notes 3-25-2020:General/Fire – occupancy classification – Chapter 5 (Kermit's notes)

Clarify mechanical ventilation in Group I-1 and I-2

- o see failed M50 and M51 in 2021 cycle
- John Tacker offers assistance – suggests working with VBOA and calbo.
- Mike Moore (mmoore@newportventures.net)
- Guy Tomberlin

4) Notes 3-25-2020: MEP - range hood in apartment in assisted living? Allow recirculating hood.

- Figure out if suspended ELECTRICAL heaters are allowed in the means of egress. See M81 2021 and public comment to add heaters (NFPA and ICC)

5) Notes 3-25-2020: MEP – No for gas and electric heaters in MOE in NFPA

- Control vestibules

6) Notes 3-25-2020: MEP/General - Energy code requiring vestibule; security vestibules

- Watch for storage in corridors restrictions.

7) Notes 3-25-2020: Fire – fixed or rolling? In corridors; ask FCAC if this is on agenda; alcove storage of equipment

- Sprinklering in I-1s?

8) Notes 3-25-2020: Fire - Do you have to upgrade for existing buildings? Changing from Condition 1 to 2?

- Task group to look at retail (millennial) healthcare.

9) Notes 3-25-2020: General – occupancy question; outpatient size

- Pharmacy – hazardous – air quality – usp 797 800

10) Notes 3-25-2020: MEP

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- Centralized monitoring, telemetry, medical / digital routing storage. Do these need to be more robust?

11) Notes 3-25-2020: MEP - monitoring and data storage, Chapter 16 for hazard list

- Labs in healthcare?

12) Notes 3-25-2020: Fire – see Jeff O'Neill for information

From:
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You requested potential topics for consideration at the March ICC meeting to improve alignment between NFPA and IBC are as follows:

2012 LSC
2015 IBC

LSC 18.2.3.6 clear minimum width 41.5 inch for sleeping, diagnostic, and treatment
IBC 1010.1.1 clear minimum width 41.5 inch clear width only for bed movement
13) Notes 3-25-2020: General – see Henry for further information

LSC 3.3.272 hazardous suite definition
LSC 18.2.5.7.1.3 hazardous suite provisions
14) Notes 3-25-2020: General – see Henry for further information

LSC 18.1.1.1.10 Assumption that staff is available in all patient-occupied areas to perform fire safety functions

18.1.3.1 Classified as other occupancies

- Not intended to provide simultaneous services for four or more inpatients … housing, treatment, or customary access by inpatients incapable of self-preservation
- Separated from areas of health care occupancies by 2 hour construction

15) Notes 3-25-2020: General – see Henry for further information

LSC 18.3.5.1 Buildings containing health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7
IBC 407.6 Smoke compartments containing sleeping rooms shall be equipped throughout with an automatic fire sprinkler system in accordance with Section 903
16) Notes 3-25-2020: General – see Henry for further information

IBC s. 425.1 requires hyperbaric facilities to meet NFPA 99.

LSC s. 18.3.2.4 requires medical gas storage and administration to meet NFPA 99.
LSC s. 18.3.2.3 requires anesthetizing locations to meet NFPA 99.
17) Notes 3-25-2020: MEP – see Henry for further information; IFC 5306

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Interp question to ICC –
Re: assisted toileting and bathing. The question I am getting is regarding the length of the grab bars. Only 30" seems to be available instead of 36", so I am look for if that come from the study or not. Also, location of controls for the assisted bathing.

Info from Amy Carpenter:

There are some manufacturers that are making the longer grab bars. I know Ponte Giulio, for one, has 34" bars. I think that there is at least one manufacturer that has 36". The research said that the bars do need to extend past the front face of the toilet in order to provide the stability needed. Anecdotally, I just did a post-occupancy review of a community that had 29" bars and one resident couldn't see them well, and tried to use other means to pull himself off the toilet (ie. The sliding door handle).

Maggie's study didn't review shower controls in this particular research. However, what we know in the industry is that the controls need to be located so that a caregiver can turn them on without getting completely soaked. In addition, most elders don't use the fold-down seat mounted on the wall. Instead, they use a shower chair. They don't trust the wall-mounted seat in most cases. If they are assisted in bathing, the wall mounted seat makes it impossible for a caregiver to access all parts of a resident to clean them well. A mobile shower seat works so much better for both elder and staff. Therefore, having the controls where they can only be accessed from a wall mounted seat makes no sense. Further, we need to make sure that the controls can be turned on without having your arm/hand in the shower stream, so that the elders don't get burned and the caregiver doesn't get wet. Having the controls nearest to the entry point of the shower, or on either short wall, makes the most sense.

One point of historical note. In PA, the Dept. of Health used to require the shower controls to be completely outside the shower enclosure, in skilled nursing settings, because it kept the staff from getting wet. Now, they recognize some people might be able to independently shower, but the controls still must be as close to the dry staff position as possible.

18) Notes 3-25-2020: address in commentary for reason

RE: In the requirements for patient care suites (Section 407.4.4.5 – 7,500 sq.ft) and care suites without patients (Section 407.4.4.6 – 12,500 sq.ft.) was the intent to require 96" wide aisles (1018.5, 1020.2) to get people out of the suite? This question is coming from Jenson Hughes. The text does not really say, and JH says this is not required in the Life Safety Code.

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Please include the care suite corridor width issue in agenda for the next meeting if possible. The commentary is confusing and perhaps contradictory. It would be beneficial to know what the AHC intended.

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“vCare suites are designed to allow for a group of rooms to function as a unit in the treatment and care of patients. Suites provide flexibility in reaching an exit access. Use of suites is a particularly useful tool at intensive care units and emergency departments in patient treatment areas. Suites allow staff to have clear and unobstructed supervision of patients/care recipients in specific treatment and sleeping rooms through the elimination of corridor width or rating requirements.”

“The exception is because of an item in Table 1020.2 that requires a 96-inch-wide (2438 mm) corridor in Group I-2 facilities. In a hospital, while this is required in the area of patient sleeping rooms and patient care areas, there are a large number of areas that will not be for the movement of beds, either for patient care or for the hospital’s defend-in-place strategies.
For example, the hospital may have office or therapy areas where patients are brought in walking on their own or using wheelchairs. Many nursing homes do not move patients in beds at all. The intent of the exception is to clarify that the 96-inch (2438 mm) corridor width is not a minimum for all corridors throughout a hospital or nursing home, but only in certain areas.

19) Notes 3-25-2020: General

Discussion with Dave Yanchulis, Access Board

1/30/2020
Dave,

I need you to help me get a discussion going. The I-codes have a classification for people receiving custodial care, but not yet needing medical care - between an apartment and a nursing home. I am being told that questions going to the DOJ or Access Board are getting the response that assisted living is a licensed long term medical care (nursing home). The best information I can get is saying this is coming from Randall Duchesneau? Do you know who he is and/or how we can get a conversation going on this? IBC is asking for 10% Accessible units instead of 50% for these facilities, so this is a big deal for the industry.

Thanks,

Kimberly Paarlberg, RA

1/30/2020
Kim,

We recently received an inquiry about a memory care facility, and staff here consulted DOJ on the question of whether it was covered as a long-term care facility under the ADA Standards. DOJ advised us that it was considered long-term care, and one of our specialists (Randall) relayed this to the caller. I will check further on the details of the inquiry and the guidance from DOJ and get back to you.

Dave Yanchulis

1/30/2020

Dave,

This is the definitions and groups in the IBC, so you understand how we are currently separating care facilities. We have a special Healthcare committee working on all of this – and they are looking at licensure as part of this. So we have a way to work on this if you want to.

CUSTODIAL CARE. Assistance with day-to-day living tasks; such as assistance with cooking, taking medication, bathing, using toilet facilities and other tasks of daily living. Custodial care includes persons

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receiving care who have the ability to respond to emergency situations and evacuate at a slower rate and/or who have mental and psychiatric complications.

MEDICAL CARE. Care involving medical or surgical procedures, nursing or for psychiatric purposes.

INCAPABLE OF SELF-PRESERVATION. Persons who, because of age, physical limitations, mental limitations, chemical dependency or medical treatment, cannot respond as an individual to an emergency situation.

The characteristics of Group I-1 occupancies include:

- *Custodial care* facility.
- The number of persons receiving *custodial care* and residing in such facilities is greater than 16.
- There is *24-hour*-a-day supervision (for counseling and assistance purposes, not for medical purposes).
- Divided into “Condition 1” or “Condition 2”
    - In Condition 1 the care recipients are capable of reaching safety in an emergency situation without assistance. (4% Accessible, 96% Type B)
    - Condition 2 applies where any of the care recipients require limited verbal or physical assistance while responding to an emergency situation to complete building evacuation. (10% Accessible, 90% Type B)

The characteristics of Group I-2 occupancies include:

- *Medical care* facility.
- There is *24-hour*-a-day medical supervision for the individuals receiving care.
- More than 5 of those persons are *incapable of self-preservatio*n in an emergency situation. They cannot respond as an individual.
- Divided into “Condition 1” and “Condition 2”
    - Condition 1 is a nursing home (50% Accessible, 50% Type B)
    - Condition 2 is a hospital –includes emergency care, surgery, obstetrics, and in-patient stabilization units (10& Accessible)

Kimberly Paarlberg, RA

2/6/2020

Kim,

In the case of a memory care facility, we confirmed with DOJ that it would be covered as long-term because of the typical length of stay. Based on how things are assessed under the ADA Standards, the determination of what is considered a “long-term” medical care facility may not track with the IBC classifications.
Let me know if you want to further discuss this.
Dave Yanchulis

2/6/2020

Dave, There are different levels of memory care. Only beginning stages could be in an assisted living because the patients would have to be cable or responding on their own or with very minimal direction from staff to evacuate. These facilities are not licensed as ‘medical’ care facilities. I think someone is lumping all memory care too much together. Since this has a significant different in accessibility requirements, I do think we need to find a way to clarify the differences.

What kind of process do we have open to us?

Kimberly Paarlberg, RA

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2/7/2020
Kim,
We assess things differently under the ADA because, in the private sector, these types of facilities get covered only if there are a licensed medical care facility (10%) or a long-term-care facility (50%). Scoping in the ADA Standards applies the 10% to hospitals and to rehab., psychiatric, and detox facilities, and the 50% broadly to long-term care facilities.

It would be good for all of us to further discuss this. I will reach out to DOJ about setting up a conference call.
Dave Yanchulis

20) Notes 3-25-2020: Special group – John, Dan, Amy, Roger Larson, Maggie Caulkins to talk to Dave Yanchulis
Dan Purgeil has stats to explain reasoning.

From Bill Koffel:
John,

Are you proposing to move Chapter 11 to the IEBC or to copy it into the IEBC? Remember that the IEBC is not intended to establish a minimum level in existing buildings; but rather, what level of protection is required when work (upgrades) are taking place in an existing building.

With respect to K131, NFPA 101 requires a fire barrier meeting horizontal exit construction requirements to not provide smoke barriers in another occupancy on the same floor as health care. The IBC requires a two-hour fire barrier. There are some subtle differences.

Bill
21) Notes 3-25-2020:
First paragraph -Fire - IEBC Group B; Performance method (Jenson Hughes); allowances for existing in IFC Chapter 11 to match IEBC allowances
2nd paragraph – General/Fire; K131

From: Williams, John (DOH)
Subject: things to talk about for next cycle
.
Corridor wall construction (again)
Notes 3-25-2020: Fire - continuity

K131 Separated versus non-separated mixed uses (2 requirements here)
22) Notes 3-25-2020: General

K233 Clear width of exit and exit access doors (2 requirements here existing and new construction)
23) Notes 3-25-2020: General

K347 Cooking facilities open to corridor
24) Notes 3-25-2020: Fire

K916 EES alarm annunciator
25) Notes 3-25-2020: MEP

K921 Elec equipment testing and maintenance requirements (Think this might be addressed by referencing NFPA 99)

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26) Notes 3-25-2020: MEP; K921 is about maintenance – is this outside scope of IBC

K930 Liquid O2 equipment and storage

27) Notes 3-25-2020: MEP

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As written in both 420.8 and 904.13, Group I occupancies would have to install a UL 300A style hood everywhere a cooktop, range, or any other domestic cooking appliance is installed. While I think the intent should be in-line with Section 407.2.6 for I-2, cooking equipment open to the corridor. The current language would require compliance with all the provisions in 420.8 in every ALF resident unit where there is any kind of cooking equipment installed.

28) Notes 3-25-2020: General - is a microwave considered a cooking appliance that needs a hood?

Is a homeless shelter an I-1 or R-1? Group homes were residents are supervised but do not need help? Literal text requires custodial care. Could be an issue with Group I-1 Condition 1 because they do not receive custodial care.

[BG] CUSTODIAL CARE. Assistance with day-to-day living tasks; such as assistance with cooking, taking medication, bathing, using toilet facilities and other tasks of daily living. Custodial care includes persons receiving care who have the ability to respond to emergency situations and evacuate at a slower rate and/or who have mental and psychiatric complications.

[BG] PERSONAL CARE SERVICE. The care of persons who do not require *medical care*. Personal care involves responsibility for the safety of the persons while inside the building

308.1 Institutional Group I. Institutional Group I occupancy includes, among others, the use of a building or structure, or a portion thereof, in which care or supervision is provided to persons who are or are not capable of self-preservation without physical assistance or in which persons are detained for penal or correctional purposes or in which the liberty of the occupants is restricted. Institutional occupancies shall be classified as Group I-1, I-2, I-3 or I-4.

308.2 Institutional Group I-1. Institutional Group I-1 occupancy shall include buildings, structures or portions thereof for more than 16 persons, excluding staff, who reside on a 24-hour basis in a supervised environment and receive custodial care. Buildings of Group I-1 shall be classified as one of the

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occupancy conditions specified in Section 308.2.1 or 308.2.2.
This group shall include, but not be limited to, the following:
Alcohol and drug centers
Assisted living facilities
Congregate care facilities
Group homes
Halfway houses
Residential board and care facilities
Social rehabilitation facilities

308.2.1 Condition 1. This occupancy condition shall include buildings in which all persons receiving custodial care who, without any assistance, are capable of responding to an emergency situation to complete building evacuation.

308.2.2 Condition 2. This occupancy condition shall include buildings in which there are any persons receiving custodial care who require limited verbal or physical assistance while responding to an emergency situation to complete building evacuation.

308.2.3 Six to 16 persons receiving custodial care. A facility housing not fewer than six and not more than 16 persons receiving custodial care shall be classified as Group R-4.

308.2.4 Five or fewer persons receiving custodial care. A facility with five or fewer persons receiving custodial care shall be classified as Group R-3 or shall comply with the *International Residential Code* provided an *automatic sprinkler system* is installed in accordance with Section 903.3.1.3 or Section P2904 of the *International Residential Code*.

29) Notes 3-25-2020: General – include Wayne

Question: If a nursing home has a cafeteria with more than 50 occupants, what are the hardware requirements?
Can you use Section 1010.1.9.6 Exception 1 and call this a place of detention and constraint?
Is the requirement for panic hardware in 1010.1.10 more restrictive than the allowances in 1010.1.9.7 for controlled egress in Group I-1 and I-2 since this is an assembly space?
30) Notes 3-25-2020: General – include Wayne

From Dan Purgiel:
2024 IBC I-1 and R-4 Change Ideas – Dan Purgiel

1. **Section 420.2:** Separation walls scoping language is confusing and could be better described. If using intervening rooms and no corridor than 420.2 still kicks in 45 min unit entry door with closer. It is not clear if the corridor wall also is required to meet this provision besides the corridor 20 minute requirement. Some interpret that the 20 minute and 45 minutes are required. At least a discussion on this is warranted.

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31) Notes 3-25-2020: Fire safety; Group I-1 Condition 2 remove door closer requirements for occupant safety (see item 6)

2. **Section 420.7:** Open spaces to corridors has been misinterpreted to be just limited to those spaces listed, since "and similar spaces" is not listed, meaning it should be inferred that this exception should also allow dining areas be open to a corridor under this provision. DCP has a had a case in CO where the corridor open was not allowed because specific room not listed.

32) Notes 3-25-2020: General – include Wayne

3. **Section 420.8:** Open to kitchen scoping language is incorrect and should match I-2 by limiting this exception to kitchens open to corridors. 2018 and 21 is not written correctly as that provision needs to move to scoping language. (Those on the HCC conf call 9/27/19 (John Williams, Wayne agree. Confirm w Amy Carpenter.)

33) Notes 3-25-2020: General – what happens in kitchens that are separated from corridor?

4. **Section 420X.** Remembering the controversy amongst many of the Chapter 2 "2018 Sleeping Unit" definition, it was agreed that a definition could not include any requirements. Instead the definition is further clarified as to what limitations it could have in the Commentary (By Kim?) The concepts presented in the Commentary of limiting the sleeping Unit to 16 bedrooms could be pursued if it was not pursued in the 2021 IBC by any other committees.

34) Notes 3-25-2020: General – include Wayne; get help with 2021 commentary

5. **Table 510.2.4.** Should at least some I-1 C1 or I-1C2 or even R4 be considered to be added to this provision or other 510 provisions?

35) Notes 3-25-2020: General

6. **Section 708 Fire partitions 716 Opening protectives.** I-1 unit entry doors in rated corridors require door closers. This is challenging for senior population to use. Consider using some of the concepts not requiring door closers from the correlating NFPA 101 Chapter 32 and 33 Residential Board and Care (RB&C) occupancy.

36) Notes 3-25-2020: Fire – see Item 1

7. **Section 1020.6 Corridor Continuity :** In R, I-1 and R-4 using intervening rooms in large household or dorms often run into the wrong interpretation of the word "an" meaning one end the corridor is required to terminate at an exit and the other end has options. It might be time to codify better the 2 pages in the Commentary trying to describe the word "an" in the Corridor Continuity section.

37) Notes 3-25-2020: General

8. **IBC I-1 Chapter 3 and IEBC:** Better describe the difference between Condition 1 and Condition 2 especially for existing buildings that may have some C2 residents now. Also consider some modification of existing buildings that are NFPA 13R that cannot get to NFPA13 but may have some C2 residents. At least allow on the first floor? And or second with horizontal exit? And add smoke barriers on each floor in combustible construction. Create a prescription path to get there?

38) Notes 3-25-2020: General

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