AD HOC HEALTHCARE COMMITTEE
FIRE SAFETY WORK GROUP
CODE CHANGE DRAFTS
11/9/2012

This report includes 13 code change proposals from the Adhoc Health Care, Fire Safety Work Group developed for Group B changes. There are 4 proposals that *have not* been approved by the AHC ("New") and 9 proposals that *have been* previously reviewed and approved by the AHC.

At the end of this report, there is a a code change being proposed by the Fire Code Action Committee (FCAC) that would affect ambulatory care facilities. This is included for AHC information and review.

New Group B Code Change Proposals

Code	Section	KTAG or Issue	Comments
IFC	1103.4.1	K20	Atriums
IFC	1103.4.8	K71	Trash & Linen Chutes
IFC	1103.5.2.1		Sprinklers in I-2 Cond 2 in 9 yrs
IFC	1106 (New)	Round 1, Issue 11	Incidental uses

GROUP B CODE CHANGE PROPOSALS
PREVIOUSLY REVIEWED AND APPROVED BY THE AHC

Code	Section	KTAG or Issue	Comments
IFC	310.3	K66	No Smoking
IFC	404.2 et. al.	K50 & Round 1, Issue 14	Evacuation
IFC	806.1.1	Round 1, Issue 1A	Natural Cut Trees
IFC	807.1	Round 1, Issue 1	Decorations
IFC	907.2.6, et.al.	Round 1, Issue 9	FIRE ALARMS
IFC	1103.3	K161	Existing Elevators
IFC	Table 5003.1.1	Round 1, Issue 12A	Alcohol-based hand rub MAQ note

IFC	5306.2.1	K76	Medical Gases
IFC	5705.5, et.al.	Round 1, Issue 12 & K211	ALCOHOL-BASED HAND RUBS

New Group B Proposals

Proposed Code Change for K-20

Fxx-13
1103.4.1

Proponent: John Williams, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

IFC 1103.4.1 Group I occupancies. In Group I occupancies, interior vertical openings connecting two or more stories shall be protected with 1-hour fire-resistance-rated construction.

Exceptions:

1. In Group I-2 Condition 2 equipped throughout with an automatic sprinkler system, atriums connecting two or more stories need not be protected with 1-hour fire-resistance-rated construction where both of the following conditions are met:

    1.1. The atrium and the adjoining spaces are accounted for in the design of a smoke control system in accordance with Section 909.

    1.2 The floor levels within the atrium shall contain only low or ordinary fire hazard uses.

2. In Group I-2 Condition 2 where an automatic sprlnkler system is installed in accordance with Section 404.6 of the *International Building Code,* glass walls shall be considered to be equivalent to 1-hour fire-resistance-rated construction for purposes of this section. Where glass doors are provided in the glass wall, they shall be either self-closing or automatic-closing.

3. In Group I-2 Condition 2 1-hour fire-resistance-rated construction is not required where a glass-block wall assembly complying with Section 2110 of the *International Building Code* and having a ¾-hour fire protection rating is provided.

Reason: The intent of this code change is to clarify the allowable use and construction of atria in hospitals. This adds language to clarify the fire hazard class allowed in the existing atrium (no higher than ordinary), as opposed to only low hazard class in new. A smoke control system is also acknowledged as a factor when it comes to separation of the atrium, and clarifies that the smoke control system's engineering analysis must account for any spaces open to it.

Glass walls points back to the language in the IBC in an attempt to set that as a minimum, retroactive standard. It is far simpler to address a potential deficiency with addition of a smoke control system or properly installed sprinklers at glass, rather than reconstructing the walls themselves.

This proposal would make the IFC consistent with federal standards that are in place to maintain hospitals, and therefore would not represent an increase in cost.

This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: http://www.iccsafe.org/cs/AHC/Pages/default.aspx

==========

Proposed Code Change FOR K-TAG K71
by Jeff O'Neill

Fxx-13

1103.4.8 (New)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Add new text as follows:

1103.4.8 Waste and linen chutes. In ambulatory care facilities and Group I-2 Condition 2, existing waste and linen chutes shall comply with Sections 1103.4.8.1 through 1103.4.8.5.

1103.4.8.1 Enclosure. Chutes shall be enclosed with 1-hour fire-resistance-rated construction. Opening protectives shall be in accordance with Section 716 of the *International Building Code* and have a fire protection rating of not less than1-hour.

1103.4.8.2 Chute intakes. Chute intakes shall comply with Section 1103.4.8.2.1 or 1103.4.8.2.2.

1103.4.8.2.1 Chute intake direct from corridor. Where intake to chutes is direct from a corridor, the intake opening shall be equipped with a chute intake door in accordance with Section 716 of the *International Building Code* and having a fire protection rating of not less than1-hour.

1103.4.8.2.2 Chute intake via a chute intake room. Where the intake to chutes is accessed through a chute intake room, the room shall be enclosed with 1-hour fire-resistance rated construction. Opening protectives for the intake room shall be in accordance with Section 716 of the *International Building Code* and have a fire protection rating of not less than ¾ hour. Opening protective for the chute enclosure shall be in accordance with Section 1103.4.8.1.

1103.4.8.3 Automatic sprinkler system. Chutes shall be equipped with an *approved automatic sprinkler system* in accordance with Section 903.2.11.2.

1103.4.8.4 Chute discharge rooms. Chutes shall terminate in a dedicated chute discharge room. Such rooms shall be separated from the remainder of the building by a minimum of 1-hour fire-resistance-rated construction. Opening protectives shall be in accordance with Section 716 of the *International Building Code* and have a fire protection rating of not less than1-hour.

1103.4.8.5 Chute discharge protection. Chute discharges shall be equipped with a self-closing or automatic-closing opening protective in accordance with Section 716 of the *International Building Code* and having a fire protection rating of not less than 1-hour..

1103.4.9 Flue-fed incinerators. The continued use of existing flue-fed incinerators is prohibited. Existing flue-fed incinerator rooms and associated flue shafts shall be protected with 1-hour fire-resistance-rated construction and have no other vertical openings connected with the space other than the associated flue. Opening protectives shall be in accordance with Section 716 of the *International Building Code* and have a fire protection rating of not less than1-hour.

Reason: The intent of this code change is to clarify the allowable use and construction of chutes and incinerators in ambulatory care facilities and hospitals. These items are still used as an integral part of the operation of a hospital, especially the waste or linen chutes. Some incinerators are still in use, but this proposed requirement seeks to separate them from other vertical openings, especially a trash chute, by requiring a separate discharge room from the incinerator. Most incinerators are not in use or are otherwise abandoned in existing facilities, due to other regulation from entities such as the EPA, and this requirement seeks to separate and protect any potential hazard from the rest of the building.

This proposal would make the IFC consistent with federal standards that are in place to maintain hospitals, and therefore would not represent an increase in cost.

This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 8 open meetings and over 100 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: http://www.iccsafe.org/cs/AHC/Pages/default.aspx

==========

Proposed Code Change
by Jeff O'Neill – November 7, 2012

Fxx-13

1103.5.2.1 (New)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Add new text as follows:

1103.5.2 Group I-2. An *automatic sprinkler system* shall be provided throughout existing Group I-2 *fire areas.* The sprinkler system shall be provided throughout the floor where the Group I-2 occupancy is located, and in all floors between the Group I-2 occupancy and the *level of exit discharge.*

1103.5.2.1 Group I-2 Condition 2. Existing buildings of Group I-2 Condition 2 occupancy shall be equipped throughout with an approved automatic sprinkler system in accordance with Section 903.3.1.1. The automatic sprinkler system required by this section shall be installed within 9 years of the date of adoption of this code.

Reason: The intent of this code change is to make mandatory the use of an approved automatic sprinkler system throughout existing hospital (Group I-2 Condition 2) occupancies. The healthcare industry recognizes sprinkler systems are a vital component of the safety of the overall building systems and components, as demonstrated by the levels of protection encountered since the more widespread use of quick response sprinklers.

To ensure continuous operation in healthcare facilities, the installation of sprinklers systems needs to be carefully planned so as to not adversely affect patient health. Accessing and exposing ceiling spaces can create conditions that will lead to infection and possibility death to patients with compromised or suppressed immune systems. In many situations, hospitals may not be able to appropriately retrofit the installation of a fire suppression system; in those situations a time frame is needed to replace facilities. The specific 9-year timeframe is intended to remain consistent with other regulatory requirements that hospitals are currently subject to.

This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 8 open meetings and over 100 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: http://www.iccsafe.org/cs/AHC/Pages/default.aspx

Cost impact: This proposal would make the IFC consistent with the direction that federal standards are taking to maintain hospitals and therefore would not represent an increase in cost.

Analysis: The "Group I-2 Condition 2" terminology used in this proposal in lieu of "Group I-2 hospital" is the result of approved Group A code change G257-12.

==========

Round 1, Issue 11 Incidental Uses (Jeff O'Neill)

Fxx-13

1106 (New)

Proponent: John Williams, Chair, ICC Ad Hoc Committee on Health Care

Add new text as follows:

SECTION 1106

INCIDENTAL USES IN EXISTING GROUP I-2 CONDITION 2

AND AMBULATORY CARE FACILITIES

1106.1 General. Incidental uses associated with and located within existing single occupancy or mixed occupancy Group I-2 Condition 2 buildings or ambulatory care facilities, and that generally pose a greater level of risk to such occupancies shall comply with the provisions of Sections 1106.2 through 1106.4.2.1. Incidental uses in Group I-2 Condition 2 occupancies and ambulatory care facilities are limited to those listed in Table 1106. Unless otherwise indicated in Table 1106, incidental use requirements shall apply to all Group I-2 Condition 2 occupancies and ambulatory care facilities.

1106.2 Occupancy classification. Incidental uses shall not be individually classified in accordance with Section 302.1 of the *International Building Code*. Incidental uses shall be included in the building occupancies within which they are located.

1106.3 Area limitations. Incidental uses shall not occupy more than 10 percent of the *building area* of the *story* in which they are located.

1106.4 Separation and protection. The incidental uses listed in Table 1106 shall be separated from the remainder of the building or equipped with an *automatic sprinkler system*, or both, in accordance with the provisions of that table.

1106.4.1 Separation. Where Table 1106 specifies a fire-resistance-rated separation, the incidental uses shall be separated from the remainder of the *building* in accordance with Section 509.4.1 of the *International Building Code*.

1106.4.2 Protection. Where Table 1106 permits an *automatic sprinkler system* without a fire-resistance-rated separation, the incidental uses shall be separated from the remainder of the building by construction capable of resisting the passage of smoke in accordance with Section 509.4.2 of the *International Building Code*.

1106.4.2.1 Protection limitation. Except as otherwise specified in Table 1106 for certain incidental uses, where an *automatic sprinkler system* is provided in accordance with Table 1106, only the space occupied by the incidental use need be equipped with such a system.

TABLE 1106

INCIDENTAL USES IN EXISTING GROUP I-2 CONDITION 2

AND AMBULATORY CARE FACILITIES

ROOM OR AREA	SEPARATION AND/OR PROTECTION
Furnace room where any piece of equipment is over 400,000 Btu per hour input.	1 hour or provide automatic sprinkler system
Rooms with boilers where the largest piece of equipment is over 15 psi and 10 horsepower	1 hour or provide automatic sprinkler system
Refrigerant machinery room	1 hour or provide automatic sprinkler system
Hydrogen cutoff rooms, not classified as Group H	2 hours in Group I-2 Condition 2; 1 hour in ambulatory care facilities
Incinerator rooms	2 hours and provide automatic sprinkler system
In Group I-2 Condition 2 occupancies, paint shops not classified as Group H	2 hours; or 1 hour and provide automatic sprinkler system
In ambulatory care facilities or Group I-2 Condition 2 occupancies, laboratories and vocational shops, not classified as Group H	1 hour or provide automatic sprinkler system

Laundry rooms over 100 square feet	1 hour or provide automatic sprinkler system
In Group I-2 Condition 2 occupancies, patient rooms equipped with padded surfaces	1 hour or provide automatic sprinkler system
In Group I-2 Condition 2 occupancies, physical plant maintenance shops.	1 hour or provide automatic sprinkler system
In ambulatory care facilities or Group I-2 Condition 2 occupancies, waste and linen collection rooms with containers with total volume of 10 cubic feet or greater.	1 hour or provide automatic sprinkler system
In ambulatory care facilities or Group I-2 Condition 2 occupancies, storage rooms greater than 100 square feet	1 hour or provide automatic sprinkler system
Stationary storage battery systems having a liquid electrolyte capacity of more than 50 gallons for flooded lead-acid, nickel cadmium or VRLA, or more than 1,000 pounds for lithium-ion and lithium metal polymer used for facility standby power, emergency power or uninterruptable power supplies	2 hours in Group I-2 Condition 2 occupancies; 1 hour in ambulatory care facilities

For SI: 1 square foot = 0.0929 m^2, 1 pound per square inch (psi) = 6.9 kPa, 1 British thermal unit (Btu) per hour = 0.293 watts, 1 horsepower = 746 watts, 1 gallon = 3.785 L.

Reason: This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 8 open meetings and over 100 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: http://www.iccsafe.org/cs/AHC/Pages/default.aspx

The provisions of this code change are being proposed for the IFC to establish requirements for the protection of incidental use areas in existing healthcare facilities. Incidental use area provisions are applicable to new construction in Section 509 of the IBC, however similar provisions are needed for existing healthcare occupancies since the hazards posed by such rooms or spaces are no different for existing buildings than for new. Proposed Section and Table 1106 are very similar to and based upon IBC Section and Table 509, except that references to occupancies other than Group I-2 Condition 2 and ambulatory care facilities are not included. The basic requirements proposed for incidental uses in existing healthcare occupancies rely upon the provisions of the IBC for the specifics of construction and protection. Proposed Sections 1106.2 through 1106.4.2.1 are based on IBC Sections 509.2 through 509.4.2.1, editorially corrected for the IFC and for correlation. These proposed provisions will provide correlation with not only the IBC but also with the current operational and CMS program standards for existing Group I-2 Condition 2 and ambulatory care facilities. A section-by-section summary follows:

1106.1 General: This proposed section establishes the scope of Section 1106 and its applicability to ambulatory care facilities and Group I-2 Condition 2 occupancies. Incidental uses are rooms or areas that constitute special hazards or risks to life safety that are not typically addressed by the provisions for the occupancy group in which they occur even though such rooms or areas may functionally be an extension of the primary use. Only those rooms or areas indicated in Table 1106 are to be regulated as incidental uses. Incidental uses can be located within both single-occupancy and mixed-occupancy buildings. The concern is that those areas designated as incidental uses pose a risk to the remainder of the building, and as such, some degree of protection is required. In general, the nature of these incidental uses is such that they are small areas that are not frequented by the building occupants very often in which a fire could get underway and go unnoticed for a longer time than in a part of the building that is constantly occupied.

1106.2 Occupancy classification: Consistent with the IBC, this proposed section expressly states that incidental uses are not considered as separate and distinct occupancy classifications but, rather, are classified the same as the occupancies in which they are located. As an example, a waste and linen collection room in a hospital would be classified as a portion of the Group I-2 Condition 2 occupancy even though it may present a level of hazard more akin to a Group S-1 occupancy if it were to be classified separately.

1106.3 Area limitations: The proposed floor area limitation of 10 percent for incidental uses emphasizes the ancillary nature of such rooms and areas and correlates with the IBC. Each incidental use would be limited to a maximum floor area of 10 percent of the floor area of the story in which it is located. Where there are two or more tenants located on the same story, the 10 percent limitation is based upon the floor area of each individual tenant space rather than that of the entire story. The application of the limit on a tenant-by-tenant basis is consistent with the concept of incidental uses typically being ancillary only to a portion of the building, i.e., the specific tenant occupancy.

1106.4 Separation and protection: In addition to identifying those rooms or areas that warrant regulation as incidental uses, proposed Table 1106 will also indicate the required degree of protection or separation. The requirements identified in Table 1106 vary depending on the incidental use. In some cases, a specific type of separation and/or protection is required, while in others there is an option.

1106.4.1 Separation: Where a fire-resistance rated separation would be required, the incidental use would need to be separated from other portions of the building in accordance with assemblies complying with the IBC.

TABLE 1106: Proposed Table 1106 identifies the accessory uses and the required separation or other protection that would need to be provided. Consistent with Section 1106.1, whereas the table would apply to all Group I-2 Condition 2 occupancies or ambulatory care facilities, certain of the listed incidental uses would be limited in their applicability to only one or the other of a Group I-2 Condition 2 occupancy or an ambulatory care facility.

1106.4.2 Protection: In this proposed section, where Table 1106 would allow protection by an automatic sprinkler system without a fire- resistance-rated separation, the construction enclosing the incidental use would still need to resist the passage of smoke. Construction details for resisting the passage of smoke are provided in the IBC.

1106.4.2.1 Protection limitation: This proposed section makes it clear that the sprinkler systems stipulated in Table 1106 would be required for the incidental use area only.

Cost Impact: The code change proposal should not increase the cost of construction because compliance with similar requirements is already required by facility licensure requirements.

Analysis: The “Group I-2 Condition 2” terminology used in this proposal in lieu of “Group I-2 hospital” is the result of approved Group A code change G257-12.

Information note: IBC Table 509 was revised by approved Group A code change G130-12, also submitted by the AHC, which is reproduced here below for reference purposes:

G130 – 12
Table 509

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

TABLE 509

INCIDENTAL USES

ROOM OR AREA	SEPARATION AND/OR PROTECTION
Furnace room where any piece of equipment is over 400,000 Btu per hour input.	1 hour or provide automatic sprinkler system
Rooms with boilers where the largest piece of equipment is over 15 psi and 10 horsepower	1 hour or provide automatic sprinkler system
Refrigerant machinery room	1 hour or provide automatic sprinkler system
Hydrogen cutoff rooms, not classified as Group H	1 hour in Group B, F, M, S and U occupancies; 2 hours in Group A, E, I and R occupancies.
Incinerator rooms	2 hours and provide automatic sprinkler system
Paint shops, not classified as Group H, located in occupancies other than Group F	2 hours; or 1 hour and provide automatic sprinkler system
In Group E occupancies, laboratories and vocational shops~~,~~ not classified as Group H~~, located in Group E or I-2 occupancy~~	1 hour or provide automatic sprinkler system
In Group I-2 occupancies, laboratories not classified as Group H	1 hour and provide automatic sprinkler system
In ambulatory care facilities, laboratories not classified as Group H	1 hour or provide automatic sprinkler system
Laundry rooms over 100 square feet	1 hour or provide automatic sprinkler system
In Group I-2, laundry rooms over 100 square feet	1 hour
Group I-3 cells and Group I-2 patient rooms equipped with padded surfaces	1 hour
In Group I-2, physical plant maintenance shops.	1 hour
In ambulatory care facilities or Group I-2 occupancies , waste and linen collection rooms ~~located in either Group I-2 occupancies or ambulatory care facilities~~ with containers that have an aggregate volume of 10 cubic feet or greater	1 hour
In other than ambulatory care facilities and Group I-2 occupancies, waste and linen collection rooms over 100 square feet	1 hour or provide automatic sprinkler system
In ambulatory care facilities or Group I-2 occupancies, storage rooms greater than 100 square feet	1 hour

Stationary storage battery systems having a liquid electrolyte capacity of more than 50 gallons for flooded lead-acid, nickel cadmium or VRLA, or more than 1,000 pounds for lithium-ion and lithium metal polymer used for facility standby power, emergency power or uninterruptable power supplies	1 hour in Group B, F, M, S and U occupancies; 2 hours in Group A, E, I and R occupancies.

For SI: 1 square foot = 0.0929 m^2, 1 pound per square inch (psi) = 6.9 kPa, 1 British thermal unit (Btu) per hour = 0.293 watts, 1 horsepower = 746 watts, 1 gallon = 3.785 L.

Reason: This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: http://www.iccsafe.org/cs/AHC/Pages/default.aspx
Currently, more detail is needed in the Incidental Use table to add spaces currently being maintained in healthcare and ambulatory care occupancies. The above chart makes the noted tables consistent with current operational and programmatic standards in the Group I-2 occupancy.

The current version of the table does not address the occasion when materials in a laboratory increases, most notably in the aggregate of larger histology / cytology laboratories. Materials such as xylene, hydrochloric acid, ethanol and fixatives (among others) are present in these areas. Although they are stored in gallon and liter quantities, and not bulk storage, the quantities add up over the larger lab control areas when they are in use at the benches.

The distinction between smaller stat labs, largely found in ambulatory care facilities, and larger clinical labs, found in hospitals, is being proposed. Ambulatory care facilities has been added to the current laboratory category to address those support spaces such as stat labs that are set up for a specific time-sensitive purpose, such as blood draw and chemotherapy, to save time in the Group B occupancy setting. Larger scale or non-critical lab operations are typically sent out to proprietary labs from ambulatory facilities. When addressing labs crossing the threshold into one hour rated construction, these labs are typically constructed as stand-alone operations and commonly appear in Group B occupancies, and are subject to the current occupancy separation requirements.

Volume thresholds are being considered in waste and linen collection rooms because basic exam spaces contain some level of waste containers and linen hampers without rising to the level of storage. The 10 cubic foot threshold represents essentially two medium sized linen hampers and/or trash receptacles. Larger linen and waste receptacle containers, and not the smaller containers typically found in an exam room or patient sleeping room, are subject to volume rather than square footage of the room because a relatively small space, with the 10 cubic foot threshold crossed in a space well below, for example, 100 square feet.

Group I-2 is also being added to the requirement for one hour rating with rooms equipped with padded surfaces. The instance of these rooms existing in a hospital is rare. It is prudent, however, to add the requirement where there is the occasion that such rooms are used in areas such as emergency departments, inpatient psychiatric units, or similar areas.

Physical plant and maintenance shops are a very specific function in a hospital building, and are being added to the table to ensure protection due to the stored materials related to the physical plant operation.

Addition of storage rooms as an area requiring 1 hour rated protection is a key functional aspect of a Group I-2 healthcare building. Areas that become unused become storage areas very quickly. Specifically calling out storage areas helps define and control the storage of combustibles, and avoid creating random storage in otherwise unmonitored or unprotected areas.

Areas addressed in the past, but are no longer included in the table, are addressed in the International Fire Code (IFC). For example, storage of combustible gases is addressed in IFC Section 5306.2 and has specific references to the Group I-2 occupancy. Gift shops, formerly listed as an incidental area requiring protection, have largely been eliminated from these requirements in the I-Codes and other model codes, and are addressed in the context of being open to the corridor.
In consideration of ambulatory care facilities, where not otherwise specifically called out, categories that are required for both Group B and I occupancies are assumed to cover Group I-2 and ambulatory care facilities. Examples of this interpretation are hydrogen cut-off rooms and stationary battery storage.

==========

GROUP B CODE CHANGES

PREVIOUSLY REVIEWED AND APPROVED BY THE AHC

K-66 Smoking Regulations: Jack Chamblee 9-30-11 Final

Fxx-13
310.3.1 (New)

Proponent: John Williams, Chair, ICC Ad Hoc Committee on Health Care

Add new text as follows:

310.3 "No Smoking" signs. The *fire code official* is authorized to order the posting of "No Smoking" signs in a conspicuous location in each structure or location in which smoking is prohibited. The content, lettering, size, color and location of required "No Smoking" signs shall be approved.

310.3.1 Group I-2 hospitals. In Group I-2 hospital occupancies where smoking is prohibited, "No Smoking " signs are not required in interior locations of the facility where signs are displayed at all major entrances into the facility.

Reason: This proposal will provide correlation with NFPA 101 Section 19.7.4.2 which contains an exception for healthcare occupancies that allows for a facility to not install secondary "No Smoking Signs" throughout a facility if primary signs are prominently displayed at all major entrances. This exception is not currently included in the IFC. Since healthcare facilities already prohibit smoking, where signs are posted at the entrances it is redundant and unnecessary to also require the signs to be posted throughout a facility that does not permit smoking, has a staff trained to monitor and policies in place to quickly stop or prevent the action.

This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 8 open meetings and over 100 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at:
http://www.iccsafe.org/cs/AHC/Pages/default.aspx

Cost impact: This proposal will not increase the cost of construction.

==========

Round 1, Issue 14 & K-tag 50 Fire Safety and Evacuation Plans

Fxx - 13
404.2, 404.3.1, 404.3.2; 408.3, 408.3.1, 408.3.2 (New); 408.6; 408.6.1, 408.6.2, 408.6.3 (New)

Proponents: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care and Carl Baldassarra, P.E., FSFPE, Chair, ICC Code Technology Committee

Revise as follows:

SECTION 404
FIRE SAFETY AND EVACUATION PLANS

404.1 General. Fire safety, evacuation and lockdown plans and associated drills shall comply with the requirements of Sections 404.2 through 404.5.1.

404.2 Where required. An *approved* fire safety and evacuation plan shall be prepared and maintained for the following occupancies and buildings:

1. Group A, other than Group A occupancies used exclusively for purposes of religious worship that have an *occupant load* less than 2,000.

2. Group B.
   2.1 . Buildings having an ambulatory care facility.
   2.2. Buildings having an *occupant load* of 500 or more *persons* or more than 100 *persons* above or below the lowest *level of exit discharge*.

3. through 15. (No change to current text.)

404.3 Contents. Fire safety and evacuation plan contents shall be in accordance with Sections 404.3.1 and 404.3.2.

404.3.1 Fire evacuation plans. Fire evacuation plans shall include the following:

1. Emergency egress or escape routes and whether evacuation of the building is to be complete, ~~or, where *approved*~~, by selected floors or areas only, or with a defend-in-place response.
2. Procedures for employees who must remain to operate critical equipment before evacuating.
3. Procedures for assisted rescue for persons unable to use the general *means of egress* unassisted.
4. Procedures for accounting for employees and occupants after evacuation has been completed.
5. Identification and assignment of personnel responsible for rescue or emergency medical aid.
6. The preferred and any alternative means of notifying occupants of a fire or emergency.
7. The preferred and any alternative means of reporting fires and other emergencies to the fire department or designated emergency response organization.
8. Identification and assignment of personnel who can be contacted for further information or explanation of duties under the plan.
9. A description of the emergency voice/alarm communication system alert tone and preprogrammed voice messages, where provided.

404.3.2 Fire safety plans. Fire safety plans shall include the following:

1. The procedure for reporting a fire or other emergency.

2. The life safety strategy including the following:

   2.1 ~~and p~~ Procedures for notifying occupants, including areas with a private mode alarm system. ~~,~~
   2.2 Procedures for ~~relocating~~ occupants under a defend-in-place response.

   2.3 Procedures ~~or~~ for evacuating occupants, including occupants who need assistance in evacuation.

3. Site plans indicating the following:
    3.1. The occupancy assembly point.
    3.2. The locations of fire hydrants.
    3.3. The normal routes of fire department vehicle access.

4. Floor plans identifying the locations of the following:
    4.1. Exits.
    4.2. Primary evacuation routes.
    4.3. Secondary evacuation routes.
    4.4. Accessible egress routes.
    4.5. Areas of refuge.
    4.6. Exterior areas for assisted rescue.
    4.7. Manual fire alarm boxes.
    4.8. Portable fire extinguishers.
    4.9. Occupant-use hose stations.
    4.10. Fire alarm annunciators and controls.

5. A list of major fire hazards associated with the normal use and occupancy of the premises, including maintenance and housekeeping procedures.

6. Identification and assignment of personnel responsible for maintenance of systems and equipment installed to prevent or control fires.

7. Identification and assignment of personnel responsible for maintenance, housekeeping and controlling fuel hazard sources.

405.2 Frequency. Required emergency evacuation drills shall be held at the intervals specified in Table 405.2 or more frequently where necessary to familiarize all occupants with the drill procedure.

TABLE 405.2
FIRE AND EVACUATION DRILL
FREQUENCY AND PARTICIPATION

GROUP OR OCCUPANCY	FREQUENCY	PARTICIPATION
Group B [c,d]	Annually	Employees
Group R-2 [~~d~~ e]	Four annually	All occupants

(Portions of table not shown do not change.)

a. The frequency shall be allowed to be modified in accordance with Section 408.3.2.
b. Fire and evacuation drills in residential care assisted living facilities shall include complete evacuation of the premises in accordance with Section 408.10.5. Where occupants receive habilitation or rehabilitation training, fire prevention and fire safety practices shall be included as part of the training program.
c. Emergency evacuation drills are required in Group B buildings having an occupant load of 500 or more persons or more than 100 persons above or below the lowest level of exit discharge.
d. Emergency evacuation drills are required in ambulatory care facilities in accordance with Section 408.3.
~~d~~ e. Applicable to Group R-2 college and university buildings in accordance with Section 408.~~3~~ 4.

SECTION 408
USE AND OCCUPANCY RELATED REQUIREMENTS

408.3 Ambulatory Care Facilities. Ambulatory Care Facilities shall comply with the requirements of Sections 408.3.1 through 408.3.3 and Section 401 through 406.

408.3.1 Fire evacuation plan. The fire safety and evacuation plan required by Section 404 shall include a description of special staff actions. This shall include procedures for stabilizing patients in a defend in place response, staged evacuation, or full evacuation in conjunction with the entire building if part of a multi-tenant facility.

408.3.2 Fire safety plan. A copy of the plan shall be maintained at the facility at all times. Plan shall include the all of following in addition to the requirements of Section 404:

1. Locations where patients are located who are rendered incapable of self preservation.
2. Maximum number of patients rendered incapable of self preservation.
3. Area and extent of each Ambulatory Care Facility.
4. Location of adjacent smoke compartments or refuge areas, where required.
5. Path of travel to adjacent smoke compartments.
6. Location of any special locking, delayed egress or access control arrangements.

408.3.3 Staff training. Employees shall be periodically instructed and kept informed of their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff at least every two months. A copy of the plan shall be readily available at all times within the facility.

408.3.4 Emergency Evacuation Drills. Emergency evacuation drills shall comply with Section 405. Emergency evacuation drills shall be conducted at least four times per year.

> **Exceptions:** The movement of patients to safe areas or to the exterior of the building is not required.

(Renumber subsequent Sections)

408.6 Group I-2. Group I-2 occupancies shall comply with the requirements of Sections 408.6.1 through 408.6.3 and Section 401 through 406. ~~Drills are not required to comply with the time requirements of Section 405.4.~~

408.6.1 Fire evacuation plans. The fire safety and evacuation plans required by Section 404 shall include a description of special staff *actions*. Plan shall include all of the following in addition to the requirements of Section 404.

1. Procedures for evacuation for patients with needs for containment or restrained and post evacuation containment, if present.
2. A written plan for maintenance of the means of egress.
3. Procedure for a defend-in-place strategy.
4. Procedures for a full floor or building evacuation, if necessary.

408.6.2 Fire safety plans. A copy of the plan shall be maintained at the facility at all times. Plans shall include all of the following in addition to the requirements of Section 404:

1. Location and number of any patient sleeping rooms and operating rooms.
2. Location of adjacent smoke compartments or refuge areas.
3. Path of travel to adjacent smoke compartments.
4. Location of any special locking, delayed egress or access control arrangements.

5. Location of elevators utilized for patient movement in accordance with the fire safety plan, where provided.

408.6.3 Emergency Evacuation Drills. Emergency evacuation drills shall comply with Section 405.

Exceptions:

1. The movement of patients to safe areas or to the exterior of the building is not required.
2. When emergency evacuation drills are conducted after visiting hours or when patients or residents are expected to be asleep, a coded announcement shall be an acceptable alternative to audible alarms.

~~**408.6.1 Evacuation not required.** During emergency evacuation drills, the movement of patients to safe areas or to the exterior of the building is not required.~~

~~**408.6.2 Coded alarm signal.** When emergency evacuation drills are conducted after visiting hours or when patients or residents are expected to be asleep, a coded announcement is allowed instead of audible alarms.~~

Reason: This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 8 open meetings and over 100 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: http://www.iccsafe.org/cs/AHC/Pages/default.aspx

This proposal is being co-sponsored by the ICC Code Technology Committee. The ICC Board established the ICC Code Technology Committee (CTC) as the venue to discuss contemporary code issues in a committee setting which provides the necessary time and flexibility to allow for full participation and input by any interested party. The code issues are assigned to the CTC by the ICC Board as "areas of study". Information on the CTC, including: meeting agendas; minutes; reports; resource documents; presentations; and all other materials developed in conjunction with the CTC effort can be downloaded from the following website: http://www.iccsafe.org/cs/cc/ctc/index.html. Since its inception in April, 2005, the CTC has held 25 meetings – all open to the public.

This code change proposal clarifies the code by accurately describing the documentation needed to understand the typical "defend in place" method of occupant protection. Defend-in-place is a widely used approach to protecting occupants who are bedridden, unconscious or otherwise unable to self-preserve in a fire event. The method relies on both active and passive fire protection systems as well as the actions of trained staff and responders. The heavy emphasis on staff action requires a comprehensive fire safety and evacuation plan.

Any building containing an ambulatory healthcare occupancy will, by definition, contain occupants who may be incapable of self- preservation. The intent of the current IBC requirements for ambulatory care is to create a type of defend-in-place environment. Fire safety and evacuations must be developed, reviewed and approved to support this strategy.

The reference to "defend-in-place" is added in Section 404.3.1 to recognize the defend- in-place method. This is not a new concept. The IBC and legacy codes have been written to support this concept for years, yet the code did not name or describe the concept.

Fire safety plans should describe in the life safety strategy the method of notifying occupants, including the use of a private mode alarm system as allowed by code. Procedures for dealing with occupants in a defend-in-place strategy should also be described for staff training.

The new Section 408.3 adds requirements for how to create fire safety and evacuation plans Ambulatory Care Facilities. This section does not include great detail, as there are many successful ways to approach a defend in place response. Rather, this section describes the minimum amount of information necessary aid in the review of facility and the plan. Fire evacuations plan are required to describe the special actions of staff, especially staff that must stabilize a patient prior to moving. This will be the basis of the staff education and training. This will also help the code official understand the expected performance of the building.

It is imperative that the building and fire official know the size and location of the facility as well as the number of patients who are incapable of self preservation. This information will help the building official determine the proper classification and mitigations required. It will also allow the fire official to preplan the response for a particular building. Any special characteristics of the means of egress, such as path to the adjacent smoke compartment and special locking arrangements should also be described to aid in verifying code compliance. Practically these documents will be the basis for staff training as well.

Section 408.6 has been rewritten to accurately reflect the needs and the current practice for this occupancy type. Much like the new section for ambulatory care, this section requires the facility to describe the special actions of staff. Due to the special nature of some facilities, specific requirements are made locations where patients are restrained. Since these facilities contain a large number of carts, beds, and other mobile equipment a written plan for maintenance of the means of egress is required. This would address the practical operational needs of the facility while ensuring that the means of egress can be maintained free of obstructions. While these facilities are defend in place, catastrophic failure may require full evacuation. Facilities are asked to describe this procedure so that the first responders can preplan.

Fire safety plans are required to show the location of area where incapable patients are likely to be. They are required to show the location of smoke compartments, routes of travel, patient movement elevators and any locking constraints that might affect the horizontal evacuation of patients. All of these will be essential to robust staff training as well as operational planning for first responders.

Finally, the requirements for emergency evacuation drill have been merged into a single subsection for clarity. The only functional change is to delete the exception which would have allowed drills to not comply with the time requirements of Section 405.4. The committee felt that holding drill at unexpected time and varying conditions was a crucial component of staff training.

These requirements, while new to the fire code, have been a widely accepted practice in the facilities for years. This code change proposal has been reviewed by representatives from both the hospital and nursing home industry who have given their support to these changes.

Cost Impact: This proposal will not increase the cost of construction.

==========

Round 1, Issue 1A: Natural Cut Trees in AHCF's

Fxx-13
806.1.1

Proponent: John Williams, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

IFC 806.1.1 Restricted occupancies. Natural cut trees shall be prohibited in ambulatory care facilities and Group A, E, I-1, I-2, I-3, I-4, M, R-1, R-2 and R-4 occupancies.

Exceptions:

1. Trees located in areas protected by an *approved automatic sprinkler system* installed in accordance with Section 903.3.1.1 or 903.3.1.2 shall not be prohibited in Groups A, E, M, R-1 and R-2.

2. Trees shall be allowed within *dwelling units* in Group R-2 occupancies.

IFC 806.3 Obstruction of means of egress. The required width of any portion of a *means of egress* shall not be obstructed by decorative vegetation. Natural cut trees shall not be located within an exit, corridor, or a lobby or vestibule that is part of the means of egress.

Reason: This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 8 open meetings and over 100 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: http://www.iccsafe.org/cs/AHC/Pages/default.aspx

Ambulatory Care Facilities are being added to the list of prohibited occupancies for natural cut trees at Section 806.1.1. Patients in these facilities are rendered incapable of self preservation in this occupancy in activities that present the same evacuation challenges presented by Group I-2 occupancies which are already in the list. Section 806.3 “Obstruction of the means of egress” is recommended for modification because the rapid manner in which a natural cut tree is consumed by fire with the associated release of heat and smoke would present a distinct hazard to egress regardless of whether it impinged on the required width of the means of egress. A burning tree could not be approached or passed by thus effectively blocking that portion of an egress path while spreading heat and smoke to additional portions of the means of egress. A significant impact would be a natural cut tree located within a lobby that has the allowed 50% of all egress capacity passing through the same lobby.

Ambulatory Care Facilities are located within Business (Group B) occupancies where natural cut trees are permitted. This added prohibition eliminates a hazard that otherwise would not occur for similar activities conducted in a Group I-2 Group occupancy and provides an improved level of protection for other occupancies. Hospital complexes are typically a mixed use occupancy with Group I-2, Group A-3, Group M and Group B activities occurring within various portions of the complex. This added prohibition further protects the means of egress from the various components of the hospital complex.

Cost impact: This proposal will not increase the cost of construction.

==========

Round 1, Issue 1: DECORATIONS ON WALLS

(CTC Care Facilities would agree & be a co-proponent with this for Group I-1 and I-2)

Fxx-13
IFC 807.1 (IBC [F] 806.1)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care and Carl Baldassarra, P.E., FSFPE, Chair, ICC Code Technology Committee

Revise as follows:

IFC 807.1 (IBC [F] 806.1) General requirements. In occupancies in Groups A, E, I and R-1 and dormitories in Group R-2, curtains draperies, hangings and other *decorative materials* suspended from walls or ceilings shall meet the flame propagation performance criteria of NFPA 701 in accordance with section 806.2 or be noncombustible.

Exceptions:

1. Curtains, draperies, hangings and other decorative materials suspended from walls of *sleeping units* and *dwelling units* in dormitories in Group R-2 protected by an *approved automatic sprinkler system* installed in accordance with Section 903.3.1 and such materials are limited to not more than 50 percent of the aggregate area of walls.
2. Decorative materials, including, but not limited to, photographs and paintings in dormitories in Group R-2 where such materials are of limited quantities such that a hazard of fire development or spread is not present.

In Groups I-1 and I-2, combustible *decorative materials* shall meet the flame propagation performance criteria of NFPA 701 ~~unless the *decorative materials*, including, but not limited to, photographs and paintings, are of such limited quantities that a hazard of fire development or spread is not present~~. In Group I-3, combustible decorations are prohibited.

Exception: In Groups I-1 and I-2, decorative materials, including, but not limited to bulletin boards, artwork, posters, photographs and paintings, covering not more than 20 percent of the specific wall area to which it is attached.

Fixed or movable walls and partitions, paneling, wall pads and crash pads applied structurally or for decoration, acoustical correction, surface insulation or other purposes shall be considered *interior finish* if they cover 10 percent or more of the wall or of the ceiling area, and shall not be considered *decorative materials* or furnishings.

In Group B and M occupancies, fabric partitions suspended from the ceiling and not supported by the floor shall meet the flame propagation performance criteria in accordance with Section 806.2 and NFPA 701 or shall be noncombustible.

SECTION 202 (IBC [F] 202)
GENERAL DEFINITIONS

DECORATIVE MATERIALS. All materials applied over the building *interior finish* for decorative, acoustical or other effect (~~such as~~ including, but not limited to, curtains, draperies, fabrics, streamers and surface coverings), and all other materials utilized for decorative effect (~~such as~~ including, but not limited to, photographs, paintings, bulletin boards, artwork, posters, batting, cloth, cotton, hay, stalks, straw, vines, leaves, trees, moss and similar items), including foam plastics and materials containing foam plastics. Decorative materials do not include floor coverings, ordinary window shades, *interior finish* and materials 0.025 inch (0.64 mm) or less in thickness applied directly to and adhering tightly to a substrate.

Reason: This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 8 open meetings and over 100 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: http://www.iccsafe.org/cs/AHC/Pages/default.aspx

This proposal is being co-sponsored by the ICC Code Technology Committee. The ICC Board established the ICC Code Technology Committee (CTC) as the venue to discuss contemporary code issues in a committee setting which provides the necessary time and flexibility to allow for full participation and input by any interested party. The code issues are assigned to the CTC by the ICC Board as "areas of study". Information on the CTC, including: meeting agendas; minutes; reports; resource documents; presentations; and all other materials developed in conjunction with the CTC effort can be downloaded from the following website: http://www.iccsafe.org/cs/cc/ctc/index.html. Since its inception in April, 2005, the CTC has held 25 meetings – all open to the public.

Healthcare occupancies have areas for long term patients. These areas are for pediatrics, psychiatric, substance abuse recovery units, etc . Patient prepared art and seasonal decorations help define a friendlier environment. Current code limits the decorative material to materials meeting NFPA 701. The proposed exception will allow up to 20% of the wall area to be decorative material without NFPA 701 documentation. This allowable area is in response to the user's needs to address to display more artwork.

The original requirements for Group I-1 & I-2 occupancies allow photos and paintings are of such limited quantities that a hazard of fire development or spread is not present. NFPA 701 flame propagation is required for other decorative material. These 2012 edition Section 806.1 requirements are independent of automatic sprinkler protection. Automatic sprinklers are required in Group I-1 & I-2 facilities. Automatic suppression will limit the fire propagation to the area of origin. The decorative finishes will not adversely affect the automatic sprinkler performance for typical materials of paper, cloth, textiles, and plastic films in quantities limited to less than 20% of the wall area. Burning characteristics vary widely based on the material used. The new automatic sprinkler technology required by NFPA 13 "Standard for the Installation of Automatic Sprinklers" will respond quicker to a fire. Quick response automatic sprinklers are required in all new light hazard areas. The quick response sprinkler technology was mandated in NFPA 13 in the 1996 edition of the standard. Group I-1 & I-2 corridor and circulation spaces are considered light hazard area for automatic sprinkler protection. These quick response sprinklers will respond 3 to 5 times faster than standard response sprinklers. This faster response will start suppression when the fire is smaller with less heat and products of combustion generation.

The 2012 IFC Section 807.4.3.2 and 807.4.4.2 for Group E and I-4 occupancies allow art work and teaching materials on the corridor walls not to exceed 20% of the wall area. These occupancy types are required to be protected with automatic sprinklers in most configurations. There is trained staff in the facility at all times it is occupied by students, children or clients. Group I-1 and I-2 occupancies have trained staff present 24 hours a day. Similar safe guards are present in these 3 types of occupancies. I-1 and I-2 also have smoke zoning and special protection of hazard requirements to control exposure to the products of combustion.

Flame spread on the decorative wall covering will be primarily in the vertical direction. Horizontal propagation will occur at a considerably slower rate than the vertical in typical corridor configurations. This slower horizontal propagation can be retarded or suppressed by the quick response sprinklers. 20% of the wall area was selected as a reasonable limit, allowing the facility flexibility in using decorative wall materials.

Cost impact: This proposal will not increase the cost of construction.

==========

Round 1, Issue 9 FIRE ALARMS - AUDIBLE AND VISIBLE

Fxx-13
907.2.6 (IBC [F] 907.2.6); 907.5.2.1 (IBC [F] 907.5.2.1); 907.5.2.3 (IBC [F] 907.5.2.3)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

907.2.6 (IBC [F]907.2.6) Group I. A manual fire alarm system that activates the occupant notification system in accordance with Section 907.5 shall be installed in Group I occupancies. An automatic smoke detection system that activates the occupant notification system in accordance with Section 907.5 shall be provided in accordance with Sections 907.2.6.1, 907.2.6.2 and 907.2.6.3.3.

Exceptions:

1. Manual fire alarm boxes in sleeping units of Group I-1 and I-2 occupancies shall not be required at exits if located at all care providers' control stations or other constantly attended staff locations, provided such stations are visible and continuously accessible and that travel distances required in Section 907.4.2.1 are not exceeded.

2. Occupant notification systems are not required to be activated where private mode signaling installed in accordance with NFPA 72 is approved by the fire code official and staff evacuation responsibilities are included in the fire safety and evacuation plan required by Section 404.

907.5.2 (IBC [F] 907.5.2) Alarm notification appliances. Alarm notification appliances shall be provided and shall be listed for their purpose.

907.5.2.1 (IBC [F] 907.5.2.1) Audible alarms. Audible alarm notification appliances shall be provided and emit a distinctive sound that is not to be used for any purpose other than that of a fire alarm.

Exceptions:

1. ~~Visible alarm notification appliances shall be allowed in lieu of audible alarm notification appliances in critical care areas of Group I-2 occupancies~~. Audible alarm notification appliances are not required in critical care areas of Group I-2 Condition 2 occupancies that are in compliance with Section 907.2.6, Exception 2.

2. A visible alarm notification appliance installed in a nurses' control station or other continuously attended staff location in a Group I-2 Condition 2 suite shall be an acceptable alternative to the installation of audible alarm notification appliances throughout the suite in Group I-2 Condition 2 occupancies that are in compliance with Section 907.2.6, Exception 2.

~~2~~ 3. Where provided, audible notification appliances located in each occupant evacuation elevator lobby in accordance with Section 3008.10.1 of the *International Building Code* shall be connected to a separate notification zone for manual paging only.

907.5.2.3 (IBC [F] 907.5.2.3) Visible alarms. Visible alarm notification appliances shall be provided in accordance with Sections 907.5.2.3.1 through 907.5.2.3.4.

Exceptions:

1. Visible alarm notification appliances are not required in alterations, except where an existing fire alarm system is upgraded or replaced, or a new fire alarm system is installed.

2. Visible alarm notification appliances shall not be required in exits as defined in Section 1002.1.

3. Visible alarm notification appliances shall not be required in elevator cars.

4. Visual alarm notification appliances are not required in critical care areas of Group I-2 Condition 2 that are in compliance with Section 907.2.6, Exception 2.

Reason: This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 8 open meetings and over 100 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at:
http://www.iccsafe.org/cs/AHC/Pages/default.aspx

The proposed changes are a clarification of the application of 'private mode' signaling as allowed by NFPA 72 and provides linkage to the emergency action plan necessary for 'private mode' to be safely implemented.

The change to Section 907.7.2.6 Exception 2 links the use of "private mode" signaling under NFPA 72 to the emergency action plan portion of the code. The use of private mode appliances relies on a trained staff to respond and provide for occupant evacuation/defend in place actions.

Exception 1 of 907.5.2.1 is proposed for modification to eliminate the requirement for the visible signal and the audible signal in Group I-2 hospital critical care areas, operating rooms for example. In private mode, as permitted by Section 907.2.6, Exception 1, there is still a requirement for an audible alarm notification from appliances, though at a much lower decibel level meant to alert staff of the alarm activation. The current language at Section 907.5.2.1, Exception 1 allows that audible alarm to be eliminated from critical care areas (operating rooms) in exchange for a visual notification device. However, the visual signal device also creates a distraction in critical care areas that may not be able to immediately stop a patient procedure and this proposal is to eliminate the visual alarm notification and to link the exception back to the primary allowance for private mode where we have provided for a link to the emergency action plan. The emergency action plan would include provisions for alerting of critical area staff and the actions to be taken.

A new second exception is added to 907.5.2.1 to allow for an alarm indicator in a control area of a hospital suite in lieu of audible devices throughout the suite. In a suite arrangement the "control area" is the centrally manned location for staff monitoring patients in the separate rooms. An alarm indicator at this location will alert staff for response in a more effective and efficient manner.

A fourth exception is added to 907.5.2.3 to correlate the allowance for eliminating the audible and visual alarm devices from the critical care areas and to link the exception back to the primary allowance for private mode where we have provided for a link to the emergency action plan.

The emergency plan should reflect the response to the private mode alarm signals including the response necessary in critical care areas and who is responsible for alerting critical care area staff.

Cost Impact: This proposal will not increase the cost of construction.

==========

K-tag K161

Fxx-13
1103.3; 1103.3.1 (New); 1103.3.2

Proponent: John Williams, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

1103.3 Existing elevators. Existing elevators, escalators, dumbwaiters and moving walks shall comply with the requirements of Sections 1103. 3.1 and 1103.3.2.

1103.3.1 Elevators, escalators, dumbwaiters and moving walks. Existing elevators, escalators, dumbwaiters and moving walks in ambulatory care facilities and Group I-2 Condition 2 shall comply with ASME A17.3.

1103.3.2 Elevator emergency operation. Existing elevators with a travel distance of 25 feet (7620 mm) or more above or below the main floor or other level of a building and intended to serve the needs of emergency personnel for fire-fighting or rescue purposes shall be provided with emergency operation in accordance with ASME A17.3.

11-9-11 Mark Goska:

Reason: The healthcare industry has historically been required to comply with regulations set forth by accreditation and certification agencies, such as The Joint Commission. Because the ICC family of codes does not currently have an existing elevator standard, ASME A17.3 *Safety Code for Existing Elevators and Escalators* is proposed for compliance of existing elevators in Group I-2 and ambulatory care facility occupancies. ASME A17.3 has been referenced by guidelines adopted by The Joint Commission for over a decade and this code change will provide correlation of the IFC with the mandated healthcare industry standard.

Adding a reference to ASME A17.3 will require that existing elevators escalators, dumbwaiters and moving walks and their related operating equipment in ambulatory care facilities and Group I-2 hospitals comply with a minimum level of safety. Because the occupants of these types of facilities are often incapable of self-preservation, it will also provide important features essential for occupant safety including escalator and moving walk emergency stop buttons and automatic skirt obstruction stop feature and, for power dumbwaiters, hoistway door locking to keep doors closed except for the floor where the car is being loaded or unloaded. A new Section 1103.3 is included editorially to conform to established code style for multiple requirement sections.

This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of

the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 8 open meetings and over 100 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: http://www.iccsafe.org/cs/AHC/Pages/default.aspx

Cost Impact: The code change proposal should not increase the cost because compliance with similar requirements is already mandated by facility licensure requirements.

==========

Round 1, Issue 12A

Fxx-13
Table 5003.1.1(1) [IBC Table [F]307.1(1)]

Proponent: John Williams, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

TABLE 5003.1.1(1) [IBC Table [F] 307.1(1)]
MAXIMUM ALLOWABLE QUANTITY PER CONTROL AREA OF HAZARDOUS MATERIALS POSING A PHYSICAL HAZARD [a, j, m, n, p]

MATERIAL	CLASS	GROUP WHEN THE MAXIMUM ALLOWABLE QUANTITY IS EXCEEDED	STORAGE [b]			USE-CLOSED SYSTEMS [b]			USE-OPEN SYSTEMS [b]	
			Solid pounds (cubic feet)	Liquid gallons (pounds)	Gas cubic feet at NTP	Solid pounds (cubic feet)	Liquid gallons (pounds)	Gas cubic feet at NTP	Solid pounds (cubic feet)	Liquid gallons (pounds)

(Portions of table not shown do not change.)

For SI: 1 cubic foot = 0.028 m3, 1 pound = 0.454 kg, 1 gallon = 3.785 L.
NL = Not Limited; N/A = Not Applicable; UD = Unclassified Detonable

a. through o. (No change to current text)
p. The following shall not be included in determining the maximum allowable quantities:
1. Liquid or gaseous fuel in fuel tanks on vehicles.
2. Liquid or gaseous fuel in fuel tanks on motorized equipment operated in accordance with this code.

3. Gaseous fuels in piping systems and fixed appliances regulated by the *International Fuel Gas Code.*

4. Liquid fuels in piping systems and fixed appliances regulated by the *International Mechanical Code*.

5. In Group I-2 Condition 2, alcohol based hand rubs classified as Class I or II liquids where installed in accordance with Sections 5705.5 and 5705.5.1. The location of the alcohol based hand rub (ABHR) dispensers shall be provided in the construction documents.

q. (No change to current text)

Reason: This proposed change will allow a reasonable amount of Alcohol based Hand Rub for Infection Control and Patient Life Safety located in Group I-2 Hospitals in appropriately sized dispensers to be located in control areas and permits the amounts not to be included in determining the maximum allowable quantities. IFC Section 5705.5 - addresses the specifics regarding these amounts and locations.

This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 8 open meetings and over 100 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at:
http://www.iccsafe.org/cs/AHC/Pages/default.aspx

Cost Impact: This proposal will not increase the cost of construction.

==========

K-tag K76 Medical Gas Ventilation

Fxx-13
5306.2.1

Proponent: John Williams, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

5306.2.1 One-hour exterior rooms. A 1- hour exterior room shall be a room or enclosure separated from the remainder of the building by fire barriers constructed in accordance with Section 707 of the *International Building Code* or horizontal assemblies constructed in accordance with Section 711 of the *International Building Code*, or both, with a fire- resistance rating of not less than 1- hour. Openings between the room or enclosure and interior spaces shall be self-closing smoke- and draft-control assemblies having a fire protection rating of not less than 1hour. Rooms shall have at least one exterior wall that is provided with at least two non-closable louvered vents. Each vent shall have a minimum free opening area of 24 square inches (155 cm^2) for each 1,000 cubic feet (28 m^3) at normal temperature and pressure (NTP) of gas stored in the room and shall not be less than 72 square inches (465 cm2) in aggregate free opening area. One vent shall be within 6 inches (152 mm) of the floor and one shall be

within 6 inches (152 mm) of the ceiling. Rooms shall be provided with at least one automatic sprinkler to provide container cooling in case of fire.

Reason: This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 8 open meetings and over 100 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at:
http://www.iccsafe.org/cs/AHC/Pages/default.aspx

The purpose of this proposal is to update Section 5306.2.1 on Medical Gas Systems to clarify and address the differences with the language in NFPA 99-2012, Section 9.3.7.5.2 with which hospitals are required to comply.

This proposed revision requires the vents to be of the non-closable type which is not currently required in the IFC, and of a larger size. It further defines the louver opening as “aggregate free opening” as required which is not currently specified in the IFC.

NFPA 99 is the more restrictive and sets the design of the louver to be specifically fixed where the IFC language may result is a “closable” louver which is not the intent of this code section. It also provides clarification on the sizing of the louver as it relates to the amount of gas being stored in the room where the IFC currently does not.

Cost impact: The code change proposal should not increase the cost of construction because compliance with the standard is already required by facility licensure requirements.

==========

Round 1, Issue 12 ALCOHOL-BASED HAND RUB DISPENSERS IN PATIENT ROOMS (See also K-tag K211)

(CTC Care Facilities would agree with this for Group I-1 and I-2)

Fxx-13
5705.5, 5705.5.1

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care and Carl Baldassarra, P.E., FSFPE, Chair, ICC Code Technology Committee

Revise as follows:

5705.5 Alcohol-based hand rubs classified as Class I or II liquids. The use of wall-mounted dispensers containing alcohol- based hand rubs classified as Class I or II liquids shall be in accordance with all of the following:

1. The maximum capacity of each dispenser shall be 68 ounces (2 L).
2. The minimum separation between dispensers shall be 48 inches (1219 mm).

3. The dispensers shall not be installed ~~directly adjacent to, directly~~ above**,** ~~or~~ below**,** or closer than 1 inch to an electrical receptacle, switch, appliance, device or other ignition source. The wall space between the dispenser and the floor or intervening counter top shall be free ~~remain clear and unobstructed~~ of electrical receptacles, switches, appliances, devices, or other ignition sources.
4. Dispensers shall be mounted so that the bottom of the dispenser is a minimum of 42 inches (1067 mm) and a maximum of 48 inches (1219 mm) above the finished floor.
5. Dispensers shall not release their contents except when the dispenser is manually activated. Facilities shall be permitted to install and use automatically activated "touch free" alcohol-based hand-rub dispensing devices with the following requirements:

    5.1. The facility or persons responsible for the dispensers shall test the dispensers each time a new refill is installed in accordance with the manufacturer's care and use instructions.
    5.2. Dispensers shall be designed and must operate in a manner that ensures accidental or malicious activations of the dispensing device are minimized. At a minimum, all devices subject to or used in accordance with this section shall have the following safety features:
        5.2.1. Any activations of the dispenser shall only occur when an object is placed within 4 inches (98 mm) of the sensing device.
        5.2.2. The dispenser shall not dispense more than the amount required for hand hygiene consistent with label instructions as regulated by the United States Food and Drug Administration (USFDA).
        5.2.3. An object placed within the activation zone and left in place will cause only one activation.

6. Storage and use of alcohol-based hand rubs shall be in accordance with the applicable provisions of Sections 5704 and 5705.

7. Dispensers installed in occupancies with carpeted floors shall only be allowed in smoke compartments or fire areas equipped throughout with an approved automatic sprinkler system in accordance with Section 903.3.1.1 or 903.3.1.2.

5705.5.1 Corridor installations. In addition to the provisions of Section 5705.5, ~~W~~ where wall-mounted dispensers containing alcohol-based hand rubs are installed in corridors or rooms and areas open to the corridor, they shall be in accordance with all of the following:

1. Level 2 and 3 aerosol containers shall not be allowed in corridors.

2. The maximum capacity of each Class I or II liquid dispenser shall be 41 ounces (1.21 L) and the maximum capacity of each Level 1 aerosol dispenser shall be 18 ounces (0.51 kg).
3. The maximum quantity allowed in a corridor within a control area shall be 10 gallons (37.85 L) of Class I or II liquids or 1135 ounces (32.2 kg) of Level 1aerosols, or a combination of Class I or II liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gallons (37.85 L) or 1,135 ounces (32.2 kg) such that the sum of the ratios of the liquid and aerosol quantities divided by the allowable quantity of liquids and aerosols, respectively, shall not exceed one.

4. The minimum corridor width shall be 72 inches (1829 mm).

5. Projections into a corridor shall be in accordance with Section 1003.3.3.

Reason: This proposed change will reduce the capacity volume of the individual dispenser located in corridors and areas open to corridors in the IFC from 68 ounces to 40.96 ounces to provide correlation with the maximum allowed volume for Group I-2 hospitals in NFPA 101. The 2 L maximum capacity dispenser in all other areas remains.

Section 5705.5(3): Because ABHR dispensers are often installed above fixed casework countertops, Section 5705.5(3) is being revised to address the practical issue of clearances from the dispenser to ignition sources associated with the countertop installation. Establishing the minimum clearance requirements provides clarity to the fire code official and to designers and facility administrators.

Section 5705.5.1: As part of the institution's infection control protocol, many places where ABHR dispensers are installed in healthcare facilities are areas that are open to the corridor as permitted by Section 407 of the *International Building Code*. As such, this section is being revised to include such areas.

Reducing the amount of liquid in the dispensers does not increase a risk within the facility. Establishing the minimum distance requirement provides clarity to the Code Official and to the Designers.

This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 8 open meetings and over 100 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: http://www.iccsafe.org/cs/AHC/Pages/default.aspx

This proposal is being co-sponsored by the ICC Code Technology Committee. The ICC Board established the ICC Code Technology Committee (CTC) as the venue to discuss contemporary code issues in a committee setting which provides the necessary time and flexibility to allow for full participation and input by any interested party. The code issues are assigned to the CTC by the ICC Board as "areas of study". Information on the CTC, including: meeting agendas; minutes; reports; resource documents; presentations; and all other materials developed in conjunction with the CTC effort can be downloaded from the following website: http://www.iccsafe.org/cs/cc/ctc/index.html. Since its inception in April, 2005, the CTC has held 25 meetings – all open to the public.

Cost impact: This proposal will not increase the cost of construction.

==========

FIRE CODE ACTION COMMITTEE
CODE CHANGE PROPOSAL AFFECTING AMBULATORY CARE FACILITIES

ITEM 126 – CODE CHANGE PROPOSAL

Ambulatory Care Facilities; IFC Section 907.2.2.1 – Group B
New proposal by Dan Finnegan, IAFC FLSS
Submitted June 14, 2012

Code: IFC – 12/13

Code Sections Proposed for Revision: IFC 907.2.2.1

Proponent: FCAC Work Group
Dan Finnegan

Revise IFC Section 907.2.2.1 as follows:

[F] 907.2.2.1 Ambulatory care facilities. *Fire areas* containing ambulatory care facilities shall be provided with an electronically supervised automatic smoke detection system installed within the ambulatory care facility and in public use areas outside of tenant spaces, including public *corridors* and elevator lobbies.

~~**Exception:** Buildings equipped throughout with an *automatic sprinkler system* in accordance with Section 903.3.1.1, provided the occupant notification appliances will activate throughout the notification zones upon sprinkler waterflow.~~

REASON: The intent of this proposal is to provide the minimum level of life safety in Ambulatory Care Facilities by having both early warning smoke detection and fire sprinklers in critical areas.

Technical justification is provided in a recent study by the University Of Maryland School Of Fire Protection Engineering, titled Performance of Smoke Detectors and Sprinklers in Residential and Health-Care Occupancies, May 14, 2010. This report supports the value of having both smoke detection and fire sprinklers in critical areas for Life Safety.

The report may be accessed at:

http://www.afaa.org/pdf/Performance%20of%20Smoke%20Detectors%20and%20Sprinklers%20in%20Residential%20and%20Healthcare%20Facilities.pdf

June 19, 2012 F-CAC Comments:

- The proponent believes this occupancy is a use where early detection of combustion products and occupant notification is necessary.
- The UOM report references a number of incidents where smoke detection activated and sprinkler activation did not occur. However the report's format makes it difficult to make meaningful conclusions.
- ACFs are Group B occupancies, Section 903.3.2 permits standard response sprinklers.

Proponent should seek review from ICC/ASHE Health Care Ad-Hoc Committee.