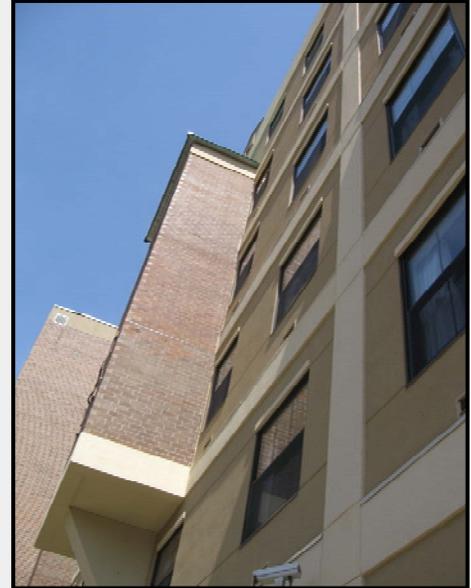




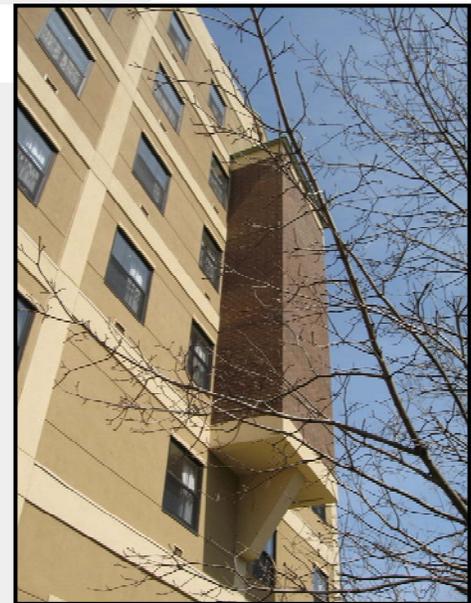
Window Replacements: Do you do windows?

A large scale window replacement is a significant undertaking for health care facility. A multitude of factors must be considered including: cost, logistics, code compliance, window style, type of operation, glazing and frame material.

A major cost component of any window replacement project is logistics. On multi-story replacements, it may be necessary to construct scaffolding to physically “get to the windows” along with sidewalk bridges and similar structures to protect pedestrians below. A facility can take added advantage of this scaffolding to undertake an “up-close”, detailed visual inspection of its facade. Such inspections can identify areas that require, pointing, caulking, flashing or even structural repairs. Very often it is such “collateral” problems that prove to be a major reason why the windows need to be replaced. Phasing is another “soft cost” that must be factored into any window replacement project. Unless a facility has significant swing space the contractor will be restricted as to how many windows it can replace in a given work day. Such restrictions, which prolong a project thereby adding cost, are usually related to how many rooms can be emptied at the beginning of a work day with the intention of leaving the building weather tight (with new windows) at the end of that same work day. The average residential care facility can usually absorb the daily shifting of 8 to 12 residents (4 to 6 rooms) to other units or areas of the building to facilitate window replacements.



For reasons of cost, durability and fire resistance, we are most often selecting aluminum replacement windows. We always specify window units certified by the Aluminum Window Manufacturers Association (AWMA) which has established tests and performance criteria for air & water infiltration, structural strength and forced entry resistance. In a replacement scenario, we are obviously forced to work within the dimensions of the existing opening. The larger the opening, the greater the flexibility in changing the style and operation of the window. Small openings (3 feet in width or less) usually dictate the installation of single hung or double hung units. Larger openings allow for sliding style units or a combination of fixed and hinged units.



Codes governing residential health care facilities require that windows be operable but be fitted with special stops to limit the opening aperture to six inches in width. Certain window types like “double-hung”, “sliders” and “crank-type” are more difficult for elderly, frail residents to operate. Hinged or pivot in-swing type units (in combination with fixed sections) are more easily operated and do not conflict with required insect screens. Energy codes (at a minimum) require that windows be double glazed. Specifying insulating glass with argon-gas in the air cavity and/or using tinted or shaded glass can increase a window’s energy efficiency. The higher first cost of these options will be offset over time by lower utility bills.