Comprehensive Emergency Management Plan (CEMP)

Taconic Rehabilitation and Nursing at Hopewell

3 Summit Court, Fishkill, New York 12524

Emergency Contacts

SEE CEMP BINDER IN NURSING SUPERVISOR'S OFFICE FOR COMPLETE PHONE LISTING

The following table lists contact information for public safety and public health representatives for quick reference during an emergency.

Table 1: Emergency Contact Information

Organization	Phone Number(s)
Local Fire Department – Fishkill, NY	First: 911; Office: (845) 471 5106
Local Police Department – Fishkill, NY	First: 911; Office (845) 831 1110
Emergency Medical Services	911
Local Office of Emergency Management (Dutchess County)	First: 911; Office (845) 486 3562 Cell (845) 527 2695
NYSDOH Regional Office (New Rochelle)	(914) 654 7058
NYSDOH Duty Officer	(914) 654 7067
New York State DOH	(845) 486 3562

Plan Approval

This Comprehensive Emergency Management Plan (CEMP) has been approved for implementation by:

Christina Bushey-Darrer 8/23/24
Administrator Taconic Rehabilitation and Nursing at Hopewell

Record Of Changes

Version #	Implemented By	Revision Date	Description of Change
1	Clayton Harby, Administrator	July 6, 2022	New Policy / Ownership Change
2	Carl Kelly, Administrator	July 1,2023	Change of Administrator
3	Christina Bushey-Darrer, Administrator	September 1, 2023	Change of Administrator
4	Christina Bushey-Darrer, Administrator	8/23/24	Annual Review

Record of External Distribution

Date	Recipient Name	Recipient Organization	Format	Number of Copies
7/6/2022	Mario Gonzalez	Dutchess County Office of Emergency Management	Email	1
7/2023	William Beale	Dutchess County Office of Emergency Management	Email	1
8/2024		Dutchess County Office of Emergency Management	Email	1

1.0 Introduction

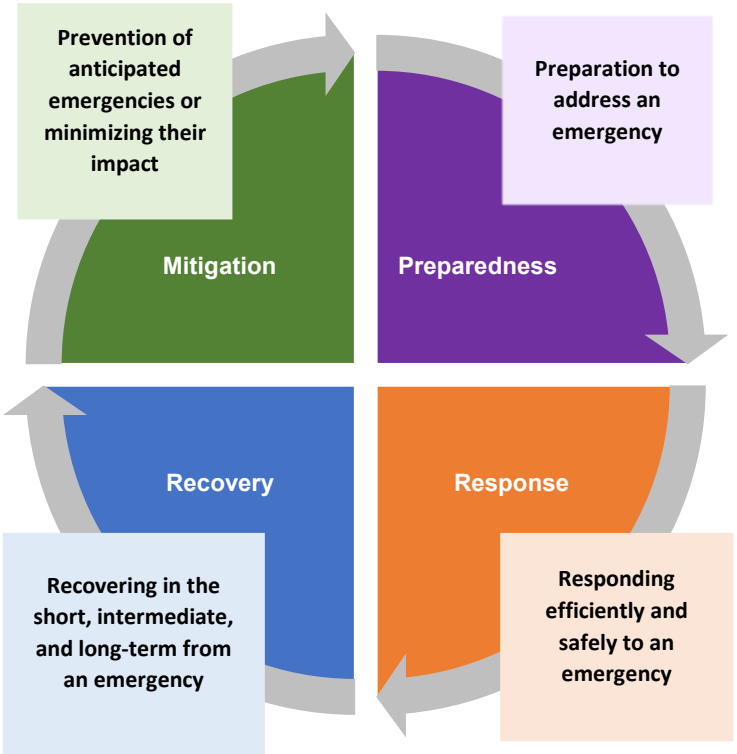
To protect the well-being of residents, staff, and visitors, the following all-hazards Comprehensive Emergency Management Plan (CEMP) has been developed and includes considerations necessary to satisfy the requirements for a Pandemic Emergency Plan (PEP). Appendix K of the CEMP has been adjusted to meet the needs of the PEP and will also provide facilities a form to post for the public on the facility's website, and to provide immediately upon request. The CEMP is informed by the conduct of facility-based and community-based risk assessments and pre-disaster collaboration with the following stakeholders:

- Facility leadership team
- Dutchess County Emergency Services
- Fishkill Police Department
- Fishkill (Rombout) Fire Department
- NYS Regional Office, New Rochelle

This CEMP is a living document that must be reviewed on an annual basis and updated as needed.

2.0 Purpose

The purpose of this plan is to describe the facility's approach to mitigating the effects of, preparing for, responding to, and recovering from natural disasters, man-made incidents, and/or facility emergencies.



3.0 Scope

The scope of this plan extends to any event that disrupts, or has the potential to significantly disrupt, the provision of normal standards of care and/or continuity of operations, regardless of the cause of the incident (i.e., man-made or natural disaster).

The plan provides the facility with a framework for the facility's emergency preparedness program and utilizes an all-hazards approach to develop facility capabilities and capacities to address anticipated events.

An Incident Command System (ICS) framework will act as the operational component of this CEMP. The ICS framework allows for maximum flexibility and scalability and is capable of utilizing a facility's present resources onsite to manage any type and size disaster.

4.0 Situation

4.1 Risk Assessment

The facility conducts an annual risk assessment (i.e. Hazard Vulnerability Assessment –HVA) to identify which natural and man-made hazards pose the greatest risk to the facility (i.e., human and economic losses based on the vulnerability of people, buildings, and infrastructure).

The facility conducted a facility-specific risk assessment on 6/28/2023 and determined the following hazards may affect the facility's ability to maintain operations before, during, and after an incident:

- Fire
- Extreme heat and/or cold
- Infectious disease (i.e. COVID 19, MRSA, C diff, etc.)
- Winter storm/severe weather
- Loss of essential services (electric, gas, water, sewage, communications)
- Hurricane/coastal storms
- High winds/tornado
- Flooding (internal and external)
- Missing resident
- Labor action (i.e. strike, work stoppage)
- Active Shooter/threat
- Intruder Onsite
- Chemical, Biological, Nuclear disaster
- Bomb threat
- Incoming surge of residents from the community

This risk information serves as the foundation for the plan—including associated policies, procedures, and preparedness activities all of which are contained within this multipart document.

4.2 Mitigation Overview

The primary focus of the facility's pre-disaster mitigation efforts is to identify the facility's level of vulnerability to various hazards and mitigate those vulnerabilities to ensure continuity of service delivery and business operations despite potential or actual hazardous conditions.

To minimize impacts to service delivery and business operations during an emergency, the facility has completed the following mitigation activities:

- Development and maintenance of a CEMP
- Procurement of emergency supplies and resources
- Establishment and maintenance of mutual aid and vendor agreements to provide supplementary emergency assistance
- Regular instruction to staff on plans, policies, and procedures
- Validation of plans, policies, and procedures through exercises.

4.2 Planning Assumptions

This plan is guided by the following planning assumptions:

- Emergencies and disasters can occur without notice, any day, and on any shift.
- Emergencies and disasters may be facility-specific, local, regional, or state-wide.
- Local and/or state authorities may declare an emergency.
- The facility may receive requests from other facilities for resource support (supplies, equipment, staffing, or to serve as a receiving facility).
- Facility security may be compromised during an emergency.
- The emergency may exceed the facility's capabilities and external emergency resources may be unavailable. The facility is expected to be able to function without an influx of outside supplies or assistance for 72 hours.
- Power systems (including emergency generators) could fail.
- During an emergency, it may be difficult for some staff to get to the facility, or alternately, they may need to stay in the facility for a prolonged period of time.

5.0 Notification and Activation

5.1 Hazard Identification

The facility may receive advance warning about an impending natural disaster (e.g., hurricane forecast) or man-made threat (e.g., law enforcement report), which will be used to determine initial response activities and the movement of personnel, equipment, and supplies. For no-notice incidents (e.g., active shooter, tornado), facilities will not receive advance warning about the disaster, and will need to determine response activities based on the impact of the disaster.

The Incident Commander may designate a staff member to monitor evolving conditions, typically through television news, reports from government authorities, and weather forecasts.

All staff have a responsibility to report potential or actual hazards or threats to their direct supervisor.

5.2 Activation

Upon notification of hazard or threat—from staff, residents, or external organizations—the senior-most on-site facility official will determine whether to activate the plan based on one or more of the triggers below:

- The potential for a significant disruption to normal clinical and/or business operations
- The facility has determined to implement a protective action.
- The facility is serving as a receiving facility.
- The facility is testing the plan during internal and external exercises (i.e., fire drills, disaster drills, etc.).

If one or more activation criteria are met and the plan is activated, the senior-most on-site facility official—or the most appropriate official based on the incident—will assume the role of “Incident Commander” and operations proceed as outlined in this document.

5.3 Staff Notification

Once a hazard or threat report has been made, an initial notification message will be disseminated to staff in accordance with the facility's communication plan.

Department Managers or their designees will contact on-duty personnel to provide additional instructions and solicit relevant incident information from personnel (e.g., status of residents, status of equipment).

Once on-duty personnel have been notified, Department Managers will notify off-duty personnel if necessary and provide additional guidance/instruction (e.g., request to report to facility).

Department personnel are to follow instructions from Department Managers, keep lines of communication open, and provide status updates in a timely manner.

5.4 External Notification

Depending on the type and severity of the incident, the facility may also notify external parties (e.g., local office of emergency management, resource vendors, relatives and responsible parties) utilizing local notification procedures to request assistance (e.g., guidance, information, resources) or to provide situational awareness.

The NYSDOH Regional Office is a mandatory notification recipient regardless of hazard type, while other notifications may be hazard-specific. **Table 2: Notification by Hazard Type** provides a comprehensive list of mandatory and recommended external notification recipients based on hazard type.

Table 2: Notification by Hazard Type

M = Mandatory
R = Recommended

Notification Recipient	Example Hazard	Active Threat	Winter Storm	Coastal Storm	Intruder Alert	Water Disruption	Earthquake	Extreme Cold	Extreme Heat	Fire	Flood	CBRNE	Infectious Disease / Pandemic	Labor Action	IT/Comms Failure	Power Outage	Tornado/High	Loss of Resident
NYSDOH Regional Office	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Facility Senior Leader	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Local Emergency Management	R	M	R	R	□	R	M	□	□	□	R	R	R	□	□	□	R	□
Local Law Enforcement		M	□	R	M	□	R	□	□	M	R	M	□	R	□	□	□	R
Local Fire/EMS		M	□	R	□	R	M	R	R	M	R	M	□	□	□	R	R	R
Local Health Department	R	M	M	M	□	M	M	M	M	M	M	M	M	M	M	M	M	M
Off Duty Staff		R	□	R	□	□	R	□	□	□	□	□	□	□	□	□	□	□
Relatives and Responsible Parties		□	□	□	□	□	R	□	□	□	□	□	M	□	□	□	□	M
Resource Vendors		□	R	R	□	R	R	R	R	R	R	R	□	R	R	R	R	□
Authority Having Jurisdiction		□	□	R	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Mutual Aid Plan Operation Ctr		R	R	R	□	□	R	□	□	R	R	R	□	□	□	□	R	□
TMG Leadership		M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M

*Notifications as they relate to this chart are only documenting the **immediate need** to update the parties above. For example, responsible parties would rarely be updated during the onset of the disaster. Rather, they would all be notified at an appropriate time after the emergency has been stabilized.

6.0 Mobilization

6.1 Incident Management Team (IMT)

Upon plan activation, the Incident Commander will activate some or all positions of the Incident Management Team, which is comprised of pre-designated personnel who are trained and assigned to plan and execute response and recovery operations.

Incident Management Team activation is designed to be flexible and scalable depending on the type, scope, and complexity of the incident. As a result, the Incident Commander will decide to activate the entire team or select positions based on the extent of the emergency.

Table 3 outlines suggested facility positions to fill each of the Incident Management Team positions. The most appropriate individual given the event/incident may fill different roles as needed.

Table 3: Incident Management Team - Facility Position Crosswalk

Incident Position	Facility Position Title	Description
Incident Commander	Highest ranking management team member onsite during the individual incident.	Leads the response and activates and manages other Incident Management Team positions.
Public Information Officer	Director of Communications	Provides information and updates to visitors, relatives and responsible parties, media, and external organizations.
Safety Officer	Director of Maintenance	Ensures safety of staff, residents, and visitors; monitors and addresses hazardous conditions; empowered to halt any activity that poses an immediate threat to health and safety.
Operations Section Chief	Director of Nursing or next highest ranking Nursing Dept. Manage	Manages tactical operations executed by staff (e.g., continuity of resident services, administration of first aid).
Planning Section Chief	Assistant Director of Nursing or Staff Educator	Collects and evaluates information to support decision-making and maintains incident documentation, including staffing plans.

Incident Position	Facility Position Title	Description
Logistics Section Chief	Medical Records Coordinator	Locates, distributes, and stores resources, arranges transportation, and makes alternate shelter arrangements with receiving facilities.
Finance/Admin Section Chief	Business Office Manager/Payroll and Human Resources Manager	Monitors costs related to the incident while providing accounting, procurement, time recording, and cost analyses.

It is important to understand that multiple different individuals based on their knowledge and/or availability can fill each Incident Management Team (IMT) position. The flexibility of the plan allows IMT positions to be filled by individuals currently onsite for the emergency, rather than being dependent upon a small group of specific individuals.

6.2 Command Center

The Incident Commander will designate a space, e.g., facility conference room or other large gathering space, on the facility premises to serve as the centralized location for incident management and coordination activities, also known as the "Command Center."

The designated location for the Command Center is the **Main Conference Room** and the secondary/back-up location is the **Education Room**, unless circumstances of the emergency dictate the specification of a different location upon activation of the CEMP, in which case staff will be notified of the change at time of activation. **In the case of a violent situation, the Plant Operations Office is designated.**

6.3 Response

The Incident Commander will convene activated Incident Management Team members in the Command Center and assign staff to assess designated areas of the facility to account for residents and identify potential or actual risks, including the following:

- Number of residents injured or affected;
- Status of resident care and support services;
- Extent or impact of the problem (e.g., hazards, life safety concerns);
- Current and projected staffing levels (clinical, support, and supervisory/managerial);
- Status of facility plant, utilities, and environment of care;
- Projected impact on normal facility operations;
- Facility resident occupancy and bed availability;
- Need for protective action; and
- Resource needs.

6.4 Staffing

Based on the outcomes of the assessment, the Planning Section Chief along with the facility Staffing Coordinator, will develop a staffing plan for the operational period (e.g., remainder of shift). The Operation Section Chief will execute the staffing plan by overseeing staff execution of response activities. The Finance/Administration Section Chief along with facility payroll and HR managers - will manage the storage and processing of timekeeping and related documentation to track staff hours. For union and non/union nurse coverage during an emergency/disaster, see policy 9.12.

6.5 Recovery

Recovery services focus on the needs of residents and staff and help to restore the facility's pre-disaster physical, mental, social, and economic conditions. Recovery services may include coordination with government, non-profit, and private sector organizations to identify community resources and services (e.g., employee assistance programs, state and federal disaster assistance programs, if eligible). Pre-existing facility- and community- based services and pre-established points of contact are provided in **Table 4**.

Table 4: Pre-Identified Recovery Services

Service	Description of Service	Point(s) of Contact
Physical Plant Related Repairs/Reconstruction/Cleanup/Waste removal	Repair or replacement of physical plant components damaged or destroyed during the emergency.	▪ TMG ▪ Facility Director of Maintenance
Trauma/Grief Counseling	Trauma/grief counseling or other necessary social services for residents and/or staff members mentally/emotionally affected by emergency situation.	▪ TMG: ▪ Director of Social Services
Emergency Staffing Services	Provision of critical/additional staffing in order to meet care requirements or backfill current staff	▪ TMG ▪ Staffing Coordinator

Service	Description of Service	Point(s) of Contact
	affected by the emergency.	

Ongoing recovery activities, limited staff resources, as well as the incident's physical and mental health impact on staff members may delay facility staff from returning to normal job duties, responsibilities, and scheduling.

Resuming pre-incident staff scheduling will require a planned transition of staff resources, accounting for the following considerations:

- Priority staffing of critical functions and services (e.g., resident care services, maintenance, dining services).
- Personal staff needs (e.g., restore private residence, care for relatives, attend memorial services, mental/behavioral health services).
- Continued use or release of surge staffing, if activated during incident.

6.6 Demobilization

As the incident evolves, the Incident Commander will begin to develop a demobilization plan that includes the following elements:

- Activation of re-entry/repatriation process if evacuation occurred;
- Deactivation of surge staffing;
- Replenishment of emergency resources;
- Reactivation of normal services and operations; and
- Compilation of documentation for recordkeeping purposes.

6.7 Infrastructure Restoration

Once the Incident Commander has directed the transition from incident response operations to demobilization, the facility will focus on restoring normal services and operations to provide continuity of care and preserve the safety and security of residents.

Table 5 outlines entities responsible for performing infrastructure restoration activities and related contracts/agreements.

Table 5: Infrastructure Restoration Activities

Activity	Responsible Entity	Contracts/Agreements
Internal assessment of electrical power.	Maintenance Director and/or Administrator	▪ Duffy Mechanical / Costa Electrical
Clean-up of facility grounds (e.g., general housekeeping, removing debris and damaged materials).	Environmental Services Manager and/or Administrator	▪ To coordinate outside contractors based on specific needs. Red Cedar 845-795-3112
Internal damage assessments (e.g., structural, environmental, operational).	Environmental Services Manager and/or Administrator	▪ VP of Enterprise integration and Facilities Management to coordinate outside contractors based on specific needs. ▪ Fire Inspector Steve Vanburen 845-249-0110 ▪ Building Inspector Joel Petrus 845-590-8674
Clinical systems and equipment inspection.	Plant Operations and/or Administrator	▪ Health Systems Services for clinical equipment inspection.
Strengthen infrastructure for future disasters (if repair/restoration activities are needed).	Plant Operations and/or Administrator	▪ TMG support
Communication and transparency of restoration efforts to staff and residents.	Facility Administrator -	▪ TMG support
Recurring inspection of restored structures.	Environmental Services Manager and/or Administrator	▪ TMG support

6.7.1 Resumption of Full Services

Department Managers will conduct an internal assessment of the status of resident care services and advise the Incident Commander and/or facility leadership on the prioritization and timeline of recovery activities.

Special consideration will be given to services that may require extensive inspection due to safety concerns surrounding equipment/supplies and interruption of utilities support and resident care services that directly impact the resumption of services (e.g., food service, laundry).

Staff, residents, and relatives/responsible parties will be notified of any services or resident care services that are not available, and as possible, provided updates on timeframes for resumption. The Planning Section Chief will develop a phased plan for resumption of pre-incident staff scheduling to help transition the facility from surge staffing back to regular staffing levels.

6.7.2 Resource Inventory

Full resumption of services involves a timely detailed inventory assessment and inspection of all equipment, devices, and supplies to determine the state of resources post-disaster and identify those that need repair or replacement.

All resources, especially resident care equipment, devices, and supplies, will be assessed for health and safety risks. Questions on resource damage or potential health and safety risks will be directed to qualified service technicians and/or the original manufacturer for additional guidance.

7.0 Information Management

7.1 Critical Facility Records

7.1.1 Critical facility records that require protection and/or transfer during an incident include:

- Resident medical records
- Staff personnel files

The Facility maintains a complete record for each resident in accordance with accepted professional standards and practice. The facility shall protect and safeguard both its medical records and employee personnel records.

7.1.2 The record will be:

- Complete
- Accurately documented

- Readily accessible; and
- Systematically organized

1. Clinical Records are retained for six (6) years from the date of discharge or death or for residents who are minors, for three (3) years after the resident reaches the age of majority (18).
2. The Facility safeguards clinical record information against loss, destruction, or unauthorized use.

3. Closed and/or thinned Medical records will be stored in a locked room and protected from fire, water damage, insects, and theft.

4. Medical records of permanently discharged residents will be stored separately, labeled alphabetically for easy identification, and protected from fire, water damage, insects, and theft.

5. Medical records of inpatients will be stored at the nurses station and maintained on the desk or chart holder when not in use.

6. The Facility maintains a complete record for each resident in accordance with accepted professional standards and practice.

7. The Facility keeps confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

   - Transfer to another health care institution;
   - Law;
   - Third party payment contract; or
   - The resident
8. The Facility:

   - Permits each resident to inspect his or her records on request; and
   - Provides copies of the record to each resident no later that 48 hours after a written request from a resident or such greater period as State statue may permit, at a reasonable photocopying cost.

9. The clinical record contains:

   - Sufficient information to identify the resident
   - An interdisciplinary record of the resident's assessments
   - The interdisciplinary plan of care and services provided
   - The results of any preadmission screening conducted by the State
   - Progress notes by all practitioners and professional staff caring for the resident including Consultants

- Reports of all diagnostic tests and results of treatments and procedures ordered for the resident

10. All entries in the Medical Records System are kept current at all times and kept in a place convenient for use by authorized personnel.

11. All reports are entered promptly in the appropriate section in the Medical Record System, dated and signed by the person providing the service.

7.1.3 Personnel Records

- In compliance with Section 415 of the State Hospital Code, the operator shall maintain "personnel records for each employee, including the administrator, containing all available pre-employment information and an employment record for each payroll period."
- Access to information contained with-in the employee file is granted as outlined.

7.2 PROCEDURE:

1. The employee personnel file shall include the following:

<u>Personnel file:</u>

Employment application
Emergency contact form
Returned reference checks
Completed I-9 form
Completed W-4 form
License/Certification
Record of orientation & Job specific orientation
Employee attendance cards
Evaluation forms/Competency evaluations
Counseling statements
Reference requests for information
Payroll deduction information
Signed job description
All miscellaneous information related to employment

<u>Medical File:</u>

Pre-employment physical

Annual health screen

Immunization record

Disability/workers compensation information

<u>Education File:</u>

In-service Records

2. Current employee files will be kept on site for duration of employment.

3. Terminated employee files are kept on site for two years and off site for six (unless employee has had an exposure incident as defined by OSHA.

4. Only authorized payroll personnel and the Administrator or his/her designee will have access to personnel records.

*If computer systems are interrupted or non-functional, the facility will utilize paper-based recordkeeping in accordance with internal facility procedures.

7.3 Tracking Evacuated Residents

The facility will use the New York State Evacuation of Facilities in Disasters System ("eFINDS") and the Resident Evacuation Critical Information and Tracking Form to track evacuated residents and ensure resident care is maintained. See Annex K for further details regarding the e FINDS system.

7.4 Resident Confidentiality

The facility will ensure resident confidentiality throughout the evacuation process in accordance with the Health Insurance Portability and Accountability Act Privacy Rule (Privacy Rule), as well as with any other applicable privacy laws. Under the Privacy Rule, covered health care providers are permitted to disclose protected health information to public health authorities authorized by law to collect protected health information to control disease, injury, or disability, as well as to public or private entities authorized by law or charter to assist in disaster relief efforts.

7.5 Tracking Facility Personnel

The facility will use the Kronos clock system and/or the NHICS Form 252 - Section Personnel Time Sheet to track facility staff.

7.6 Staff Accountability

Staff accountability enhances site safety by allowing the facility to track staff locations and assignments during an emergency. Staff accountability procedures will be implemented as soon as the plan is activated.

The facility will utilize the Kronos system and the NHICS Form 252 - Section Personnel Time Sheet to track the arrival and departure times of staff. During every operational period (e.g., shift change), Department Managers or designees will conduct an accountability check to ensure all on-site staff are accounted for.

If an individual becomes injured or incapacitated during response operations, Department Managers or designees will notify the Incident Commander to ensure the staff member's status change is reflected in the NHICS Form 206 - Staff Injury Plan.

7.7 Non Facility Personnel

The Incident Commander will coordinate with the facility Medical Director to ensure that appropriate credentialing and verification processes are followed for the utilization of clinical volunteers. Throughout the response, Regional QA Nurse and Medical Records will track non-facility personnel providing surge support along with their respective duties and the number of hours worked. NHICS Form 253 - Clinical Volunteer Staff Registration form will be used to document approved/credentialed clinical volunteers, and NHICS Form 252 - Section Personnel Time Sheet will be utilized to track and verify their time. Form 252 will also be used to track non-clinical volunteers as well.

7.8 Communications

As part of CEMP development, the facility conducted a communications assessment to identify existing facility communications systems, tools, and resources that can be utilized during an incident and to determine where additional resources or policies may be needed.

Primary (the best and intended option) and alternate (secondary back-up option) methods of communication are outlined in **Table 6.**

Table 6: Methods of Communication

Mechanism	Primary Method of Communication	Alternate Method of Communication
Landline telephone	☒	☐
Cell Phone	☒	☐
Text Messages	☒	☐
Email	☒	☐
News Media	☐	☒
Radio Broadcasts	☐	☒
Social Media	☐	☒
Runners	☐	☒
Facility Website		
Robo Calls	☐	☒
Satellite Phone	☐	☒
Walkie Talkies	☐	☒

All forms of communication directed to the news media or other members of the public will be coordinated and approved by the TMG Communications Department. All internal communication, as well as external communications with stakeholders such as Emergency Services, Police/Fire Officials, DOH, etc. will be coordinated and approved by the Incident Commander.

Upon plan activation, the Incident Commander may designate a staff member as the Public Information Officer to serve as the single point of contact for the development, refinement, and dissemination of internal and external communications.

Key Public Information Officer functions include:

- Develops and establishes mechanisms to rapidly receive and transmit information to local emergency management;
- Develops situational reports/updates for internal audiences (staff and residents) and external audiences;
- Develops coordinated, timely, consistent, and reliable messaging and/or tailor pre-scripted messaging;
- Coordinates, in concert with the IC, direct resident and relative/responsible party outreach, as appropriate; and
- Addresses rumors and misinformation.

7.8.1 Staff Communications

The facility maintains an updated employee roster listing the names of all staff members, including emergency contact information in the facility payroll system as well as in the TMG Corporate Payroll System. To prepare for impacts to communication systems, the facility also maintains redundant forms of communication with on-site and off-site staff. The facility will ensure that all staff are familiar with internal communication equipment, policies, and procedures.

7.8.2 Staff Reception Area

Depending on the nature of the incident, the facility may choose to establish a staff reception area (e.g., in a break room or near the time clock) to coordinate and check-in staff members as they arrive to the facility to support incident operations.

The staff reception area also provides a central location where staff can receive job assignments, checklists, situational updates, and briefings each time they report for their shift. Implementing a sign-in/sign-out system at the staff reception area will ensure full staff accountability. The staff reception area also provides the Incident Commander with a central location for staffing updates and inquiries.

7.8.3 Resident Communication

Upon admission, annually, and prior to any recognized threat, the facility will educate residents and responsible parties on the CEMP efforts. Resident communication may include:

- Admission Documents and paperwork
- Website postings
- Resident Council Meetings
- Annual Facility Mailings
- Robo-calls

During and after an incident, the Incident Commander—or Public Information Officer, if activated—will establish a regular location and frequency for delivering information to staff, residents, and on-site responsible parties (e.g., set times throughout the day), recognizing that message accuracy is a key component influencing resident trust in the facility and in perceptions of the response and recovery efforts.

Communication will be adapted, as needed, to meet population-specific needs, including memory-care residents, individuals with vision and/or hearing impairments, and individuals with other access and functional needs.

7.8.4 External Communications

Under no circumstances will protected health information be released over publicly-accessible communications or media outlets. All communications with external entities shall be in plain language, without the use of codes or ambiguous language.

7.8.5 TMG Communication

The facility will coordinate all messaging with The McGuire Group to ensure external communications are in alignment with corporate policies, procedures, and brand standards. Prior to an incident, the facility will coordinate with The McGuire Group to ensure an on-site facility staff member(s) has authorization and approval to disseminate messages.

7.8.6 Families/Guardians

The facility maintains a list in the EMR of all identified authorized family member's and guardian's (responsible parties') contact information, including phone numbers and email addresses. Such individuals will receive information about the facility's preparedness efforts upon admission.

During an incident, the facility will notify responsible parties about the incident, status of the resident, and status of the facility by phone and/or other appropriate forms of communication depending on the nature of the incident. Additional updates may be provided on a regular basis to keep residents relatives/responsible parties apprised of the incident and the response.

The initial notification message to residents' primary point of contact (e.g., relative) will include the following information:

- Nature of the incident;

- Status of resident;
- Restrictions on visitation; and
- Estimated duration of protective actions
- Direct contact information for the designated facility liaison assigned to each resident

When incident conditions do not allow the facility to contact residents' relatives/responsible parties in a timely manner, or if primary methods of communication are unavailable, the facility will utilize local or state health officials, the facility website, and/or a recorded outgoing message on voicemail, among other methods, to provide information to families on the status and location of residents.

7.8.7 Media/General Public

During an emergency, the facility will utilize traditional media (e.g., television, newspaper, radio) and social media (e.g., Facebook, Twitter) to keep relatives and responsible parties aware of the situation and the facility's response posture.

The Incident Commander—or Public Information Officer, if activated—may assign a staff member to monitor the facility's social media pages and email account to respond to inquiries and address any misinformation.

7.9 Administration

As part of the facility's preparedness efforts, the facility conducts the following tasks:

- Identify and develop roles, responsibilities, and delegations of authority for key decisions and actions including the approval of the CEMP;
- Ensure key processes are documented in the CEMP;
- Coordinate annual CEMP review, including the *Annexes for all hazards*;
- Review and update, if needed, the facility HVA
- Ensure CEMP is in compliance with local, state, and federal regulations; and
- Continued dialogue with community partners such Dutchess County Emergency Services for training and educational purposes.

7.10 Finance

The McGuire Group Financial Operations Department has established policies and procedures for the management of facility finances and accounting before, during and after an emergency situation.

7.10.1 Incident Response

Financial functions during an incident include tracking of personnel time and related costs, initiating contracts, arranging for personnel-related payments and Workers' Compensation, tracking of response and recovery costs, and payment of invoices.

The Finance/Administration Section Chief or designee will account for all direct and indirect incident-related costs from the outset of the response, including:

- Personnel (especially overtime and supplementary staffing)
- Event-related resident care and clinical support activities
- Incident-related resources
- Equipment repair and replacement
- Costs for event-related facility operations
- Vendor services
- Personnel illness, injury, or property damage claims
- Loss of revenue-generating activities
- Cleanup, repair, replacement, and/or rebuild expenses

7.10.2 Logistics

Logistics functions prior to an incident include identifying and monitoring emergency resource levels, and executing mutual aid agreements, resource service contracts, and memorandums of understanding. These functions will be carried out pre-incident by the Administrator or their designee.

7.10.3 Response

To assess the facility's logistical needs during an incident, the Logistics Section Chief or designee will complete the following:

- Regularly monitor supply levels and anticipate resource needs during an incident;
- Identify multiple providers of services and resources to have alternate options in case of resource or service shortages; and
- Coordinate with the Finance Section Chief to ensure all resource and service costs are being tracked.
- Restock supplies to pre-incident preparedness levels,
- Coordinate distribution of supplies to service areas.

7.11 Plan Development and Maintenance

To ensure plans, policies, and procedures reflect facility-specific needs and capabilities, the facility will conduct the following activities:

Table 7: Plans, Policies, and Procedures

Activity	Led By	Frequency
Review and update the facility's risk assessment.	Facility Administrator	Annually or more frequently with necessary changes.

Activity	Led By	Frequency
Review and update contact information for response partners, vendors, and receiving facilities.	Facility Administrator; Medical Records Coordinator	Annually or as response partners, vendors, and host facilities provide updated information.
Review and update contact information for staff members and residents' emergency contacts.	Payroll manager – staff Medical records managers - residents	Annually or as staff members provide updated information.
Review and update contact information for residents' point(s) of contact (i.e., relatives/responsible parties).	Medical Records Coordinator and Social Services Department	At admission/readmission, at each Care Plan Meeting, and as residents, relatives, and responsible parties provide updated information.
Maintain electronic versions of the CEMP in folders/drives that are accessible by others.	Facility Administrator	Annually
Revise CEMP to address any identified gaps.	Facility Administrator	Upon completion of an exercise or real-world incident.
Inventory emergency supplies (e.g., potable water, food, resident care supplies, communication devices, batteries, flashlights,	DON, Environmental Services Manager and Food Service Director	Quarterly

7.12 Protective Actions

The Incident Commander may decide to implement protective actions for an entire facility or specific populations within a facility. For more information, refer to the *NYSDOH Evacuation Plan Template*, *NYSDOH Healthcare Facility Evacuation Center Metropolitan Area Regional Office Region Facility Guidance Document for the 2018 Coastal Storm Season*, and the *NYSDOH Healthcare Facility Evacuation Center Manual*.

Protective Action		Potential Triggers	Authorization
Defend-in-Place	**Defend-in-Place** is the ability of a facility to safely retain all residents during an incident-related hazard (e.g., flood, severe weather, wildfire).	▪ Unforeseen disaster impacts cause facility to shelter residents in order to achieve protection.	▪ May be initiated by the Incident Commander **ONLY** in the absence of a mandatory evacuation order. ▪ Does not required NYSDOH approval.
Shelter-in-Place	**Shelter-in-Place** is keeping a small number of residents in their present location when the risks of relocation or evacuation exceed the risks of remaining in current location.	▪ Disaster forecast predicts low impact on facility. ▪ Facility is structurally sound to withstand current conditions. ▪ Interruptions to clinical services would cause significant risk to resident health and safety.	▪ Can only be done for coastal storms. ▪ Requires pre-approval from NYSDOH prior to each hurricane season and re-authorization at time of the incident.
Internal Relocation	**Internal Relocation** is the movement of residents away from threat within a facility.	▪ Need to consolidate staffing resources. ▪ Consolidation of mass care operations (e.g., clinical services, dining). ▪ Minor flooding. ▪ Structural damage. ▪ Internal emergency (e.g., fire). ▪ Temperature presents life safety issue.	▪ Determined by facility based on safety factors. ▪ If this protective action is selected, the NYSDOH Regional Office must be notified.
Evacuation	**Evacuation** is the movement of residents to an external location (e.g., a receiving facility) due to actual or anticipated unsafe conditions.	▪ Mandatory or advised order from authorities. ▪ Predicted hazard impact threatens facility capacity to provide safe and secure shelter conditions. ▪ Structural damage. ▪ Emergency and standby power systems failure resulting in facility inability to maintain suitable temperature.	▪ Refer to the *NYSDOH Evacuation Plan Template.*

Protective Action		Potential Triggers	Authorization
Lockdown	**Lockdown** is a temporary sheltering technique used to limit exposure of building occupants to an imminent hazard or threat. When "locking down," building occupants will shelter inside a room and prevent access from the outside.	▪ Presence of an active threat (e.g., active shooter, bomb threat, suspicious package). ▪ Direction from law enforcement.	▪ Determined by facility based on the notification of an active threat on or near the facility premises.

7.13 Resource Management

Additionally, the facility maintains an inventory of emergency resources and corresponding suppliers/vendors, for supplies that would be needed under all hazards, including:

- Generators
- Fuel for generators and vehicles
- Food and water for a minimum of 72 hours for staff and residents
- Disposable dining supplies and food preparation equipment and supplies
- Medical and over-the-counter pharmaceutical supplies
- Personal protective equipment (PPE), as determined by the specific needs for each hazard
- Emergency lighting, cooling, heating, and flashlights/lanterns
- Resident movement equipment (e.g., stair chairs, bed sleds, lifts)
- Durable medical equipment (e.g., walkers, wheelchairs, oxygen, beds)
- Linens, gowns, privacy plans
- Housekeeping supplies, disinfectants, detergents
- Resident specific supplies (e.g., identification, medical risk information, medical records, physician orders, Medication Administration Records, Treatment Administration Records, Contact Information Sheet, last 72 hours of labs, x-rays, nurses' notes, psychiatric notes, doctor's progress notes, Activities of Daily Living (ADL) notes, most recent History and Physical (H&P), clothing, footwear, and hygiene supplies)
- Administrative supplies
- Critical tools and maintenance/physical plant related equipment (hand/power tools for emergency repairs, air compressor, snow removal equipment, extension cords, dollies, gas powered water pumps, voltage detector, batteries (all sizes), pry bars, sledge hammer)
- Cell phones, chargers and two way radios (walkie talkies – Nursing stations, Maintenance, Dietary, Therapy, Reception, Environmental)

The facility's resource inventory will be updated annually, or as needed to ensure that adequate resource levels are maintained, and supplier/vendor contact information is current.

7.14 Resource Distribution and Replenishment

During an incident, the Incident Commander—or Logistics Section Chief, if activated—will release emergency resources to support operations. The Incident Commander—or Operations Section Chief, if activated—will ensure the provision of subsistence needs.

- The Incident Commander—or Planning Section Chief, if activated—will track the status of resources used during the incident. When defined resource replenishment thresholds are met, the Planning Section Chief will coordinate with appropriate staff to replenish resources, including:
- Procurement from alternate or nontraditional vendors
- Procurement from communities outside the affected region
- Resource substitution
- Resource sharing arrangements with mutual aid partners
- Request for external stockpile support from healthcare associations, local emergency management. Resource replenishment from TMG Corporate stockpile

7.14.1 Resource Sharing

In the event of a large-scale or regional emergency, the facility may need to share resources with mutual aid partners or healthcare facilities in the community, contiguous geographic area, or across a larger region of the state and contiguous states as indicated.

7.15 Emergency Staffing

If off-duty personnel are needed to support incident operations, the facility will conduct the following activities in accordance with facility-specific employee agreements:

Table 8: Off-Duty Personnel Mobilization Checklist

Off-Duty Personnel Mobilization Checklist	
☐	The senior most on-site facility official will confirm, with Administrator, that mobilization of off-duty personnel is permissible (e.g., overtime pay).
☐	Once approved, Department Managers will be notified of the need to mobilize off-duty personnel.

☐	Off-duty personnel will be notified of the request and provided with instructions including: ▪ Time and location to report ▪ Assigned duties ▪ Safety information ▪ Resources to support self-sufficiency (e.g., water, flashlight)
☐	Once mobilized, off-duty staff will report for duty as directed.
☐	If staff are not needed immediately, staff will be requested to remain available by phone.
☐	To mobilize additional off-duty staff, the facility may need to provide additional staff support services (e.g., childcare, respite care, pet care). These services help to incentivize staff to remain on site during the incident, but also need to be carefully managed (e.g., reduce liability, manage expectations).
☐	Coordinate to provide transportation services (facility vehicles, Uber, taxi services, etc.) to staff members willing to report, but do not have a means of transportation.

7.16 Other Job Functions

In accordance with employment contracts, collective bargaining agreements, etc., an employee may be called upon to aid with work outside of job-prescribed duties, work in departments or carry out functions other than those normally assigned, and/or work hours in excess of (or different from) their normal schedule. Unless temporarily permitted by an Executive Order issued by the Governor under section 29-a of Executive Law, employees may not be asked to function out-of-scope of certified or licensed job responsibilities.

The Incident Management Team will request periodic updates on staffing levels (available and assigned). In addition to deploying clinical staff as needed for resident care activities, non-medical assignments from the labor pool may include:

- Security augmentation
- Runners / messengers
- Switchboard support
- Clerical or ancillary support
- Transportation/drivers
- Resident information, monitoring, and one-on-ones, as needed
- Preparing and/or serving meals, snacks, and hydration for residents, staff, visitors, and volunteers
- Cleaning and disinfecting areas, as needed
- Laundry services
- Recreational or entertainment activities
- Providing information, escorts, assistance, or other services to relatives and visitors
- Other tasks or assignments as needed within their skill set, training, and licensure/certification.

In accordance with employment contracts, collective bargaining agreements, etc., and at the determination of the Incident Commander, all or some staff members may be changed to 12-hour emergency shifts to maximize staffing. These shifts may be scheduled as around regular work hours, in six or 12-hour shifts, or as needed to meet facility emergency objectives.

7.17 Surge Staffing

If surge staffing is required—for example, staff has become overwhelmed—it may be necessary to implement surge staffing (e.g., per diem staff, staffing agencies).

The facility may coordinate with pre-established credentialed volunteers included in the facility roster or credentialed volunteers associated with programs such as Community Emergency Response Team (CERT), Medical Reserve Corps (MRC), and ServNY.

The facility will utilize emergency staffing as needed and as identified and allowed under executive orders issued during a given hazard/emergency.

Emergency Power Systems

In the event of an electrical power disruption causing partial or complete loss of the facility's primary power source, the facility is responsible for providing alternate sources of energy for staff and residents (e.g., generator).

In accordance with the facility's plans, policies, and procedures, the facility will ensure provision of the following subsistence needs through the activation, operation, and maintenance of permanently attached onsite generators:

- Maintain temperatures to protect resident health and safety and for the safe and sanitary storage of provisions;
- Emergency lighting;
- Fire detection and extinguishing, and alarm and life safety systems; and
- Sewage and waste disposal.

Onsite generators and associated equipment and supplies are located, installed, inspected, tested, and maintained in accordance with the National Fire Protection Association's (NFPA) codes and standards.

In extreme circumstances, incident-related damages may limit generator and fuel source accessibility, operability, or render them completely inoperable. In these instances, an urgent or planned evacuation will be considered if a replacement generator cannot be obtained in a timely manner.

Training and Exercises

To empower facility personnel and external stakeholders (e.g., emergency personnel) to implement plans, policies, and procedures during an incident, the facility will conduct the following training activities:

Table 9: Training

Activity	Led By	Frequency
Conduct comprehensive orientation to familiarize new staff members with the CEMP, including PEP specific plans, the facility layout, and emergency resources.	HR Manager and Staff Educator	Orientation held on the first day of employment.
Incorporate into annual educational update training schedule to ensure that all staff are trained on the use of the CEMP, including PEP specific plans, and core preparedness concepts.	Human Resources and Staff Educator	Annually and as needed
Maintain records of staff completion of training.	Human Resources and Staff Educator	Ongoing
Ensure that residents are aware appropriately of the CEMP, including PEP specific plans, including what to expect of the facility before, during, and after an incident.	Facility Administrator	Upon admission and minimally on an annual basis Repeat briefly at time of incident.
Identify specific training requirements for individuals serving in Incident Management Team positions.	Facility Administrator	Ongoing
Determine appropriate exercises and drills (based on HVA) to properly simulate emergency situations.	Facility Administrator; Director of Maintenance	Ongoing

To validate plans, policies, procedures, and trainings, the facility will conduct the following exercise activities:

Table 10: Exercises

Activity	Led By	Frequency
Conduct, at minimum, one operations-based exercise (e.g., full-scale or functional exercise).	Facility Administrator and the Safety Committee.	Annually
Conduct, at minimum, one discussion-based exercise (e.g., tabletop exercise).	Facility Administrator and the Safety Committee	Annually

Documentation

In alignment with industry best practices for emergency preparedness, the facility will maintain documentation and evidence of course completion through the use of sign in sheets, NHICS Form 201 – Incident Briefing and Operational Log and After Action Reports. These forms will be used for all disaster drills as well as real time emergency situations.

After Action Reports

The facility will develop After Action Reports to document lessons learned from tabletop and full-scale exercises and real-world emergencies and to demonstrate that the facility has incorporated any necessary improvements or corrective actions.

After Action Reports will document what was supposed to happen; what occurred; what went well; what the facility can do differently or improve upon; and corrective action/improvement plan and associated timelines.

Infectious Disease/Pandemic Emergency

The circumstances of infectious disease emergencies, including ones that rise to the level of a pandemic, vary due to multiple factors, including type of biological agent, scale of exposure, mode of transmission and intentionality. Infectious disease emergencies can include outbreaks, epidemics and pandemics. The facility must plan effective strategies for responding to all types of infectious diseases, including those that rise to the higher level of pandemic.

The following Infectious Disease/Pandemic Emergency Checklist outlines the hazard-specific preparedness, response, and recovery activities the facility should plan for that are unique to an incident involving infectious disease as well as those incidents that rise to the occasion of a pandemic emergency. The facility should indicate for each checklist item, how they plan to address that task.

The Local Health Department (LHD) of each New York State county, maintains prevention agenda priorities compiled from community health assessments. The checklist items noted in

this Annex include the identified LHD priorities and focus areas. Nursing homes should use this information in conjunction with an internal risk assessment to create their plan and to set priorities, policies and procedures.

A summary of the key components of the PEP requirements for pandemic situations is as follows:

o development of a Communication Plan,

o development of protection plans against infection for staff, residents, and families, including the maintenance of a 2-month (60 day) supply of infection control personal protective equipment and supplies (including consideration of space for storage), and

o A plan for preserving a resident's place in and/or being readmitted to a residential health care facility or alternate care site if such resident is hospitalized, in accordance with all applicable laws and regulations.

Finally, any appendices and documents, such as regulations, executive orders, guidance, lists, contracts, etc. that the facility creates that pertain to the tasks in this Annex, and/or refers to in this Annex, should be attached to the corresponding Annex K of the CEMP Toolkit rather than attached here, so that this Annex remains a succinct plan of action.

Infectious Disease/Pandemic Emergency Checklist	
Preparedness Tasks for <u>all Infectious Disease Events</u>	
☐ Required	Provide staff education on infectious diseases (e.g., reporting requirements (see Annex K of the CEMP toolkit), exposure risks, symptoms, prevention, and infection control, correct use of personal protective equipment, regulations, including 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); 42 CFR 483.15(e) and 42 CFR § 483.80), and Federal and State guidance/requirements Facility utilizes multiple different presentation methods for infectious disease education such as: • Face to face presentation • Video education • Webinars • Hands on training and observation • 1 on 1 teaching and mentoring
☐ Required	Develop/Review/Revise and Enforce existing infection prevention, control, and reporting policies. • The TMG Best Practices Committee is charged with the management of all

	infection control related policies and procedures. All policies are reviewed on a regular basis and updated to reflect current industry standards, best practices and all regulatory requirements.
☐ Recommended	Conduct routine/ongoing, infectious disease surveillance that is adequate to identify background rates of infectious diseases and detect significant increases above those rates. This will allow for immediate identification when rates increase above these usual baseline levels. See Annex K
☐ Recommended	Develop/Review/Revise plan for staff testing/laboratory services See Annex K
☐ Required	Review and assure that there is, adequate facility staff access to communicable disease reporting tools and other outbreak specific reporting requirements on the Health Commerce System (e.g., Nosocomial Outbreak Reporting Application (NORA), HERDS surveys See Annex K
☐ Required	Develop/Review/Revise internal policies and procedures, to stock up on medications, environmental cleaning agents, and personal protective equipment as necessary. (Include facility's medical director, Director of Nursing, Infection Control Practitioner, safety officer, human resource director, local and state public health authorities, and others as appropriate in the process) See Annex K
☐ Recommended	Develop/Review/Revise administrative controls (e.g., visitor policies, employee absentee plans, staff wellness/symptoms monitoring, human resource issues for employee leave). See Annex K
☐ Required	Develop/Review/Revise environmental controls (e.g., areas for contaminated waste) See Annex K
☐ Required	Develop/Review/Revise vendor supply plan for re-supply of food, water, medications, other supplies, and sanitizing agents. The facility has executed agreements with local vendors to supply the following critical items in an emergency situation: • US Foods – food and water • ProCare Pharmacy – medication • Medline – medical supplies and equipment • Cleanslate. – disinfection and cleaning supplies
☐ Required	Develop/Review/Revise facility plan to ensure that residents are isolated/cohorted and or transferred based on their infection status in accordance with applicable NYSDOH and

	Centers for Disease Control and Prevention (CDC) guidance See Annex K
☐ Recommended	Develop plans for cohorting, including using of a part of a unit, dedicated floor, or wing in the facility or a group of rooms at the end of the unit, and discontinuing any sharing of a bathroom with residents outside the cohort. See Annex K
☐ Recommended	Develop/Review/Revise a plan to ensure social distancing measures can be put into place where indicated See Annex K
☐ Recommended	Develop/Review/Revise a plan to recover/return to normal operations when, and as specified by, State and CDC guidance at the time of each specific infectious disease or pandemic event e.g., regarding how, when, which activities /procedures /restrictions may be eliminated, restored and the timing of when those changes may be executed. See Annex K – reopening plan.
Additional Preparedness Planning Tasks for <u>Pandemic Events</u>	
☐ Required	***In accordance with PEP requirements,*** Develop/Review/Revise a Pandemic Communication Plan that includes all required elements of the PEP See Annex K
☐ Required	***In accordance with PEP requirements,*** Development/Review/Revise plans for protection of staff, residents and families against infection that includes all required elements of the PEP. See Annex K
Response Tasks for <u>all Infectious Disease Events</u>:	
☐ Recommended	The facility will implement the following procedures to obtain and maintain current guidance, signage, advisories from the NYSDOH and the U.S. Centers for Disease Control and Prevention (CDC) on disease-specific response actions, e.g., including management of residents and staff suspected or confirmed to have disease: See Annex K
☐ Required	The facility will assure it meets all reporting requirements for suspected or confirmed communicable diseases as mandated under the New York State Sanitary Code (10 NYCRR 2.10 Part 2), as well as by 10 NYCRR 415.19. (see Annex K of the CEMP toolkit for reporting requirements). See Annex K
☐ Required	The facility will assure it meets all reporting requirements of the Health Commerce System, e.g. HERDS survey reporting See Annex K
☐ Recommended	The Infection Control Practitioner will clearly post signs for cough etiquette, hand washing, and other hygiene measures in high visibility areas. Consider providing hand sanitizer and

	face/nose masks, if practical.
☐ Recommended	The facility will implement the following procedures to limit exposure between infected and non-infected persons and consider segregation of ill persons, in accordance with any applicable NYSDOH and CDC guidance, as well as with facility infection control and prevention program policies See Annex K
☐ Recommended	The facility will implement the following procedures to ensure that as much as is possible, separate staffing is provided to care for each infection status cohort, including surge staffing strategies: See Annex K
☐ Recommended	The facility will conduct cleaning/decontamination in response to the infectious disease in accordance with any applicable NYSDOH, EPA and CDC guidance, as well as with facility policy for cleaning and disinfecting of isolation rooms.
☐ Required	The facility will implement the following procedures to provide residents, relatives, and friends with education about the disease and the facility's response strategy at a level appropriate to their interests and need for information. See Annex K
☐ Recommended	The facility will contact all staff, vendors, other relevant stakeholders on the facility's policies and procedures related to minimizing exposure risks to residents This facility regularly communicates its policies regarding exposure risks to all critical vendors i.e. medical suppliers, food suppliers, emergency building related contractors, providers, etc.
☐ Required	Subject to any superseding New York State Executive Orders and/or NYSDOH guidance that may otherwise temporarily prohibit visitors, the facility will advise visitors to limit visits to reduce exposure risk to residents and staff. If necessary, and in accordance with applicable New York State Executive Orders and/or NYSDOH guidance, the facility will implement the following procedures to close the facility to new admissions, limit visitors when there are confirmed cases in the community and/or to screen all permitted visitors for signs of infection: See Annex K
Additional Response Tasks for <u>Pandemic Events</u>:	
☐ Recommended	Ensure staff are using PPE properly (appropriate fit, don/doff, appropriate choice of PPE per procedures) See Annex K
☐ Required	***In accordance with PEP requirements,*** the facility will follow the following procedures to post a copy of the facility's PEP, in a form acceptable to the commissioner, on the facility's public website, and make available immediately upon request: The facility will have the properly formatted PEP posted on the organization's website no later than 9/15/20.

☐ Required	**In accordance with PEP requirements,** the facility will utilize the following methods to update authorized family members and guardians of infected residents (i.e., those infected with a pandemic-related infection) at least once per day and upon a change in a resident's condition: See Annex K
☐ Required	***In accordance with PEP requirements***, the facility will implement the following procedures/methods to ensure that all residents and authorized families and guardians are updated at least once a week on the number of pandemic-related infections and deaths at the facility, including residents with a pandemic-related infection who pass away for reasons other than such infection: See Annex K
☐ Required	***In accordance with PEP requirements***, the facility will implement the following mechanisms to provide all residents with no cost daily access to remote videoconference or equivalent communication methods with family members and guardians: See Annex K
☐ Required	***In accordance with PEP requirements,*** the facility will implement the following process/procedures to assure hospitalized residents will be admitted or readmitted to such residential health care facility or alternate care site after treatment, in accordance with all applicable laws and regulations, including but not limited to 10 NYCRR 415.3(i)(3)(iii), 415.19, and 415.26(i); and 42 CFR 483.15(e): See Annex K
☐ Required	***In accordance with PEP requirements,*** the facility will implement the following process to preserve a resident's place in a residential health care facility if such resident is hospitalized, in accordance with all applicable laws and regulations including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e): See Annex K
☐ Required	***In accordance with PEP requirements,*** the facility will implement the following planned procedures to maintain or contract to have at least a two-month (60-day) supply of personal protective equipment (including consideration of space for storage) <u>or any superseding requirements under New York State Executive Orders and/or NYSDOH regulations governing PPE supply requirements executed during a specific disease outbreak or pandemic</u>. As a minimum, all types of PPE found to be necessary in the COVID pandemic should be included in the 60-day stockpile. This includes, but is not limited to: – N95 respirators – Face shield – Eye protection – Gowns/isolation gowns – Gloves – Masks – Sanitizer and disinfectants (meeting EPA Guidance current at the time of the pandemic) See Annex K

Recovery for <u>all Infectious Disease Events</u>	
☐ Required	The facility will maintain review of, and implement procedures provided in NYSDOH and CDC recovery guidance that is issued at the time of each specific infectious disease or pandemic event, regarding how, when, which activities/procedures/restrictions may be eliminated, restored and the timing of when those changes may be executed. See Annex K
☐ Required	The facility will communicate any relevant activities regarding recovery/return to normal operations, with staff, families/guardians and other relevant stakeholders See Annex K

Facility Overview

The facility overview provides an immediate reference sheet about each facility (or individual buildings within a facility's campus) for use when communicating with external parties during an emergency (e.g., law enforcement, fire department, emergency management officials).

LOCATION AND CONTACT INFORMATION	
Name of Facility	Taconic Nursing and Rehabilitation at Hopewell
Address	3 Summit Court Fishkill NY 12524
Cross Streets	Route 52
Telephone	845 869 1500
Fax	845 896 1531
Email	n/a
Website	www.livinglegendshealth.com
CONSTRUCTION	
Construction Type	Masonry and Steel
Year Building Constructed	1995
Number of Floors (above/below grade)	3
Square Footage	**105,500**

CAPACITY AND STAFFING	
Non-Traditional Surge Space	All Dining Rooms, Recreation and PT Gym
Number of Facility-Owned Vehicles (including accessible spots/seats)	0
UTILITY AND SERVICE PROVIDERS	
Electric Provider	Central Hudson 845-452-2700
Local Water Provider	East Fishkill Town Water Department 845-226-8626
Telephone Provider	Verizon (long term resident phones), ICM VoIP for all other phones
Internet Service Provider	AireSpring-primary Optimum-secondary
Generator Services	Penn Power 845-416-3407
Diesel for the Generator	Bottini Fuel
Plumbing	Duffy Mechanical 845-705-3815
Elevator	Excel Elevators
HVAC Equipment	Duffy Mechincal 845-705-3815
Fire Equipment/Sprinklers	Regan Mae Contracting

Hazard Vulnerability Assessment

HVA Tools

The Centers for Medicare and Medicaid Services (CMS) requires healthcare facilities to conduct annual facility-specific risk assessments to identify and assess potential hazards and their impacts. HVAs are used to estimate the hazards (and associated risks) that are most likely to occur and/or may affect a facility's ability to maintain operations and services. The results of the analysis can be used to prioritize planning, mitigation, response, and recovery projects and initiatives.

HVA Process

The following outlines the process and recommendations for conducting a facility-specific HVA:

Convene Staff with Facility-Specific Knowledge

Conducting an HVA requires an in-depth knowledge of facility preparedness and response capabilities. In addition, understanding the capabilities of response partners is another important piece of completing an HVA. As a result, staff possessing this knowledge should be involved in the HVA process, including:

- Facility Senior Leader
- Lead Clinical Staff
- Head of Administration/Finance
- Communications Staff
- Environmental Services/Plant Operations Leadership

Completing the HVA can be done by a single knowledgeable staff member or as a collaborative process with multiple staff members. For example, multiple staff members can complete an individual HVA, then they can be compared to validate each assessment and a consensus can be reached using the variety of assessments.

Identify Facility-Specific Hazards

In order to complete an HVA, staff must know the hazards which might affect their facility. The list of hazards can be developed through a variety of means, including:

- Historical knowledge of hazards
- Subjective predictions of hazards
- Using predetermined hazards in HVA tools
- Using local emergency plans to determine hazards (also known as a “community-based assessment”). Examples of these plans, which can be obtained from your Local Office of Emergency Management, include:
  - Hazard Mitigation Plans
  - Emergency Operations Plans
  - Threat and Hazard Identification and Risk Assessment

Assess Hazards

The risk each hazard poses to the facility is determined through a variety of factors. The table below presents each factor and the considerations to make when evaluating them.

Table 3: HVA Considerations

Hazard Factor	Considerations
Probability	▪ Current local and regional plans ▪ Manufacturer/vendor statistics ▪ Subjective evaluations or best estimate
Human Impact	▪ Potential for staff, resident, or visitor injury or death ▪ Emotional or psychological impact

Hazard Factor	Considerations
	▪ Local cultural norms
Property Impact	▪ Cost to replace ▪ Cost to set up temporary replacement ▪ Cost to repair ▪ Time to recover
Business Impact	▪ Business interruption ▪ Staff unable to report to work ▪ Violation of contractual agreements, regulatory standards ▪ Interruption of critical supplies ▪ Reputation and public image ▪ Financial impact or burden
Preparedness	▪ Status of current plans ▪ Staff training completion status ▪ Availability of alternate sources for critical resources
Internal Response	▪ Emergency resource levels ▪ Durability/longevity of resources (without replenishment) ▪ Internal resources ability to withstand disasters ▪ Availability of backup systems
External Response	▪ Types of agreements with community agencies ▪ Relationship with local and state agencies ▪ Relationship with local healthcare facilities ▪ Relationship with community volunteers ▪ Vendor pre-incident response plans and contracts

Facility Profile and HVA

Facility Profile and Building Features

Three-Story Type II Non Combustible

Built in 1995

105,500 sq. feet

Natural Gas for main service and Diesel for the Generator

Heat; Hot water radiated baseboard in patient rooms. Rooftop units provide backup HVAC.

Natural gas fed boilers with tempered Fresh Air for hallways and rooms.

(3) 100 gallon potable hot water storage tanks

Cooling; Roof top A/C units

Resident Population*

Licensed for 160 beds

Subacute and orthopedic rehabilitation and recovery, hip, knee, pulmonary, post-surgical and wound care therapies, physical and occupational therapy, pain management, intravenous antibiotics, electrical stimulation for wound healing, bariatric care and telemetry services.

* see facility assessment for full description of resident population.

Generator

Tested / Inspected: Dry cycle weekly and Full load Monthly / Inspected: Twice a year

Powers: Emergency lighting, 50% outlets, all elevators

Kaiser Permanente

Emergency Management

Hazards - Taconic Rehabilitation & Nursing at Beacon
Hazard Vulnerability Assessment Tool

Alert Type	PROBABILITY	ALERTS	ACTIVATIONS	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
				HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur			Possibility of death or injury	Physical losses and damages	Interuption of services	Preplanning	Time, effectiveness, resources	Community Mutual Aid staff and supplies	* Relative threat
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	Number of Alerts	Number of Activations	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 =High 2 = Moderate 3 = Low	0 - 100%
Active Shooter	2	0	0	3	3	3	2	3	2	36%
Act of Terrorism	1	0	0	3	3	3	3	1	1	16%
Air Quality Issue	2	0	0	1	1	1	1	1	1	13%
Bomb Threat	1	0	0	3	3	2	3	3	1	17%
Building Move	0	0	0	0	0	0	0	0	0	0%
Chemical Exposure, External	1	0	0	1	1	1	3	2	1	10%
Chemical Exposure, Internal	1	0	0	1	1	1	2	2	1	9%
Chemical Spill	1	0	0	1	1	1	3	3	1	11%
Child Abduction	0	0	0	0	0	0	0	0	0	0%
Civil Unrest / Protesting	1	0	0	1	2	1	1	1	1	8%
Communication / Telephony Failure	1	0	0	1	1	2	1	1	1	8%
Dam Failure	0	0	0	0	0	0	0	0	0	0%
Drought	1	0	0	1	1	1	2	1	1	8%
Earthquake	1	0	0	1	2	1	3	3	1	12%
Epidemic	1	0	0	2	1	1	1	1	1	8%
Evacuation	1	0	0	1	1	3	1	1	1	9%
Explosion	1	0	0	3	3	3	1	1	1	13%
Fire, External	1	0	0	1	1	1	0	1	1	6%
Fire, Internal	2	0	0	1	2	2	1	1	1	18%
Flood, External	1	0	0	1	1	1	3	3	1	11%
Flood, Internal	2	0	0	1	2	2	1	1	1	18%
Forensic Admission	1	0	0	1	1	1	0	0	1	4%
Gas / Emmissions Leak	1	0	0	1	1	2	0	1	1	7%
Generator Failure	1	0	0	1	1	2	1	1	1	8%
Hostage Situation	1	0	0	2	1	3	3	3	1	14%
Hurricane	2	0	0	1	2	2	1	1	1	18%
HVAC Failure	2	0	0	1	1	2	1	1	1	18%
Inclement Weather	2	0	0	1	1	2	1	1	2	18%
Infectious Disease Outbreak	2	0	0	1	1	2	1	1	2	18%
IT System Outage	2	0	0	0	1	3	1	1	0	13%
Landslide	0	0	0	0	0	0	0	0	0	0%
Mass Casualty Incident - Hazmat	1	0	0	2	1	2	3	3	1	13%
Mass Casualty Incident - Medical	1	0	0	2	1	2	3	3	1	13%
Mass Casualty Incident - Trauma	1	0	0	2	1	2	3	3	1	13%
Medical Gas Disruption	1	0	0	1	1	1	1	1	1	7%
Natural Gas Disruption	1	0	0	1	1	2	1	1	1	8%
Pandemic	1	0	0	2	1	3	1	1	2	11%
Patient Elopement	2	0	0	2	1	1	1	1	1	16%
Patient Surge	1	0	0	1	1	2	1	1	1	8%
Picketing	2	0	0	1	1	1	1	1	2	16%
Planned Power Outage	1	0	0	1	1	1	1	1	1	7%
Power Outage	1	0	0	1	1	2	1	1	1	8%
Radiation Exposure	1	0	0	3	1	3	0	0	1	9%
Seasonal Influenza	2	0	0	1	1	1	1	1	1	13%
Sewage Failure	1	0	0	1	1	1	1	1	1	7%
Shelter in Place	2	0	0	1	1	1	1	1	0	11%
Strikes / Labor Action / Work Stoppage	2	0	0	1	1	2	1	1	1	16%
Suicide	1	0	0	3	1	1	1	1	1	9%
Supply Chain Shortage / Failure	1	0	0	1	1	3	1	1	2	10%
Suspicious Package / Substance	1	0	0	1	1	1	2	2	1	9%
Temperature Extremes	2	0	0	1	1	1	1	1	2	16%
Tornado	1	0	0	2	2	2	2	1	1	11%
Transportation Failure	1	0	0	1	1	1	1	1	0	6%
Trauma	1	0	0	2	1	1	2	1	1	9%
Tsunami	0	0	0	0	0	0	0	0	0	0%
Utility Failure	1	0	0	1	1	2	1	1	1	8%
VIP Situation	1	0	0	1	1	1	1	1	1	7%
Water Contamination	1	0	0	1	1	1	1	1	1	7%
Water Disruption	1	0	0	1	1	2	1	1	1	8%
Weapon	2	0	0	2	2	2	3	2	1	27%
Workplace Violence / Threat	2	0	0	2	2	2	1	1	1	20%

Activation Checklist

Any incident large or small can warrant the activation of the CEMP and the processes contained within. This checklist describes the activities that should take place whenever the CEMP is activated and the position that is responsible. Additional facility specific processes can be added into the checklist.

The facility CEMP uses an Incident Command System (ICS) framework as the operational component. All protocols are based around the standard ICS operational procedures due to the flexible and scalable nature of these protocols. Please see the ICS framework below:

ICS Background

NIMS

The National Incident Management System (NIMS) is a systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work together seamlessly and manage incidents involving all threats and hazards—regardless of cause, size, location, or complexity—in order to reduce loss of life, property and harm to the environment. The NIMS is the essential foundation to the National Preparedness System (NPS) and provides the template for the management of incidents and emergency operations.

The purpose of the NIMS is to provide a common approach for managing incidents. The concepts provide for a flexible but standardized set of incident management practices with emphasis on common principles, a consistent approach to operational structures and supporting mechanisms, and an integrated approach to resource management.

Incidents typically begin and end locally, and they are managed daily at the lowest possible geographical, organizational, and jurisdictional level. There are other instances where success depends on the involvement of multiple jurisdictions, levels of government, functional agencies, and/or emergency-responder disciplines. These instances necessitate effective and efficient coordination across this broad spectrum of organizations and activities. By using NIMS, facilities are part of a comprehensive national approach that improves the effectiveness of emergency management and response personnel across the full spectrum of potential threats and hazards (including natural hazards, terrorist activities, and other human-caused disasters) regardless of size or complexity.

Incident Command Center (ICS)

NIMS is designed to prepare for, prevent, and manage response to emergency and disaster situations, and to coordinate emergency response disaster responders. An Incident Command System (ICS) is one of the most common tools utilized by NIMS during an emergency situation. The ICS is a personnel management structure, utilized by NIMS through which disaster response is controlled.

An Incident Command System (ICS) is a standardized on-scene incident management concept designed specifically to allow responders to adopt an integrated organizational structure equal to the complexity and demands of any single incident or multiple incidents without being hindered by jurisdictional boundaries.

The Incident Command System (ICS) is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in domestic incident management activities. It is used for a broad spectrum of emergencies, from small to complex incidents, both natural and manmade, including acts of catastrophic terrorism. **ICS is organized around five major functional areas: command, operations, planning, logistics, and finance/administration.**

An ICS enables integrated communication and planning by establishing a manageable span of control. An ICS divides an emergency response into five manageable functions essential for emergency response operations: Command, Operations, Planning, Logistics, and Finance/Administration. The figure below shows a typical ICS structure.

A disaster scenario can affect a nursing home at any time. It is, therefore, important for all facilities to be prepared to handle a variety of different types and severity levels of emergencies. An ICS allows a facility to have the flexibility to adapt to any type of emergency, and gives personnel the ability to manage operations during that emergency regardless of the type or severity level. The Nursing Home Incident Command System (NHICS) was developed specifically to address the many unique challenges faced by nursing home personnel during a potential disaster situation. The NHICS utilizes the nationally accepted NIMS framework to address situation/issues that arise during an emergency at a Nursing Home. The goals in developing a Nursing Home Incident Command System (NHICS) include the following:

- Customization of a well-developed and tested incident management system for use by non-traditional health care partners
- Incorporation of assets and resources of the nursing home community into all-hazard emergency management
- Development of nursing-home-specific planning and response tools for emergency management
- Introduction to and utilization of incident action planning for nursing homes

- Development and implementation guidance for use of an incident management system that promotes collaboration and interoperability

NHICS is designed to help avoid the following issues related to mismanagement of emergent situations:

- Inadequate communication because of conflicting terminology or inefficient or improper use of technology
- Lack of a standardized management structure that would allow integration, command and control, and workload efficiency
- Lack of personnel accountability
- Lack of a systematic planning process

NHICS is designed to meet these challenges by:

- Being effectual in managing all emergency, routine, or planned events, of any size or type, and by establishing a clear chain of command
- Allowing personnel from different agencies or departments to be integrated into a common structure that can effectively address issues and delegate responsibilities
- Provide needed logistical and administrative support to operational personnel
- Ensure key functions are covered and eliminate duplication

The fundamental features of the ICS include:

1. Common terminology/clear text

The use of common terminology provides for a clear message and sharing of information. It avoids the use of codes, slang, or discipline- specific nomenclature that may not be clearly understood by all planning and response partners. A common terminology helps to define the common organizational structure: as an example, the identification of sections, section chiefs, and branch directors. Another key benefit of common terminology is the ability to share resources in the response, such as personnel to oversee incident management or operations. By using consistent terminology, the opportunity to develop memorandums or agreements to share personnel is enhanced.

2. Modular organization

The ICS structure begins from the top and expands as needed by the event. Positions within the structure are activated as dictated by the incident size or complexity. As complexity increases, the ICS organization expands. Only those functions or positions necessary for an incident are activated.

3. Management by objectives

The Incident Commander initiates the response and sets the overall command and control objectives. The mission of the response is defined for all members of the response team through a clear understanding of the organization’s policy and direction. This includes an assessment of the incident from the current situation to projected impacts. To meet the

overall mission, or command objectives, individual sections will establish incident objectives as well as the strategies to achieve these objectives through clear tactics. Because emergency response is not “business as usual,” clearly defined objectives will allow staff to focus on the roles in the response, avoiding duplication of efforts or omission of critical actions.

4. Incident Action Planning

The development of objectives is documented in the Incident Action Plan (IAP). A written plan provides personnel with direction for taking actions based on the objectives identified in the IAP and reflects the overall strategy for incident management while providing measurable strategic operations for the operational period. To ease this process, ICS forms are designed and developed for nursing homes and are contained within the NHICS guidebook.

5. Manageable span of control

A key concept in ICS is maintaining a span of control that is both effective and manageable. Because emergency events are not business as usual situations, the span of control for operations that are not routine should be kept at an effective number. Within ICS, the optimum span of control is one supervisor to five reporting personnel. If the number falls outside these ratios, the incident management team should be expanded or consolidated.

6. Pre-designated incident locations/facilities

In the planning stages, planners should determine the location of their response and coordination sites, including the coordination and command sites. Within ICS, sites are identified for both scene and regional coordination, such as staging areas, command posts, triage locations and emergency operations centers. Planners within the nursing home or long-term care facility should identify sites for ICS management, staging areas for receipt of supplies and equipment, evacuation sites if the infrastructure is unsafe, and so on.

7. Resource management

Resources used in the response are categorized as *tactical* and *support*. Tactical resources include personnel and major equipment available or potentially available for use in the response. Support resources are all other resources to support the incident, including food, equipment, communications, supplies, vehicles, etc. It is critical in the response to understand the availability and status of both tactical and support resources. It is important to have a clear picture of current and needed resources when working within the medical mutual aid system in the jurisdiction of state, allowing those providing the response support to provide the necessary assets through a clear understanding of current capability.

8. Integrated communications

There are three elements within integrated communications: modes, plans and networks. The modes include the hardware systems that transfer information, such as radios, facility

owned cell phones, and pagers. Plans should be developed in advance on how to best use the available modes through a clear and concise communication policy and plans (for example, determining who can use radios and what information should be communicated). The networks identified within the jurisdiction will determine the procedures and processes for transferring information internally and externally.

9. Common command structure

The ICS provides for a common command structure that identifies core principles for an efficient chain of command. *Unity of Command* dictates that each person within the response structure reports to only one supervisor. A *single command* exists when a single agency or discipline responds to an event; for example, the fire service at a warehouse fire is commanded by a fire captain or chief. When multiple agencies or disciplines are working together at a scene, there is a *unified command* structure that allows for coordination in response actions. For nursing homes, this may occur when the facility is the scene of the incident, such as a fire. The nursing home administration and the fire command work together in a unified command structure.

Incident Management Team

Incident Management Functions

It is important to understand that ICS is a management system-not an organizational chart. It is predicated on a number of principal tenets:

- Every incident or event requires that certain management functions be performed. The problem encountered is evaluated, a plan to remedy the problem is identified and implemented, and the necessary resources assigned. Management by Objectives (MBO) is thus a critically important component to the successful implementation of an incident command system and involves the inclusion of both control and operational period objectives.
- The ICS organization frequently does not correlate to the daily administrative structure of the agency or nursing home. This practice is purposeful and done to reduce role and title confusion. Those positions activated in the response come together to serve as the **Incident Management Team (IMT),** whose purpose is to respond to and recover from the event through coordinated objectives and tactics.
- Position titles within the IMT should remain unchanged; this promotes interoperability between response partners, allowing for sharing of personnel resources among organizations.
- The IMT structure consists of the command, general, branch and unit staff, with sections clearly identified by the roles and responsibilities they carry out.
- The **Incident Commander** is the only position always activated in an incident regardless of its nature. In addition to Command, which sets the objectives, devises strategies and priorities, and maintains overall responsibility for managing the incident, there are four other management functions.
- **Operations** conducts the tactical operations (e.g., resident services, clean-up) to carry out the plan using defined objectives and directing all needed resources.

- **Planning** collects and evaluates information for decision support, maintains resource status information, prepares documents such as the Incident Action Plan, and maintains documentation for incident reports.
- **Logistics** provides support, resources, and other essential services to meet the operational objectives set by Incident Commander.
- **Finance** monitors costs related to the incident while providing accounting, procurement, time recording, and cost analyses.

In traditional Incident Command, there are five sections: Command, Operations, Planning, Logistics, and Finance. The Incident Commander Position is the only one that is always activated in an emergency and in small scale incidents, the Incident Commander may be able to accomplish all five management functions without the activation of additional positions. On larger incidents effective management may require that the Incident Commander establish one or more of the four other functions and appoint Section Chiefs with the overall goal to maintain the span of control and meet the needs of the facility based on the available resources. An important feature of the incident command system is its scalability. NHICS positions are assigned to personnel as indicated by the situation, and may be activated or deactivated as the incident unfolds and the needs change or become more clearly defined.

Building the IMT

The development of the IMT is based on the essential elements of ICS. The system is scalable and flexible, and uses a modular organization to respond to the event. As previously stated, **the Incident Commander is the only position that is always activated.** Activating additional positions is considered when the event duration increases, when situational information provides insight on the possible impact to the facility and when the span of control is exceeded. Management tools have been developed to help determine the need for activating additional positions; these tools (Job Action Sheets, Forms, and Incident Response Guides) should be customized by individual facilities based on their staffing and possible response actions.

**Position titles within the IMT define the role and the tasks assigned to that role. Titles identify the hierarchy within the chain of command. Job Action Sheets break down the roles and responsibilities of each position title.

These titles include:

Commander: there is only one commander position during the incident response, this being the Incident Commander.

Officers: officers are part of the command section. In NHICS, the officer roles are the Liaison Officer, Public Information Officer, Medical Director/Specialist and Safety Officer. Each of these positions report directly to the Incident Commander.

Chiefs: oversight for the section is provided by a Section Chief.

Directors: branches may be activated under the sections to maintain the chain of command and provide specific duties and actions as identified by the position title. For example, within the Operations Section, there is a Resident Services Branch and an Infrastructure Branch, with oversight provided by Directors.

Leaders: units may be activated within a branch when there is a specialized but complex set of duties that relate to a specific assignment. The person assuming responsibility for a Unit is a Leader.

***Not all of the ICS positions need to be active in each incident. The ICS structure is meant to expand and contract as the scope of the incident requires. For small-scale incidents, only the incident commander may be assigned. Command of an incident would likely transfer to the senior on-scene officer of the responding public agency when emergency services arrive on the scene. Command transfers back to the facility when the public agency depart.*

NHICS Incident Management Team:

Command

The **Incident Commander** is the only position that is always activated. The Incident Commander activates and directs the response through the development of command objectives to direct the response. In many cases, the Incident Commander may be the only position that is activated. A critical responsibility of the Incident Commander is the decision to evacuate the facility. Based on the incident hazard that causes evacuation, this can be a difficult decision and is based on overall situational information, the projected impact, the threat to life and property, and the capability for safe evacuation.

The Incident Commander (IC) is responsible for all aspects of the response, including developing incident objectives and managing all incident operations.
Unless specifically assigned to another member of the Command or General Staffs, these responsibilities remain with the IC. Some of the more complex responsibilities include:

- Assess the situation
- Establish immediate priorities especially related to the safety of residents, emergency responders and any other individuals affected by the incident in question.
- In charge of the organization’s on-scene response
- Stabilize the incident by ensuring life safety and managing resources efficiently and cost effectively.
- Determine the incident objectives and strategy; identify information needed or required by others; ensure planning/strategy meetings are held and attend as needed
- Determine incident objectives and strategy to achieve those objectives.
- Establish and monitor incident organization.
- Approve the implementation of the written (or verbal) Incident Action Plan (IAP).
- Ensure adequate health and safety measures are in place at all times.
- Maintain command until public agencies arrive and assume command or when relieved at start of next operational period
- Order warning of persons at risk or potentially at risk to take appropriate protective actions
- Notify or verify internal teams, departments, public agencies, regulators, contractors and suppliers have been notified

- Appoint others to incident command positions as needed
- Brief staff on current organization and activities; assign tasks; schedule planning meeting
- Coordinate activities with the EOC; identify priorities and activities; provide impact assessment for business continuity, crisis communications and management
- Review requests for resources; confirm who has authority to approve procurement; approve all requests for resources as required
- Provide information to and coordinate with crisis communications or media relations team
- Terminate the response and demobilize resources when the situation has been stabilized

Safety Officer

The **Safety Officer** within the Command Staff is responsible for overall safety of the response actions, modifying or suspending operations if the conditions are unsafe to continue. Example: the facility may be forced to evacuate all or part of the building due to an imminent roof collapse. The Safety Officer should evaluate the site where residents are moved to, ensuring that this location as well as the route to the new location is free of hazards.

The Safety Officer's role is also to develop and recommend measures to the IC for assuring resident/personnel health and safety and to assess and/or anticipate hazardous and unsafe situations. The Safety Officer also develops the Site Safety Plan, reviews the Incident Action Plan for safety implications, and provides timely, complete, specific, and accurate assessment of hazards and required controls.

Key Responsibilities:

- Identify and assess hazardous situations; prevent accidents
- Prepare safety plan; ensure messages are communicated
- Stop unsafe acts; correct unsafe conditions

Liaison Officer

The **Liaison Officer** serves as the link for the facility with external partners, and to serve as the point of contact for assisting and coordinating activities between the IC and various outside agencies and groups. This position provides information to external response agencies such as NYDOH, emergency management officials, first responders, and other agencies as identified by the facility during planning and response.

Key Responsibilities:

- Point of contact with outside agencies and companies
- Monitors operations to identify inter-organizational problems

Information Officer

The **Information Officer's** role is to develop and release information about the incident to the news media, incident personnel, and other appropriate agencies and organizations.

Key Responsibilities:

- Notify spokespersons and Crisis Communications Team
- Develop information for use in media briefings
- Obtain IC's and management approval for all news releases
- Conduct periodic media briefings
- Arrange for tours, interviews and or briefings
- Monitor and forward useful information to the media

Medical Director

The **Medical Director** is the person with specific expertise in clinical areas such as infectious disease, trauma management, and medical ethics who may be asked to provide the Incident Command staff with needed advice and coordination assistance. This role may be filled by persons outside of the facility but ideally will be filled by the facility's Medical Director who has familiarity with the resident population, and the disaster plan for the facility. The **Medical Director** reports to the Incident Commander; however, in actual event, this specialist may work directly with operations personnel providing advice or guidance in the clinical response activities.

NHICS Incident Management Team: Operations

Many incidents that occur involve altered conditions of care for the residents. There could be environmental changes such as loss of power and/or poor air quality that will require emergency measures to protect residents from harm. There also could be injured or ill residents and staff who will require first aid and/or an environment that needs immediate cleaning or repair. These critical actions become the responsibility of the Operations Section who will be responsible for managing the tactical objectives outlined by the Incident Commander.

The Operations Section is responsible for managing tactical operations at the incident site directed toward reducing the immediate hazard, saving lives and property, establishing situation control, and restoring normal conditions. Incidents can include acts of terrorism, severe winter weather, wild land and urban fires, floods, hazardous material spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, war-related disasters, public health and medical emergencies, and other incidents requiring an emergency response.

Because of its functional unit management structure, the ICS is applicable across a spectrum of incidents differing in size, scope, and complexity. The types of agencies that could be included in the Operations Section include fire, law enforcement, public health, public works, and emergency services, working together as a unit or in combinations, depending on the situation. Many incidents may involve private individuals, companies, or nongovernmental organizations, some of which may be fully trained and qualified to participate as partners in the Operations Section.

Incident operations can be organized and executed in many ways. The specific method selected will depend on the type of incident, agencies involved, and objectives and strategies of the incident management effort. The ICS offers extensive flexibility in determining the appropriate approach using the factors described above.

Operations Key Responsibilities:

- Manage all tactical operations during the incident
- Assist in the development of the operations portion of the Incident Action Plan
- Ensure safe tactical operations for all responders (in conjunction with any assigned Safety Officer)
- Request additional resources to support tactical operations
- Expedite appropriate changes in the operations portion of the Incident Action Plan
- Maintain close communication with the Incident Commander

The **Operations Section** staff are responsible for all operations directly applicable to the primary mission of the incident response. Operations staff typically consists of nine positions. Oversight of this Section is by a Chief. Additional positions include a Resident Services Branch Director, and an Infrastructure Branch Director. Under these two branches, the unit positions of Nursing, Psychosocial, Admit/Transfer & Discharge, Dietary, Environmental, and Physical Plant/Security may be activated depending on the situation.

The **Operations Section Chief** oversees all tactical operations carried out within the response and implements the IAP. He/she will activate the additional positions based on the needs of the event, as well as the availability of qualified personnel to fill the positions. If a position is needed but there is insufficient staffing to fill that position, the functions of that position are assumed by the highest position activated in that section.

The **Resident Services Branch Director** is responsible for the continuation of resident services as well as the provision of care to residents, staff and visitors who are injured or become ill due to the incident. The **Resident Services Branch Director** may assign staff to ensure continuation of resident services, including rehabilitation and clinical services as provided by the facility. The Resident Services Branch Director must also ensure that residents are accounted for and tracked, and that services needed to sustain operations are identified and provided.

The **Infrastructure Branch Director** is responsible for the continuation of those services that support the care in the facility including dietary, housekeeping, power, lighting, water, sewage, and other essential services. The **Infrastructure Branch Director** may also be required to assess the structural soundness of the facility in the event of an assault on the building such as from an earthquake, tornado, or fire, and then advise the Operations Section Chief on the capacity of the structure to sustain occupancy.

The **Physical Plant/Security Unit Leader** under the Infrastructure Branch is responsible for ensuring that the nursing home and the surrounding grounds are secure during the response. This may include traffic control as well as lock- down of the facility due to security threats, structural damage or infectious disease outbreaks. Planning should address the use of facility

personnel to perform this role but also the integration of local law enforcement and/or private security firms if needed.

Within these established positions in the IMT, staff in day-to-day positions may continue their tasks and actions, reporting their status to the applicable branches. For example: the facility housekeeper(s) may report observed damages after a flood to the Infrastructure Branch Director. Those personnel who provide resident services, such as physical or occupational therapy, may report their status to the Resident Services Branch Director.

NHICS Incident Management Team: Planning

When sufficient staff are available, and when the impact of the event is sustained, the **Planning Section** or "thinkers" may be activated. The role of the Planning Section within the NHICS Incident Management Team is to gather and validate information from both internal and external sources. The **Planning Section** must also gather, analyze, and track situational response data, providing up-to-date and accurate information regarding residents, staff, supplies, and equipment and other resources, and projecting the ability to sustain operations based on the current and future status. This section consists of three positions: The Planning Section Chief, Situation Unit Leader and Documentation Unit Leader.

The Planning Section is responsible for collecting, evaluating, and disseminating tactical information pertaining to the incident. This section maintains information and intelligence on the current and forecasted situation, as well as the status of resources assigned to the incident. The Planning Section prepares and documents IAPs and incident maps and gathers and disseminates information and intelligence critical to the incident. The Planning Section may include a number of technical specialists to assist in evaluating the situation and forecasting requirements for additional personnel and equipment.

Planning Section Key Responsibilities:

- Conduct and facilitate planning meetings
- Supervise preparation of the Incident Action Plan
- Determine need for technical experts from within the company or outside as well as specialized resources to support the incident
- Coordinate with business continuity and senior management teams
- Assemble information on alternative strategies and plans
- Assess current and potential impacts on people, property, environment
- Compile and display incident status information

The **Planning Section Chief** oversees the section and determines the need for activation of the **Situation Unit** and **Documentation Unit**. As outlined in NIMS, the Planning Section will "collect, evaluate, and disseminate incident situation information and intelligence to Incident Command." They will also be responsible for preparing status reports, displaying various types of information, and developing the Incident Action Plan (IAP). The effectiveness of the Planning Section has a direct impact on the availability of information needed for the critical, strategic decision-making done by the Incident Commander and the other General Staff positions.

The **Situation Unit Leader** will be responsible for writing and maintaining incident updates based on internal and external events, including those related to patient tracking and bed tracking. The status of supplies and equipment, both those available and in use for the response will be tracked by the Situation Unit Leader.

Multiple types of information should be documented during an incident. This information may originate from the incident scene, in one of the nursing home's operating service areas, or from the (facility) Command Center. The Planning Section will take the lead in coordinating documentation efforts. The role of the **Documentation Unit Leader** is to work with other members of the incident management team to document the incident. They also are responsible for archiving the documents created during the response.

Multiple methods of documentation will likely be used during an incident. Written documentation will be the primary method of information recording. Each Incident Management Team position is tasked with maintaining their own log of issues, actions, and outcomes.

NHICS Incident Management Team: Logistics

The Logistics Section is considered the "getters" for the response. Logistics provides the necessary services and support to sustain operations during the emergency response. This section identifies and inventories current resources including supplies, equipment, and personnel, and obtains those additional items needed to support operations.

The Logistics Section meets all support needs for the incident, including ordering resources through appropriate procurement authorities from off-incident locations. It also provides facilities, transportation, supplies, equipment maintenance and fueling, food service, communications, and medical services for incident personnel. The Logistics Section is led by a Section Chief, who may also have a deputy. Having a deputy is encouraged when all designated units are established at an incident site. When the incident is very large or requires a number of facilities with large numbers of equipment, the Logistics Section can be divided into two branches.

The Logistics Team consists of eight positions including the Chief, the Service and Support Branch Directors, and the Communication/Hardware, IT/IS, Supply, Staffing/Scheduling, and Transportation Units. This section's responsibilities include personnel/manpower, supplies, equipment, pharmaceuticals, and vehicles. The Logistics Section works closely with the Operations Section, responding to supply requests and their acquisition based on the needs of the response. During pre-event planning, a staging area (or areas) should be established and identified in the Emergency Operations Plan (EOP). The staging area will be a central location, large enough to allow for the collection of personnel, vehicles, and equipment/supplies needed in the response. The Logistics Section Chief, with the assistance of the Support Branch Director provides oversight and direction at the staging area(s), maintaining an inventory of those supplies.

The **Logistics Section Chief** oversees the provision of services and support to sustain current operations and the operational response to the incident.

There are two branches within the **Logistics Section:** Service and Support.

The **Service Branch** will ensure the preservation of those essential services; of communications and information technology. Under the Service Branch Director, the Communications and IT/IS Unit Leaders may be activated to assist with this function. The

Logistics Section **Support Branch** organizes and maintains the facility's supplies, equipment, transportation and labor pool in support of the residents, staff, and staff dependents in accordance with facility policy. The Support Branch must also account for those resources used and requested for operations. Under the Support Branch Director, the Supply, Staffing/Scheduling, and Transportation Unit Leaders may be activated to assist with this function.

Pre-incident planning should identify critical items that may be needed for various responses based on annual completion of a Hazard Vulnerability Analysis. The on-hand inventory documentation should be kept current and readily available for use when needed.

During a response, needed items that are not "in-house" may be obtained from off the shelf stores or through standard ordering procedures, emergency procurement contracts, mutual aid agreements between facilities, corporate support, and/or requests to the local Emergency Operations Center – Emergency Support Function #8-Health and Medica

Key Logistics Section Responsibilities:

- Provides resources to stabilize the incident and support personnel, systems and equipment:
- Workspace or facilities for incident management staff
- Media briefing center
- Transportation
- Communications equipment
- Food, water, shelter and medical care
- Ensures Incident Command Post and other facilities have been established as needed
- Assesses communications needs and facilitates communications between teams/personnel/agencies
- Attends planning meetings; provides input to Incident Action Plan
- Provides updates on resources (availability, response time, deployment)
- Estimates and procures resources for the next operational period

NHICS Incident Management Team: Finance/Administration

When there is a specific need for financial, reimbursement (individual and agency or department), and/or administrative services to support incident management activities, a Finance/Administration Section is established. Under the ICS, not all agencies will require such assistance. In large, complex scenarios involving significant funding originating from multiple sources, the Finance/Administrative Section is an essential part of the ICS. The Finance/Administration Section must also account for lost revenue associated with the response and recovery and ensure thorough investigation and documentation of incident-related claims.

The **Finance/Administration Section Chief** oversees the costs and expenditures incurred by the response actions, including the purchasing of supplies and equipment. In addition to

monitoring multiple sources of funds, the Section Chief must track and report to the IC the financial “burn rate” as the incident progresses. This allows the IC to forecast the need for additional funds before operations are affected negatively. The Section Chief may also need to monitor cost expenditures to ensure that statutory rules that apply are met. Close coordination with the Planning Section and Logistics Section is also essential so that operational records can be reconciled with financial documents. The Finance/Administration Section Chief will determine, given current and anticipated future requirements, the need for establishing specific subordinate units. In some of the functional areas (e.g., procurement), an actual unit need not be established if it would consist of only one person. In such a case, a procurement technical specialist would be assigned in the Planning Section instead. Because of the specialized nature of finance functions, the Section Chief should come from the agency that has the greatest requirement for this support. Additionally, the Finance/Administration Section Chief must assist in the screening of volunteers who will be assigned to duties during the response.

Finance/Administration Team Key Responsibilities:

- Manages all financial aspects of the incident
- Provides financial and cost analysis information as requested
- Create accounts for claims and costs; coordinates with Logistics
- Tracks worker time and costs for materials and supplies
- Documents claims for damage, liability and injuries
- Notifies risk management/insurance to initiate claims reporting
- Provides incurred and forecasted costs at planning meetings
- Provides oversight of financial expenditures, new leases, contracts and assistance agreements to comply with corporate governance

The **Time Unit Leader** ensures that all staff and volunteers who are utilized in the response efforts account for their hours and assists with the screening of volunteers or newly recruited staff if possible before they are assigned to any resident areas.

The **Procurement/Claims/Costs Unit Leader** works closely with the Logistics Section to obtain those supplies and equipment needed for the response. The costs of items procured in the response will be documented, with projections for ongoing costs that may be incurred in the response and recovery phases. The position is also responsible for coordinating all claims and compensations related to response and recovery efforts. These may include insurance and government claims related to the response as well as compensation claims related to employee, visitor, or resident injury or illness.

Position Crosswalk

To further explain the roles within the IMT, suggested facility positions that may fill the IMT roles have been identified. The identification of traditional facility positions to fill the IMT roles provides a source of discussion in the planning stage. A key step in this process is to review

the roles and responsibilities of the position as identified in the Job Action Sheet, and identify the most skilled person to fill the role.

The following chart is a list of ***suggested*** persons to fill the IMT roles.

ICS POSITION	NURSING HOME POSITION
Incident Commander	**Administrator/TMG VP**
Medical Director/Specialist	Medical Director
Public Information Officer	Marketing Coordinator
Liaison Officer	Administrator
Safety Officer	ESM
Operations Section Chief	**Director of Nursing**
Resident Services Branch Director	Asst. Director of Nursing (LTC)
Nursing Unit Leader	Unit Coordinator
Psychosocial Unit Leader	Social Worker
Admit/Transfer & Discharge Unit Leader	Admissions Coordinator/RCC Lead
Infrastructure Branch Director	Maintenance/Housekeeping supervisor
Dietary Unit Leader	FSD
Environmental Unit	Maintenance/Housekeeping Supervisor
Physical Plant/Security Unit Leader	Maintenance
Planning Section Chief	**Administrator**
Situation Unit Leader	Medical Records Staff
Documentation Unit Leader	Medical Records Staff
Logistics Section Chief	**Director of Quality**
Service Branch Director	ESM/TMG IT
Communication Hardware Unit Leader	Maintenance /TMG IT
IT/IS Unit Leader	TMG IT
Support Branch Director	Asst Director of Nursing (Sub Acute)
Supply Unit Leader	Housekeeping Sup or Central Supply
Staffing/Scheduling Unit Leader	Staffing Coordinator
Transportation Unit Leader	Activity Director
Finance/Admin Section Chief	**VP Finance**
Time Unit Leader	Payroll/TMG
Procurement /Costs / Claims Unit Leader	ESM/TMG AP

Establishing an Area Command

An Area Command is established when the complexity of the incident and incident management span-of-control considerations so dictate. Generally, the Incident Commander for the emergency makes the decision to establish an Area Command.

The purpose of an Area Command is either to oversee the management of multiple incidents that are each being handled by a separate ICS organization or to oversee the management of a very large or complex incident that has multiple incident management teams engaged.

This type of command is generally used when there are a number of incidents in the same area and of the same type, such as two or more HAZMAT spills or fires. These are usually the kinds of incidents that may compete for the same resources. When incidents are of different types and/or do not have similar resource demands, they are usually handled as separate incidents or are coordinated through an EOC.

Area Commands are particularly relevant to public health emergencies, given that these events are typically not site specific, not immediately identifiable, geographically dispersed, and evolve over time ranging from days to weeks. Such events as these, as well as acts of biological, chemical, radiological, and nuclear terrorism, call for a coordinated intergovernmental, private-sector, and nongovernmental organization response, with large-scale coordination typically conducted at a higher jurisdictional level.

Incident Action Planning and Incident Command System Forms

In developing the response to the event, certain steps should be taken to guide the response. These steps are part of the Incident Action Planning. The incident planning process is a core concept of ICS and takes place regardless of the incident size or complexity. This planning involves six essential steps:

1. Understanding the nursing home's policy and direction

The command and general staff, in developing the response actions to undertake, must first understand the facility policy and purpose.

For example, the nursing home may be active in community medical disaster planning and have developed plans to provide first aid services during the emergency. This policy should be established in written policy and be clearly understood by the Incident Management Team as an established response action.

2. Assessing the situation

Situational intelligence is critical in developing the response actions, providing insight to the impact, and projecting the span of the event. Nursing homes should have access to established mechanisms and systems within the community (city, county, regional, or state) that will provide and verify situational information. Another component in assessing the situation is determining the potential impact on the facility itself, based on current resident and employee status, the status of the building(s) and grounds, and the ability to maintain resident services.

3. Establishing incident objectives

The Incident Commander sets the overall command objectives for the response. He/she sets the direction for the response actions, setting the mission of the nursing home in the emergency response.

For example, in an incident involving power failure, ensuring the safety of the residents and employees is the highest priority. The Incident Response Guides provide examples of objectives that apply to the response based on the cause. These may be used in the Incident Action Planning process.

4. Determining appropriate strategies to achieve the objectives

After the Incident Commander has set the command objectives, the section chiefs then determine the appropriate strategies to undertake in the response. This provides a plan of action for each section, clearly identifying actions and duties while ensuring that there is no duplication of efforts. Objectives should be developed that provide clear direction and clearly define what is to be done. For example, assessing the building for structural damage after an earthquake is a clear objective to be carried out.

5. Giving tactical direction and ensuring that it is followed

Tactical directions provide the responders with the actions to be taken, and identifies the resources needed to complete the task. For example, assessing the facility after a blizzard will require the necessary tools such as protective equipment, checklists to document the assessment, etc. Actions undertaken should be assessed for their effectiveness, with the objectives and directions adapted if they are unsuccessful.

6. Providing necessary back-up

When tactical direction is initiated, support is needed to meet the objectives. This may include revision of the actions taken in the response, the assignment of additional resources (personnel, supplies and equipment) as well as the revision of tactical objectives.

Management by Objectives: Example

The foundation of healthcare incident action planning is Management by Objectives (MBO). The Incident Commander sets the overall command objectives for the response and recovery. Through this process, staff within operations, logistics, and planning are given a clear direction to follow and will then develop strategies for their respective sections. Consider the following example that demonstrates the application of command objectives and strategies. A community-wide infectious disease outbreak impacts the nursing home through illness of residents and staff. The outbreak must be contained, and local health authorities advise restrictions on visitations to nursing homes, hospitals, long-term care, and residential facilities. At the nursing home, the emergency operations plan has been activated, as over 50% of the residents and almost 35% of the facility staff are ill. The Incident Commander identifies the command objectives for this response as:

1. Ensure the safety of residents, visitors, and staff
2. Continuation of essential resident services and provision of medical care as needed

For the Operations Section (those who provide care to residents and maintain the facility infrastructure) the strategies and tactics that meet the command objectives include:

1. Command Objective: Ensure the safety of residents, visitors, and staff

    a. Strategy: Restriction of visitors to residents

        i. Tactic: Notify residents and family members of restricted visitation to prevent possible spread of infectious disease

        ii. Tactic: Post signage of restricted visitation

        iii. Tactic: Consolidate all entry into facility to one portal to control visitors

2. Command Objective: Continuation of essential resident services and provision of medical care as needed

    a. Strategy: Cancellation of nonessential services in order to utilize available staff for essential resident services

        i. Tactic: Identify nonessential services that can be cancelled or postponed; reassign staff to essential services or to an on-site labor pool

For the Logistics Section, whose role is to provide the necessary supplies and equipment to support Operations, the strategies and tactics may include:

1. Command Objective: Ensure the safety of residents, visitors, and staff a.

    Strategy: Provide infection control supplies as needed and

    directed.

    i. Tactic: Inventory all available infection control supplies, including gloves and masks, currently available

Documenting the Objectives, Strategies and Tactics: The Incident Action Plan (IAP)

The Federal Emergency Management Agency (FEMA) has developed ICS forms that can be utilized in Incident Action Planning. The forms provide a documentation tool that directs the response and archives the objectives, strategies, and tactics. It is also used as a method for documenting the personnel, supplies, and equipment used in response and recovery phases.

Key information on the NHICS forms

Incident Name: The event that triggers the activation of the emergency operations plan and the incident management team structure is given a specific name that is then recorded on all ICS forms. If the event affects only the nursing home, the Incident Commander will identify the name. For example, a fire at the facility may be named Nursing Home Fire. If the incident occurs outside of the nursing home, the lead agency or local emergency management will name the incident. This name will be widely communicated, and allow for all response and recovery actions to be tracked under one name. For example, if there is a wildfire that triggers the evacuation of the nursing home, the incident name will come from the lead agency (the fire service) for the response. This incident name should be used on all ICS forms produced by the nursing home, providing clear documentation of the evacuation in response to the external event.

Operational Period: This refers to the amount of time it is projected to take to meet the strategies and tactics identified in the response. The operational period does not need to correspond to shift hours. The operational period may be revised to a longer or shorter period based on the incident, the response actions, and the evaluation of efforts undertaken. There is one Incident Commander for the operational period. Turnover of incident management team positions and new strategies and tactics signals a new operational period. It is the role of the Incident Commander to set the operational period.

Recording of time and date: The time used on all forms is based on a 24-hour clock. For example, 10 o'clock in the morning is documented at 1000 while

10 o'clock at night is documented at 2200. Standardizing everyone's watches and clocks at the outset of an operational period will help to insure reporting time accuracy.

Dates are expressed in a year / month / day format. For example, June 18, 2009 is written as 2009-06-18.

Names and Titles: Position titles have been identified for NHICS that are consistent with standard incident command system terminology. These include Commander, Section Chiefs, Branch Directors, and Unit Leaders. This allows for positions to be shared with other organizations, and also enhance communication among response partners through the use of common terminology.

In documenting the response on the NHICS forms, the names of persons filling the IMT positions should include the full name.

Prepared by: Each form identifies the position within the Incident Management Team responsible for completing the form. This task is also reflected on the Job Action Sheet for each position.

Facility Name: The name of the nursing home or long-term care facility that is utilizing the form is documented. This allows for information to be shared with other response partners or with other facilities that may be part of a larger consortium.

Approved by: On some forms, the completion of the form for accuracy and applicability may be reviewed by another position within the IMT. This will be noted on each form, with space provided for signatory approval.

Purpose and Copies: In the footer section of each form there is guidance provided on the purpose of each form and the routing or distribution of each form. Nursing homes may elect

in the planning stage to review the routing of forms, providing customization in the distribution.

Legibility: As with all documentation in healthcare, writing should be legible. Beyond guiding the response, ICS forms may be used in recovery, review of the response, and financial reimbursement. The documentation should be legible, providing a clear message for all response partners internal and external of the nursing home.

NHICS Incident Action Planning Forms

For use in Incident Action Planning by nursing homes, 18 individual forms have been created. Each form has a specific purpose in both directing and documenting the response.

NHICS Form 201: Incident Briefing and Operational Log

The Incident Briefing contains the initial overview of the event, including the cause, the initial impact, the actions taken, and other critical information. This form is completed by the Incident Commander and should provide a clear and succinct overview of the situation to incident management team members. Then, this form can be used for the Command and General staff as their Operational Log to document assignments and key actions taken in their section/branch during the event. Each person with a Command or General staff assignment should complete an operational log, documenting their assignment, actions taken, critical information received, and other key information and decisions as determined by the individual. This critical chronology of information serves multiple functions: as a record of the work performed during the operational period; as a personnel log to assist with reimbursement; as a guide for the after-action review; and as a resource tool for personnel assuming the same position in follow-up operational periods.

NHICS Form 202: Incident Objectives

As previously noted, the Incident Commander sets the overall command objectives for the response. These are documented on NHICS form 202. The incident name and operational period, as first identified on NHICS form 201, are repeated on NHICS form 202. Weather conditions are documented on this form, in consideration of any operations that may be impacted by inclement weather, such as heat, rain, extreme cold, etc. As an example of the importance of weather conditions, consider a nursing home evacuation due to power failure. If there is extremely hot weather predicted for the next 12 hours, it may not be safe to move residents to an external location to await transportation. The Logistics Section may be required to provide shelter from the heat if residents must wait outside for prolonged periods.

General safety information is also reflected on NHICS form 202. In the example above, safety information may include use of tents or overhead shelters for staging of residents, directions to drink water and watch for signs of heat exposure to residents and staff.

A separate section is available to indicate any attachments to the form; some examples are contained but there is opportunity here for customization. For example, if a local health alert is issued in response to an infectious disease outbreak, the guidance from the health officer may be attached here. This is a key reference document in the development of strategies and tactics identified for the event response.

The Incident Commander will approve all information contained on

NHICS form 202. The Planning Chief has the responsibility for completing the form; if this role has not been activated or cannot be filled, the Incident Commander assumes the responsibility.

NHICS Form 203: Organization Assignment List

This form provides a documentation tool that reflects those positions on the Incident Management Team chart that are activated in the response, and the nursing home personnel currently assigned to the position. In larger facilities, a representative from the nursing home may respond to the (external) Emergency Operations Center (EOC) within the jurisdiction. This position should be documented on the form.

NHICS Form 205: Incident Communications Plan

Communications are an integral element of the response, and are most often cited as a failure in the response. This form allows for clear assignment of available technology, including radios, telephones, pagers, and other devices. Facilities may elect in the planning stage to complete this form with the systems and technology currently available. Decisions may also be made in the planning stage concerning the assignment of response specific to technology and tools. For example, if the nursing home has 4 two-way radios available for use in the response, these may be indicated on the form along with the IMT position to which each radio is assigned.

NHICS Form 206: Staff Injury Plan

In some cases, the care of ill or injured employees must be considered. If there is infrastructure damage to the facility that causes injuries to staff or if there is an infectious disease outbreak that requires assessment and prophylaxis of employees, the nursing home may need to care for its staff. NHICS form 206 documents these actions, providing clear direction as to the location of occupational health services and accountability for protection of employees.

NHICS Form 207: Organizational Chart

Similar to the information contained on NHICS form 203, position assignments are documented in a visual organization chart / incident management team format that can be distributed to appropriate personnel.

NHICS Form 213: Incident Message Form

Clear documentation of messages received and sent in activation is important both for ensuring critical information flow and follow-up actions taken. The person sending the message should document legibly the request being made, including the need for follow-up of actions taken. Persons receiving messages should use the form to document actions taken as requested and provide answers to messages. This form may also be used for documentation of telephone or radio messages received, again serving as a tool to record requests and actions. The NHICS form 213 may be produced on NCR (non- carbon) paper, allowing for multiple copies of the messages to be routed accordingly. When used effectively, this allows for message archive without the use of a copy machine.

NHICS Form 251: Facility System Status Report

This form can and should be customized to the individual nursing home. Used when there is structural damage (power failure, earthquake, severe weather, and fire) key information is gathered on the infrastructure of the facility. This will aid in determining the capability of the facility to sustain operations, as well as provide clues to system recovery for engineers.

NHICS Form 252: Section Personnel Time Sheet

This form is used when an alternative staff time tracking system is needed due to power failure or other incident related conditions. This form can also be used to document the persons assigned to IMT positions, facilitating cost projections and financial reimbursement when possible.

NHICS Form 253: Volunteer Staff Registration

This form is used to document those non-nursing home personnel who respond and are assigned to the nursing home in support of operations. This form is used to document the screening of volunteers through reference or criminal background checks and/or credentialing if feasible, and then is used to track these persons to facilitate financial reimbursement when possible.

NHICS Form 256: Procurement Summary Report

This form is used by the Finance/Administration Section to track all supplies and equipment procured in the response and recovery phase, providing an ongoing cost assessment tool for current and projected operations.

NHICS Form 257: Resource Accounting Record

A major component in a successful response that utilizes outside resources is the ability to track and account for supplies and equipment used. This form provides a tracking tool for those items, allowing for rapid identification of what is being used in the response and what is still needed.

NHICS Form 258: Facility Resource Directory

The resource directory can be customized in the planning stage to identify those current resource partners, such as transportation services and supply vendors, as well as those resources that may only be used in an emergency such as emergency management officials, health officials, and repair services. It is critical during the response to have accurate contact information, with redundancies of information. This data can be collected well in advance of an event, and may serve to identify those response partners within the jurisdiction of the nursing home that can be engaged in planning.

NHICS Form 259: Master Facility Casualty and Fatality Report

In the event of resident injury or death, this form may be used to report to local health and emergency management officials, as defined within the jurisdiction. In planning, the release of information should be discussed, identifying those agencies or individuals to whom potentially confidential information will and will not be released.

NHICS Form 261: Incident Action Safety Analysis

All Incident Action Plans contain a safety analysis. This form directs the Safety Officer to identify those potential hazards and direct mitigation efforts to lessen the risk of injury or illness. For example, in a power failure it may be advised to restrict all residents to their rooms to prevent falls in areas where lighting is limited. This is information that would be documented, with the assignment of restriction of resident movement assigned to branches.

Emergency Resident Tracking/Evacuation Tracking

In the event the facility receives residents or other individuals from the response or as transfers from another facility or hospital, or evacuation is necessary, please refer to the Efinds policy and procedure (8.2.13.2).

Facility Command Center

It will be important that an area be designated within the nursing home to serve as the Facility or Nursing Home Command Center. Conference rooms are often used for this purpose. The room ideally should be in a secure location and suitable in size to accommodate the anticipated number of personnel filling IMT positions who will operate from this area. Access to phones, computers with internet capability, printers, fax machine, and general supplies (paper, pencils, etc.) will be important. Having a large whiteboard for documentation and projection capability may be helpful. Convenient access to bathrooms and food will also be important.

Space should be organized so each command position has a desk area and access to available technology. Persons assuming a command role should be easily identified by use of vests or other suitable clothing item (i.e. hat, armband).

If staffing allows, assigning persons to serve as assistants to those in charge has been shown to be invaluable. They can assist by answering phones and documenting key pieces of information.

Incident Action Plan

An incident action plan (IAP) formally documents incident goals (known as control objectives in NIMS), operational period objectives, and the response strategy defined by incident command during response planning. It contains general tactics to achieve goals and objectives within the overall strategy, while providing important information on event and response parameters. Equally important, the IAP facilitates dissemination of critical information about the status of response assets themselves. Because incident parameters evolve, action plans must be revised on a regular basis (at least once per operational period) to maintain consistent, up-to-date guidance across the system.

The following should be considered for inclusion in an IAP:

- Incident goals (where the response system wants to be at the end of response)
- Operational period objectives (major areas that must be addressed in the specified operational period to achieve the goals or control objectives)
- Response strategies (priorities and the general approach to accomplish the objectives)

- Response tactics (methods developed by Operations to achieve the objectives)
- Organization list with ICS chart showing primary roles and relationships
- Assignment list with specific tasks
- Critical situation updates and assessments
- Composite resource status updates
- Health and safety plan (to prevent responder injury or illness)
- Communications plan (how functional areas can exchange information)
- Logistics plan (e.g., procedures to support Operations with equipment, supplies, etc.)
- Responder medical plan (providing direction for care to responders)
- Incident map (i.e., map of incident scene)
- Additional component plans, as indicated by the incident.

The facility's Emergency Preparedness Management Plan's scope is to provide for a program that ensures effective response to disasters or emergencies affecting the environment of care. As stated above, an Incident Command System framework will be utilized to manage/respond to all emergent situations that may affect the facility.

The objective of the Emergency Preparedness Plan is to effectively manage a disaster.

- The goals of the Emergency Preparedness Management Plan includes the following:
  - Utilize Incident Command System (ICS) to manage individual emergency situations as per attached ICS policy.
  - Providing education to personnel on the elements of the Emergency Preparedness Management Program and ICS program;
  - Establishing and implementing procedures in response to an assortment of disasters;
  - Identifying alternate sources for supplies and services in the event of a disaster.

RESPONSIBILITY

The Safety Officer in conjunction with the Administrator in conjunction with the director of Environmental Services is responsible for developing, implementing, and monitoring the Emergency Preparedness Program at this facility. The facility's Incident Commander (See ICS Policy) will activate the emergency management system as needed for all emergent situations.

SPECIFIC PROCEDURES IN RESPONSE TO A VARIETY OF DISASTERS

This facility has developed specific procedures in response to potential disasters that may occur. (The samples included in this manual are intended to be used as a guideline for development of facility-specific disaster policies, i.e., Bomb Threat, Earthquake Response Procedure Policy, Tornado, Severe Weather, Work Stoppage, Loss of Resident, Loss of Communications, and emerging infectious diseases. All variety of potential incidents will be managed through the facility Incident Command System.

DEFINE AND INTEGRATE THE FACILITY'S ROLE WITH THE COMMUNITYWIDE EMERGENCY PREPAREDNESS EFFORTS

- Implementation of the facilities Emergency Preparedness Plan will be conducted at least semiannually (and no less than four months apart or more than eight months apart), either in response to a disaster or as a planned drill.
- This facility cooperates with all local, county and state disaster preparedness drills. The Organization is a member of the countywide emergency preparedness system and coordinates with other agencies any large scale drills.
- The facility ICS protocol will be utilized to allow for seamless integration into the community wide Emergency Management System.

Notification of External Authorities

- The facility shall have two-way radio or cellular equipment and operators, which are familiar with the equipment. External communication will be mostly with Emergency Control Centers.

NOTIFICATION OF PERSONNEL WHEN EMERGENCY RESPONSE MEASURES ARE INITIATED

- In an emergency, which is so widespread to be considered a disaster and/or involving mass casualties, all facility personnel, regardless of position are expected to report to

the facility for duty as soon as it is feasible to travel. Each department director maintains a current callback list of all employees. Once the emergency preparedness plan has been activated, the department director will assign a staff member to initiate the callback list.

- Facility volunteers will be asked to leave the facility and not participate in emergency events. The facility will utilize and rely on its sister facilities and corporate employees in the event of an emergency. A Disaster Liaison facilities contact information staff listing is maintained by the Payroll Department and distributed periodically to the facility Administrators. If such need arises, the Administrator will notify the corporate office who will assist in coordination of resources and sister facility staff assistance.

- Please see below for the 1135 waiver regarding Medical/Professional Volunteers.

- In the event there is excess personnel, the Command Post will communicate with department directors regarding rescheduling of personnel for future needs. The medical staff will report to the Incident Commander for assignments.

- See Emergency Preparedness Delegation of Responsibilities Policy. Incident Management Team Roles Policy.

ASSIGNMENT OF PERSONNEL IN EMERGENCIES TO COVER ALL NECESSARY STAFF POSITIONS

- All personnel reporting to the facility in the event of a disaster shall report to the Incident Commander to sign in. Personnel who have been directed to report to their assigned unit will do so all others will be assigned to areas where help is needed. Personnel may not necessarily be assigned to their regular duties. Personnel will be asked to perform various jobs or working hours, which will be considered vital to an effective operation.

MANAGEMENT OF SPACE, SUPPLIES AND SECURITY

- Essential supplies, equipment, food, water and utilities must be provided to meet shelter requirements for up to two weeks. Procedures are in place for the procurement of additional supplies in an emergency. At the time the Emergency Preparedness Plan is activated, the Maintenance Department Personnel on duty will be responsible for locking all exits and entrances. Employees are required to wear nametags or carry cards identifying them as employees. Only persons with proper identification shall be admitted to the facility during an emergency.
- Emergency Delivery of supplies-The facility maintains a 5 day supply of medical supplies on hand. In the event of an emergency, the facility takes precedence for delivery of medical supplies for resident services. In the event of power outages, the facility's last order will be repeated and delivered as soon as possible and in concert with the usual

deliver. Should additional supplies be required, the facility can phone in orders and supply trucks will be on standby for delivery.

- US Foods Emergency Provisions
  - U.S. Foods Buffalo will keep Emergency/Disaster Plan documents on file for any customer wishing to participate.
  - In the event of an Emergency/Disaster the Customer should contact US Foods to arrange for shipment of their Emergency Order.
  - In the event of a local Production System failure, US Foods has a redundant system in place to handle order entry and warehouse functions. In the event of a local disaster, U.S. Foods has sister distribution facilities ready to help supply product, equipment, personnel and computer services if necessary. In the event of a disaster, our National Processing Center in Greenville, SC, our data is maintained in disaster recovery centers thought the U.S that will enable us to keep functioning. In the event of an usfood.com catastrophic failure, our customer service teams can take orders over the phone.
  - US Foods commits to:
    - Refrigerated/Freezer Truck (U.S. Foods Buffalo, Inc. will make available when possible or assist in making rental arrangements)
    - Flexible delivery schedule
    - Cooking Supplies - Steamtable Trays, Sterno, Etc.
    - Food Supplies: Cereals, Non-Fat Dry Milk, Instant Foods, Canned Juices, Bottled Water, Portion Control Items, Supplements
  - In the event of an in-house disaster, the above accommodations will be made within twenty-four hours; however, if the disaster is external, food and/or supplies will be delivered within forty-eight hours.
  - If a disaster should strike our facility, U.S. Foods Buffalo will use, as needed, our facilities in the East and/or West areas to provide service and delivery to your location.

EVACUATION OF THE FACILITY

- When a situation arises requiring evacuation of patients from threatened or affected areas; safety of lives is the facility's primary concern. Authority to order an evacuation is vested only in the Incident Commander or his/her designee. Patients shall be evacuated to an area of safety by whatever means are available. Formal agreements are in place with ambulance services and neighboring facilities to transfer patients as necessary. All personnel have been trained in evacuation procedures. Evacuation routes are posted throughout the facility.

- Universal Transportation assistance (TAL) are utilized to help streamline and coordinate planned evacuations. TAL classifications are used to assess the types of resources needed (bus, vans, ambulances) by each patient during a planned evacuation. TAL tags are located in the facility evacuation tote located in a designated area within the facility.

- See Emergency Preparedness Evacuation Procedure.

ESTABLISHING AN ALTERNATE CARE SITE WHEN THE ENVIRONMENT CANNOT SUPPORT ADEQUATE PATIENT CARE

- Formal agreements are in place so that, patients may be transferred to a facility that can provide adequate patient care. The following agreements are in place:
    - Ambulance contract agreements for transfer of patient between facilities.
    - Transfer agreements will be made between neighboring facilities.
    - Vendors will be contracted for special needs or arrangements.
- See Emergency Preparedness Evacuation Policy.

MANAGEMENT OF PATIENTS DURING EMERGENCIES (I.E., SCHEDULING, MODIFICATION OR DISCONTINUATION OF SERVICES, CONTROL OF PATIENT INFORMATION AND PATIENT TRANSPORTATION)

- Upon activation of the Emergency Preparedness Plan, normal admission requirements will be abolished. Initially, admissions to the facility will be limited to those whose survival depends upon services obtainable only through facility bed care.

Alternate Sources of Essential Utilities

The facility will provide for alternative sources of essential utilities including:

- An emergency source of electrical power capable of operating all essential electrical equipment and a plan for failure of back up generators;
- An alternate source of safe water;
- An alternate means of waste disposal in the event of sewage system failure;
- Sufficient fuel to last for at least two weeks of expanded operation.

Backup Communication System

The Facility will provide for alternate communication methods in the event of a failure. Two-way radio equipment and facility owned cell phones shall be available in the event of a disaster.

Alternate Roles and Responsibilities of Employees during Emergencies

Employees may not be assigned to their regular duties. Employees will be asked to perform various jobs, which will be considered vital to the effective operation of the facility. Employees will be assigned duties based on the needs of the facility.

Orientation and Education Program for those Who Implement the Plan

Personnel will attend orientation upon hire and an annual update of their specific roles and responsibilities and the skills they require to perform their duties during a disaster. Inservice education will be given on the back-up communication system and obtaining supplies/equipment in the event of a disaster.

Performance Standards

There is a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization wide safety. The organization will develop and establish performance measures and related outcomes, in a collaborative fashion, based those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:

- The measure can identify the events it was intended to identify;
- The measure can detect changes in performance over time;
- The measure allows for comparison over time within the organization or between the organization and other entities;
- The data intended for collection are available; and
- Results can be reported in a way that is useful to the organization.

- On an ongoing basis, monitor performance regarding actual or potential risk related to one or more of the following:
    - Staff knowledge and skills,
    - Level of staff participation,
    - Monitoring and inspection activities,
    - Emergency and incident reporting, or
    - Inspection, preventive maintenance, and testing of safety equipment;
    - Other performance measures and outcomes will be established based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection, aggregation and reporting will be determined by the Administrator or the organization.
- To identify opportunities for improvement, follow the organization's improvement methodology.
- Should a team approach be necessary for performance and process improvement to occur, the facility will follow the organization's performance improvement guidelines for improvement team member selection (QOC, QOL, QOWL, QOE). Determination of team necessity will be based on those priority issues listed (high risk, volume and problem prone situations and sentinel event occurrence). Should team development be deemed necessary, primarily, team members will be selected on the basis of their knowledge of the subject identified for improvement, and those individuals who are "closest" to the subject identified. The team will be interdisciplinary, as appropriate to the subject to be improved.
- Performance improvement monitoring and outcome activities will be presented to the Administrator by the Director of Environmental Services at least on a quarterly basis, with a report of performance outcome forwarded to the Continuous Performance Improvement Committee and Governing Body quarterly.
- The following performance measures may be used:
    - Percent of staff able to demonstrate knowledge and skill of their role and expected participation in the Emergency Preparedness Plan/ICS.

- Percent of staff able to demonstrate knowledge of their responsibilities during a drill.

- Number of emergency preparedness drills conducted within specified time span.

ANNUAL EVALUATION OF THE EMERGENCY PREPAREDNESS PLAN'S OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS

- The performance and effectiveness of the Emergency Preparedness Management Program shall be reviewed by the organization, the Continuous Quality Improvement Committee and Administration.

ACTIONS UNDER 1135 WAIVER

1. For the purposes of this Section, an “emergency” is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his/her license and regardless of department/section, Medical Staff membership or clinical privileges or allied health professional (AHP) status or practice prerogatives, shall be permitted to do, and shall be assisted by Facility personnel in doing, everything possible to save the life of a patient or to save a patient from serious harm. All efforts will be made to obtain a Medical Staff member with appropriate clinical privileges. Clinical privileges granted under an emergency situation shall terminate when a Medical Staff member with appropriate clinical privileges becomes available or the emergency ceases.

2. Emergency privileges in case of a disaster will be granted in accordance with the following:
    a. Consistent with the current Facility Emergency/ Disaster Credentialing Policy (Facility Disaster Policy) clinical privileges or practice prerogatives may be granted when the Facility Incident Command System (ICS) plan has been activated and the Facility is unable to handle the immediate patient needs. This includes events of a bioterrorism attack or any other type of disaster situation whereby Volunteer Practitioners and AHPs, as those terms are defined in the Facility Disaster Policy, may require disaster credentialing.
        i. Medical Records will set up a satellite post in the Medical Staff Services Department or other appropriate area where non-credentialed Volunteer Practitioners and AHPs will check in.

3. Emergency privileging for disaster situations is specialty-specific and Volunteer Practitioners or AHPs shall not carry out any clinical activities for which they do not already hold clinical privileges or practice prerogatives at another facility.

Procedure:

1. Upon presentation to the campus, Volunteer Practitioners and/or AHPs shall be directed to the Facility Representative responsible for disaster credentialing under the ICS plan. Volunteer Practitioners and/or AHPs must sign in and present required identification as follows: a valid government issued photo identification issued by a state or federal agency (e.g., driver's license or passport), and at least one of the following:
    a. A current facility photo ID badge that clearly identifies the person's professional designation;
    b. A current license, certificate, or registration to practice;
    c. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
    d. Identification that indicates that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
    e. Identification of Volunteer Practitioners by current Facility Medical Staff member(s) who possess personal knowledge regarding the Practitioner's ability to act as a practitioner during a disaster, and of Volunteer AHPs by current Facility Medical Staff member(s) or AHPs who possess personal knowledge regarding the AHP's qualifications.

2. Required documentation on the Disaster Clinical Privileges Approval Form: The Volunteer Practitioner shall include all of the following information on the Disaster Clinical Privileges Approval Form:
    a) Name of Practitioner or AHP (printed and signed)

    b) Specialty or AHP Category

    c) Office Address and Phone Number

    d) Professional License/Certificate/Registration Number and Expiration Date

    e) Driver's License or Passport Number and Expiration Date

    f) Date of Birth

    g) Name of Professional Liability Insurance Carrier and Limits of Liability

    h) Name of Professional School and Year of Graduation

    i) Facility Affiliation(s) and Staff Status

3. Verification Process:

The Facility Representative shall verify professional licenses /certificates/registrations as follows:

1. Primary Source Verification: Query the appropriate licensing/certification/registration board online, and print verification if possible.
2. If computer access is not available, a copy (if possible) of the Practitioner's or AHP's professional license/certificate/registration and driver's license or other identification

shall be made and attached to the Disaster Clinical Privileges Approval Form. If a copier is not available, the Facility Representative shall perform a visual verification of the above documents, and document such verification.

3. If primary source verification of professional licensure/certification/registration cannot be accomplished at the time of initial credentialing, it must be performed as soon as the immediate situation is under control and completed no later than seventy-two hours from the time the Volunteer Practitioner or AHP presented to the campus. In extraordinary circumstances when primary source verification cannot be completed within seventy-two hours (e.g., no means of communication or lack of resources), it shall be accomplished as soon as possible. In this extraordinary circumstance, the following must be documented:
   a. Why primary source verification could not be performed in the required timeframe;
   b. Evidence of the Practitioner's or AHP's demonstrated ability to continue to provide adequate care, treatment, and services;
   c. Attempt(s) to rectify the situation as soon as possible.

4. The Medical Staff Credentialing Department shall query the National Practitioner Data Bank and other sources as needed as soon as the emergency situation has been contained.
5. Primary source verification shall not be required if the Volunteer Practitioner or AHP has not provided care, treatment and services under the Disaster Clinical Privileges Approval Form, as appropriate.

a. Who May Grant Disaster Clinical Privileges/Practice Prerogatives: Medical Director or their designees may grant Disaster Clinical Privileges or Practice Prerogatives. The option to grant Disaster Clinical Privileges or Practice Prerogatives to Volunteer Practitioners and/or AHPs shall be made on a case-by-case basis in accordance with the immediate needs of the Facility's patients, based on the qualifications of the Volunteer Practitioners and/or AHPs.

6. Temporary Badges:

a. So that they may be readily identified, Volunteer Practitioners and/or AHPs shall be issued badges containing the following information:

1. Name
2. Licensure
3. Specialty or AHP category
4. Practicing with Disaster Clinical Privileges, as appropriate
5. Oversight:

The Medical Staff shall oversee the care, treatment, and services provided by a Volunteer Practitioner or AHP who has been granted Disaster Clinical Privileges. Oversight shall be accomplished whenever possible by partnering the Practitioner or AHP with a current credentialed Facility Medical Staff member or AHP, as appropriate, to observe or mentor the Volunteer Practitioner or AHP.

If partnering is not possible, oversight shall be by clinical record review. A Volunteer Practitioner or AHP may be assigned additional responsibilities by the Medical Director as designated under the ICS plan.

b. Continuation of Disaster Clinical Privileges: The Facility shall make a decision within seventy-two hours regarding the continuation of a Volunteer Practitioner's or AHP's Disaster Clinical Privileges, based on information obtained regarding the professional performance of the Volunteer Practitioner or AHP.

c. Termination of Disaster Clinical Privileges: A Practitioner's or AHP's Disaster Clinical Privileges shall be terminated immediately in the event that any information received through the verification process or otherwise indicates adverse information or suggests the Practitioner or AHP is not capable of exercising Disaster Clinical Privileges. Disaster Clinical Privileges are time-limited and shall expire automatically at the time the Administrator or designee declares the disaster to be over, or that the services of Volunteer Practitioners or AHPs are no longer required.

B. Section 1135 Waivers

1. Section 1135 waiver(s) applies when a major disaster or emergency is declared and the Secretary of HHS has declared a public health emergency.

a. Facility must implement its disaster protocol and Mutual aide as outlined in Manual 8-2.

b. Facility must notify CMS through the appropriate State Survey Agency when it implements its disaster protocol.

c. The Secretary exercises his or her waiver power under Section 1135 to cover the area in which the Facility is located.

d. The Facility Administrator/Incident Commander will complete the 1135 waiver form when applicable and as declared by the Secretary.

e. Waivers typically end no later than the termination of the emergency periods, or 60 days from the date the waiver or modification is first published, unless otherwise extended by the Secretary for additional periods of up to 60 days.

f. Emergency Medical Treatment and Labor Act (EMTALA) sanctions for redirection of an individual to receive medical screening and examination in an alternative location pursuant to a state emergency preparedness plan or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances. EMTALA requirements are effective only if actions under the

waiver do not discriminate in the basis of a patient's source of payment or ability to pay.

g. Waivers for Emergency Medical Treatment and Labor Act (EMTALA) and HIPPA requirements are limited to a seventy-two-hour period beginning with the implementation of the Facility's disaster protocol or, in the case of a pandemic infectious disease, until the termination of the declaration of the public health emergency.

h. Under the waiver, the Secretary authorizes SNF coverage in the absence of a qualifying hospital stay, as long as this action does not increase overall program payments and does not alter the SNF benefits acute care nature. The facility will accept beneficiaries who have not met the qualifying stay and are eligible to access part A benefits under the waiver.

2. The 1135 waiver of the Facility's requirements will apply only for the period during which the waiver has been authorized by the Secretary of HHS.

This facility utilizes an Emergency Management Committee to oversee the management and updating of the facility's CEMP.

RESPONSIBILITIES OF THE EMERGENCY MANAGEMENT COMMITTEE (EMC):

The EMC and its members, jointly and separately, shall meet monthly and assume responsibility for the facility's Emergency Management/Preparedness Program (EMP).

The Safety Committee shall inform itself of standards for Emergency Preparedness incorporated in the Department of Health; Code of Federal Regulations Title 29; Occupational Safety and Health Act (OSHA); and be thoroughly versed in the Emergency Management related sections of The Life Safety Code (NFPA 101 2012 edition) and The Health Care Facilities Code (NFPA 99 2012 Edition). It shall acquaint itself with the functioning of the facility, its employees and environments. It shall apply this information to design, implement, maintain and advance the facility's Emergency Management Program.

The EMC will develop written policies and procedures as needed in order to ensure that the facility's Emergency Management Program is viable, up to date and compliant with current codes and regulations.

The EMC will report in writing pertinent findings and recommendations to the Administration, Medical and Nursing Staffs and all departments as needed.

Periodic inspections of the facility and grounds shall be conducted for the purpose of assuring compliance with the facility Emergency Preparedness Program. The EMC shall:

- Meet monthly and shall record its activities. Summaries of all activities shall be forwarded to Administration and Department Heads.
- Report quarterly to Administration, on the key Emergency Preparedness initiatives.
- Review/update facility Hazard Vulnerability Assessment (HVA) on an annual basis
- Act as organizational "Risk Team" and review/update facility "NFPA 99 Risk Assessments" as per NFPA 99 (2012 Ed) minimally on an annual basis or as needed to address changes in facility systems and/or equipment.
- Work with Education Department to in-service all facility staff on new and ongoing Emergency Preparedness initiatives.

RESPONSIBILITIES OF ADMINISTRATION:

Toward fulfillment of the general and specific emergency preparedness goals of the Facility, the Administrator shall:

- Assure the formation and development of the EMC.
- Appoint a chairperson who is qualified and the members to the EMC.
- Provide Administration representation on the EMC. Ensure the participation and representation on the EMC.
- Assure that the facility's emergency preparedness policies and plan is reviewed and shared at resident council minimally on an annual basis.
- Assure that the facility's emergency preparedness policy family/responsible party notification flyer is included with the facility admission packet for all new residents

The duty of the administrator shall be to convene the EMC, assure the maintenance of appropriate records, assure timely follow-up of actions and business of the EMC, supervise inspection, survey activity and report recommendations and actions, and act as liaison with the community Emergency Management Personnel and other agencies as needed on matters relative to Emergency Preparedness.

The Administrator/designee has authority and responsibility to convene the EMC outside of the regular meeting schedule as needed to ensure that any newly arising Emergency Preparedness related issues are addressed by the committee in a timely manner.

RESPONSIBILITIES OF DEPARTMENT DIRECTORS:

The role of the Department Directors in our EMP is vitally important. The EMP through verbal and/or in writing shall alert departments or services of Emergency Management issues that require intervention.

The following responsibilities lie with the Department Directors:

- Implement and organize Emergency Preparedness activities and tasks for department.
- Develop techniques and procedures for specific operations.
- Select and train employees.
  - Each Department Director is responsible to verify and ensure that staff members are able to effectively demonstrate their roles/responsibilities within the EMP for their particular position.
  - It is the responsibility of the EMC to ensure that Department Directors have a thorough knowledge of the EMP and apply on-the-job instructions for all employees.
- Supervise and evaluate employee performance.
- Cooperate with the EMC in the promotion of its activities.
- Assist in monitoring Emergency Preparedness recommendations as outlined by the EMC and/or organization.

Utilize the following checklist as guidance for activation of the facility CEMP.

Task		Completed By
☐	Upon notification of hazard or threat from staff, residents, or visitors, activate the CEMP.	Incident Commander
☐	Activate the Communications Plan.	Incident Commander
☐	Notify staff of CEMP activation and the hazard or threat through the facility receptionist and/or overhead paging system.	Incident Commander
☐	Assess the potential or actual impact of the incident on residents, staff, and the facility.	Incident Commander along with situation specific staff.
☐	Direct Incident Management Team to convene at designated Command Center location.	Incident Commander
☐	Based on the hazard and using the “Notification by Hazard Type” table in the CEMP, conduct required notifications.	Staff to be assigned based on nature of incident and real time resource levels.
☐	Set-up the facility’s Command Center. *Refer to section below checklist for more information.*	Staff to be assigned based on nature of incident and real time resource levels.

Task		Completed By
☐	Deliver briefing to Incident Management Team, and other staff as appropriate, on the incident including: ▪ Extent or impact of the problem (e.g., hazards, life safety concerns) ▪ Number of residents injured or affected ▪ Status of resident care and ancillary services ▪ Current and projected staffing levels ▪ Status of facility plant, utilities, and environment of care.	Incident Commander
☐	Develop an Incident Action Plan to establish goals and objectives to guide incident response throughout the next operational period. Operational period duration will be determined by Incident Commander (e.g., 12 hours, shift change).	Incident Commander along with Planning Section Chief and Safety Officer
☐	Prepare and distribute position-specific checklists for the Incident Management Team to use during incident response.	Planning Section Chief
☐	Establish a meeting schedule for Incident Management Team to maintain situational awareness of incident and response operations.	Planning Section Chief
☐	Notify residents and their relatives or responsible parties of hazard information and response actions.	Designated by Incident Commander at time of incident via Incident Action Plan
☐	Task facility staff with completing additional tasks to meet established response goals and objectives.	Incident Management Team
☐	Continue to collect information about incident and its current or projected impacts and perform position duties as assigned.	Incident Management Team

Command Center

The facility Command Center serves as the central location for the Incident Management Team to conduct the following activities:

- Plan and execute emergency operations;

- Exchange information (e.g., briefings, check-in meetings); and
- Store incident-related documentation.

Prior to an incident, facilities should consider the following when identifying a primary and contingency location for the Command Center:

- Located within the facility (e.g., not off-site);
- Provide space for tables and chairs; and
- Provide access to computers/internet and communications equipment (e.g., landline telephones, cell phones).

After an incident, if the pre-identified locations are rendered unusable—or if incident conditions require the Command Center to be relocated—the facility can utilize nearby facilities, or if absolutely necessary, a vehicle to serve as an off-site, mobile Command Center.

Incident Management Team (IMT) Position Checklist

The following checklists outline the responsibilities of each Incident Management Team position. They should be adapted as needed based on the internal policies and procedures of the facility.

INCIDENT COMMANDER	
☐	Activate the CEMP and necessary Incident Management Team positions.
☐	Analyze potential threats or hazards (e.g., weather forecast, law enforcement intelligence) and assess potential or impacts on residents, staff, and the facility. Incident Management Team to assist.
☐	Brief the Incident Management Team on the nature of the problem, immediate issues, and the initial plan of action.
☐	Evaluate expected or actual facility damage and assign staff to conduct a thorough site assessment. Incident Management Team to assist.
☐	In accordance with local plans or procedures, notify emergency management, law enforcement, and fire officials of incident conditions for situational awareness and to relay critical needs.
☐	Facilitate regular briefings to review the status of response operations. Request status reports from staff on resident health and safety.
☐	Observe the Incident Management Team for signs of stress and exhaustion and provide rest periods.
☐	Determine the appropriate protective action based on the presence of potential or actual hazards to resident safety and well-being. Incident Management Team to assist.
☐	Share regular updates with residents and staff to maintain situational updates. Incident Management Team to assist.

INCIDENT COMMANDER	
☐	Authorize procurement and distribution of resources.

PUBLIC INFORMATION OFFICER	
☐	Obtain briefing from Incident Commander and TMG Leadership representatives.
☐	Draft initial message for notification of relatives and responsible parties regarding facility and resident status.
☐	Answer inquiries from residents' relatives and responsible parties, the general public, and the media and direct questions/requests to appropriate individuals. Incident Management Team members will assist with resident and family questions/concerns.
☐	Develop and disseminate status updates to be reviewed and approved by the Incident Commander and TMG Leadership before dissemination to relatives and responsible parties, media, and the public.
☐	Provide guidance to other Incident Management Team members on the appropriate release of information to requesting entities.
☐	Develop regular status updates to keep staff informed of the incident and facility status. Updates will be communicated to staff with the help of the Incident Management Team.
☐	Assist in the development and distribution of signage as needed.
☐	Communicate concerns to the Incident Commander, as needed.

SAFETY OFFICER	
☐	Obtain briefing from Incident Commander.
☐	Conduct site assessment to determine safety risks of the incident to residents, staff, and visitors.
☐	Document the treatment plan for injured or ill staff. This will be completed in concert with a senior clinical team member designated by the Incident Commander.

☐	Post non-entry signs around unsafe areas.
☐	Evaluate building or incident hazards and identify vulnerabilities.
☐	Assess operations and practices of staff, terminate any unsafe activity, and recommend corrective actions to ensure safety of residents, staff, and visitors.
☐	Direct laundry and housekeeping staff to: ▪ Ensure adequate supplies of linens, blankets, and pillows. ▪ Ensure emergency linens are available for soaking up spills and leaks.
☐	Direct food and dietary staff to: ▪ Provide and prepare food as needed during an emergency. ▪ Ensure gas appliances are turned off before evacuating.
☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

OPERATIONS SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Assign staff to assess the facility and resident well-being.
☐	Determine how facility clinical/resident care related services will continue as routinely as possible, including the provision of: ▪ Routine nursing services and documentation ▪ Medication dispersal per resident schedules. ▪ Routine hygienic and nutritional care for residents.
☐	Arrange for the provision of and/or documentation, transfer, and transportation critical medical services, such as dialysis and oxygen therapy, and emergency discharges for at-risk residents.
☐	Maintain resident and staff accountability.
☐	Secure resident records during shelter-in-place operations.
☐	Assess pharmacy supplies and contact pharmacy, as needed, to determine: ▪ Cancellation of deliveries. ▪ Availability of backup pharmacy. ▪ Availability of medical supplies.

OPERATIONS SECTION CHIEF	
☐	Evaluate clinical staffing needs and activate additional staff, as needed. Work with Planning Section Team for activation of additional staff.
☐	Direct nursing, rehabilitation and Social Services staff to: ▪ Tend to physical and emotional needs of residents. ▪ Assist in clearing rooms and hallways, exits, etc. ▪ Support movement of residents during an evacuation.
☐	For receiving facility operations, ensure proper management of arriving residents and their records, including documentation of triage, treatment, and disposition of emergency admits.
☐	Document resident injuries (and action plan to ensure treatment) or deaths.
☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

PLANNING SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Document Incident Management Team position assignments and contact information for all positions. Utilize NHICS forms 258 Facility Resource Directory, 207 Organization Chart and 203 Organization Assignments for the above information.
☐	Assist Incident Commander with planning response actions for next operational period (e.g., shift).
☐	Ensure backup and protection of existing data including paper-based and digital systems.
☐	Maintain all historical information and records related to the incident.
☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

LOGISTICS SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Distribute resource request forms to each Incident Management Team member. Document the request, use, return, and condition of resources used to respond. Utilize NHICS form 257 Resource Accounting Record for this task.
☐	Ensure the following resources are mobilized, assigned, and tracked: ▪ Staff and Surge Support ▪ Emergency Supplies ▪ Communications Equipment ▪ Food and Water ▪ Transportation
☐	Document volunteer sign-in and sign-out for each operational period (e.g., shift). This will be completed in concert with facility Staffing Coordinator and HR Manager.
☐	Request Incident Commander approval to activate emergency service related vendor agreements for additional resources.
☐	Communicate concerns to the Incident Commander, as needed.

FINANCE/ADMINISTRATION SECTION CHIEF	
☐	Obtain briefing from Incident Commander.
☐	Initiate protection of, or move/relocate facility records, as needed. Completed in concert with facility medical records and Business office representatives.
☐	Maintain incident cost tracking and analysis, including the documentation, retrieval, safeguarding and distribution of cash, credit card, and receipt/invoice processes. Business office manager will coordinate with TMG Financial Operations Representatives to manage this process.
☐	Document and track facility-wide personnel work hours worked relevant to the emergency. Facility Payroll and HR Managers will coordinate with TMG VP of Administration.
☐	Contact insurance company to notify them of the incident and identify and document requirements for submitting damage/claim reports. TMG Financial Operations Representatives.
☐	Consult with government officials regarding reimbursement regulations, requirements, and forms. TMG Financial Operations Representatives.

FINANCE/ADMINISTRATION SECTION CHIEF	
☐	Approve and submit a financial status report to the Incident Commander summarizing cost-to-date financial data relative to personnel, supplies, and miscellaneous expenses. Only as requested.
☐	Ensure that required financial and administrative documentation is properly prepared and maintained.
☐	Process invoices received.
☐	Submit resource requests to the Logistics Section Chief (if activated), as needed.
☐	Communicate concerns to the Incident Commander, as needed.

Demobilization Checklist

Tasks	
Activate repatriation process.	
☐	Refer to the *NYSDOH Evacuation Plan Template* for further guidance.
☐	Ensure compliance with all local and NYSDOH requirements regarding inspections, remediation actions, and conditions for approval of repatriation.
☐	Receive approval from NYSDOH to reopen the facility as well as any necessary local municipality approvals.
☐	Initiate repatriation plans and procedures.
Deactivate IMT positions and surge staffing.	
☐	Determine if there is an adequate number of facility personnel to meet remaining incident needs.
☐	Deactivate IMT positions that are no longer needed.
☐	Reduce surge staff (e.g., off-duty personnel, volunteers, contract support) and provide guidance on close-out procedures (e.g., where to submit documentation).
Return or restore emergency resources.	
☐	Estimate current and anticipated resource requirements.

Tasks	
☐	Determine which facility-owned resources need to be returned to storage locations in the facility; or replenished/repaired for future incidents.
☐	Determine processes for transitioning borrowed resources back to sending facility/provider.
☐	Reactivate normal services and operations.
☐	Determine when it is safe to resume normal operations after conferring with the local authority, NYSDOH Regional Office, fire department, law enforcement, public health, and/or any other response authority.

Stakeholder Engagement

This tool describes the relationships facilities should strive to build with local response partners during pre-incident planning. Building a better relationship with these agencies will streamline incident response and information sharing. Trying to construct these relationships will be considerably more difficult during the middle of an incident.

County Office of Emergency Management

Forming a partnership with the County Office of Emergency Management is one of the more important relationships a facility can build within the community. Emergency management agencies are often the source of the most current and up to date information regarding incidents and hazards.

Establishing a line of communication with the local office of emergency management will help streamline critical information sharing and coordination with facilities. In addition, emergency management agencies can provide opportunities to better prepare for incidents through informational materials, trainings and exercises.

The following table outlines suggested action items for developing and maturing relationships with emergency management agencies.

Office of Emergency Management	
☐	Establish point of contact at the County Office of Emergency Management. (Note: A list of county-specific agencies is available at http://www.dhses.ny.gov/oem/contact/map.cfm)
☐	Clarify protocol and mechanisms for accessing information from the County Office of Emergency Management, including: ▪ Resource availability throughout the region ▪ Pre-determined location list

Office of Emergency Management	
	▪ Current available services and utilities ▪ Hazard forecasts ▪ Mass notification systems
☐	Understand jurisdiction's response processes and capabilities, including available resources and response priorities in a large disaster.
☐	Identify available opportunities for training and exercises with the County Office of Emergency Management.
☐	Identify critical information that the facility should relay to the County Office of Emergency Management before and during a disaster (e.g., facility status, number of residents needing transport, or infrastructure status).
☐	Seek County Office of Emergency Management input on CEMP development.

Fire Department and Law Enforcement

Enhancing relationships with first responder agencies are also critical to expediting the response process. These agencies will often be the first of the group to support facilities and relay critical incident information.

The following table outlines suggested action items for maturing relationships with fire department and law enforcement agencies.

Fire Department and Law Enforcement	
☐	Establish point of contact at fire department, emergency medical services, and law enforcement agency.
☐	Identify what critical information should be relayed to fire department, emergency medical services, and law enforcement agencies before, during, and after a disaster.
☐	Identify opportunities for training and exercises with fire department and law enforcement agencies.
☐	Solicit fire department and law enforcement agency input on recommendations to expedite response and recovery actions, including pre-staging equipment/resources, best ingress and egress from facility, and debris removal to restore emergency access.

Corporate Organization

If the facility is part of a larger multi-facility system, the facility should coordinate with its parent organization to ensure pre- and post-incident activities adhere to corporate policies, and to ensure the facility is appropriately empowered to execute incident management functions (e.g., permissions for external messaging, clarification of branding standards).

Community Stakeholders

Facilities are encouraged to build relationships with additional community stakeholders to assist with the disaster response and recovery. Some examples of the assistance that can be provided include volunteer support, surge staffing, and resources.

Community stakeholders may be different for every facility, but may include resource providers and vendors (e.g., transportation providers, fuel); local subject matter experts (e.g., engineering, finance and recovery, sustainability and mitigation); and volunteer resources.

The table below outlines potential volunteer resources that may be utilized to augment or supplement facility staff and operations prior to, during, or after an emergency.

Entity	Description and Skills
ServNY	Administered by the NYSDOH Office of Health Emergency Preparedness, ServNY is an online registration system for licensed healthcare professionals to volunteer when local and regional resources are exhausted. Volunteers are notified of staffing requests via phone or email. ServNY may also be activated by: ▪ County Office of Emergency Management submits a request to the New York State Office of Emergency Management, which sends the request to Emergency Support Function-8 State Health Desk, and then to the NYSDOH Emergency Preparedness; or ▪ Direct order of the NYSDOH Commissioner or designee.
Community Emergency Response Team (CERT)	Community volunteers that are trained in disaster preparedness and basic disaster response skills. These skills include: ▪ Fire Suppression ▪ Simple Triage and Rapid Treatment – Airway obstruction – Bleeding – Shock – Basic first aid – Establishing a medical treatment area ▪ Light Search and Rescue ▪ Team Organization

Entity	Description and Skills
Medical Reserve Corps (MRC)	MRC volunteers are imbedded in ServNY. Volunteers include practicing and retired medical and public health professionals. MRC volunteers can support response capabilities such as: ▪ Disaster medical support ▪ Health screenings ▪ Vaccination clinics ▪ Medical facility surge capacity ▪ Planning, logistical, and administrative support

Communications Plan

A communications plan helps facilities maintain situational awareness throughout the duration of an incident and enables facilities to share information effectively across the organization, as well as with any external partners who may be supporting the response.

Objectives

- Ensure communication policies, roles, and activities are clearly defined and well-understood by staff.
- Ensure internal and external communications are accurate, timely, and informative.
- Provide frequent updates to residents, staff, relatives/responsible parties to mitigate concerns and manage expectations.
- Only share known/confirmed information (i.e., do not speculate).
- Utilize one unified voice to avoid confusion or misinformation.

Implementation

Communications Checklist	
Preparedness	
☐	Designate and train personnel to serve as Public Information Officer prior to an incident (i.e., during normal operations). Potential training courses include: ▪ FEMA IS-29: Public Information Officer Awareness (Free Online Course) ▪ FEMA IS-42: Social Media in Emergency Management (Free Online Course)
☐	Develop and refine pre-scripted messaging that can be tailored for incident use.
☐	Determine primary and redundant forms of communication:

Communications Checklist	
	▪ Primary forms include landline-dependent communications such as telephones and cellphones. ▪ Redundant forms are not dependent on functioning landline communication (e.g., include two-way radios, satellite radios).
☐	Ensure multiple personnel have administrative access, training, and policies and procedures to the facility's website, social media accounts, and voicemail system.
☐	Maintain up-to-date contact information for designated notification parties for all residents (e.g., relatives/responsible parties).
☐	Maintain up-to-date contact information for all staff.
☐	Clarify approval processes for internal and external messaging content (e.g., peer review, senior leader final approval).
Incident Response	
☐	Request an updated on the incident from the Incident Management Team: ▪ What happened? ▪ What is the status of residents and personnel? ▪ When will the incident be resolved?
☐	Inform internal audiences (e.g., personnel) about incident updates before informing external audiences.
☐	Provide office personnel (e.g., receptionist) with guidance on where to direct incoming inquiries (e.g., media, personnel, relatives/responsible parties, vendors).
☐	Maintain a log of incoming calls, including: ▪ Name of caller ▪ Name of publication or media source ▪ Phone number ▪ Email address ▪ General nature of inquiry and any deadlines
☐	Develop a press release (or official facility statement) to post on facility website and social media pages.
☐	Update the facility's voicemail recording to provide alternative contact information if the facility is evacuated and/or to field incoming inquiries.

Pre-scripted Messages

Depending on the situation, numerous forms of alerts and warnings may be required to reach staff, residents, relatives and responsible parties, and the media.

It is vital to have several staff members who are solely responsible for fielding calls from residents' relatives and responsible parties and who are familiar with pre-scripted messaging usage. Only authorized spokespersons (e.g., Public Information Officer) should manage media and public inquiries.

Internal Pre-Scripted Messaging

To facilitate timely and effective communications, the use of pre-scripted messaging templates can aid facilities to tailor for incident-specific messaging. During an incident, the facility will manage or coordinate the development and dissemination of these messages.

Immediate Messaging

Please note that for incidents that pose an immediate threat to health or safety (e.g., active threat or fire), messaging should be short and direct (i.e., "Intruder Alert Main Entrance," or in the case of fire, "Dr. Red" followed by the location").

CEMP Activation

The following process will be used for on-duty staff members who will be needed to fill Incident Management Team positions:

> On duty staff will be contacted directly and/or via overhead page. They will be told where to report and then will receive further information upon arrival.

The following process will be used for off-duty staff members who will be needed to support incident operations:

> Off duty staff will be contacted directly and provided with all necessary situational information. Staff will be given all role assignments, obligations and their individual reporting structure along with appropriate team member contact information.

Informing the Residents

Resident care personnel are responsible for informing their residents of the incident. It is important to accommodate for the unique needs of each resident and provide messaging appropriate to each resident's level of understanding.

> Social Services staff will coordinate the process of informing facility residents of the emergent situation. Based on need and specific circumstances, other facility personnel may need to be involved in resident updates. Social Services staff will inform the Incident Commander of the needs and the IC will assign additional staff accordingly.

Informing Staff about Evacuation to Receiving Facility

On duty staff will be informed of all evacuation related information and protocols through the standard Incident Command System reporting structure. Incident Management Team members will notify and update their direct reports, and those individuals will update their direct reports. This process will continue until all appropriate staff has been updated.

Informing Residents about Evacuation to Receiving Facility

The Incident Commander will assign appropriate facility staff to work in concert with Social Services in order to properly notify each resident of the impending evacuation and relocation. Social Services Staff will coordinate with assigned support staff to ensure that any residents with communication issues or other special needs are properly updated.

External Pre-scripted Messages

Robo-Call/Website Posting/Social Media Message

Example Message

[Facility Name] is currently experiencing [Description of Conditions] caused by [Incident Name]. Emergency operations have been initiated to manage the incident. [Provide high level information on residents' status]. We are taking extensive actions to protect residents. [For your safety and that of others, please do not attempt to come to the facility]. [In the event of evacuation, add] *For resident safety and well-being, residents are being evacuated to [Location].*

For more information, please contact [Name, Title] at [Phone/Email].

Proactive Communication to Relatives and Responsible Parties

When communicating with relatives and responsible parties it is important to provide high level information on the status of residents. If it is known that certain residents have been injured, or there are fatalities, stress the seriousness of the incident but do not release resident information until the status of injured residents and fatalities can be confirmed and the incident is contained.

Proactive communications with families and responsible parties will be conducted via Robo-Call utilizing the pre scripted message above or an alternate message if needed. Families and responsible parties will be contacted individually with more specific information once the situation permits such actions. At that time, appropriate staff members will be assigned to contact specific resident responsible parties in order to communicate high level facility information as well as resident specific information. Staff will also provide responsible parties with the name and contact information for their assigned facility liaison. On a go forward basis, all facility/responsible party communications will be conducted via the assigned facility liaison.

Communications with the Public

The facility should notify media outlets of the incident as deemed necessary by the Incident Commander. Only the Public Information Officer and authorized facility spokespersons should communicate with the public.

Key principles of communicating with the media and public are:

- Be knowledgeable. Know the facts before reporting out.
- Be strategic in what information is shared.
- Be credible. Do not try to distort facts to protect the facility. The facility will be held responsible for any misinformation that is provided by the Public Information Officer.
- Be accessible to inquiries; be transparent.
- Avoid statements such as “no comment” or other language that may appear deceptive. This will invite the public to draw their own misinformed conclusions.
- Be proactive. Control messaging that is released and do not let the media and public distort messaging. Correct any rumors that arise.
- Be flexible. Ensure the audience understands that the situation is unfolding, and information will be shared as it is made available.
- Be calm and collected.
- Be sure to provide contact information where the media and public can direct inquiries.

Protective Action Decision Support

Facilities should use sound decision-making criteria when considering which protective action to implement (e.g., evacuate, defend-in-place). The following questions can be used to arrive at a decision.

Protective Action Considerations	
Information and Intelligence	
☐	Have local authorities issued protective action guidance?
☐	Have adjacent counties/municipalities protective action guidance?
☐	What is the status of traffic near the facility?
☐	What is the acuity of the current resident population?
☐	What is the status of receiving facilities?
☐	What is the capacity of receiving facilities to receive residents?

Protective Action Considerations	
☐	Have send-receive arrangements been put in place and verified?
Anticipated Impacts	
☐	What are the anticipated impacts on the facility?
☐	What is the forecasted external temperature for the next seven days?
☐	What facility infrastructure might be affected?
☐	Are there any anticipated life safety issues?
Resource Levels	
☐	What are staffing levels?
☐	Have surge-staffing options been implemented?
☐	What is the status of medical, pharmaceutical, and resident care supplies?
☐	What is the status of food and water?
☐	What is the status of generators and fuel levels?
☐	What is the status of transportation resources?
☐	Have any vendors/service provider agreements been activated?

After Action Review Process

Following every exercise or real-world incident, it is vital to capture best practices, lessons learned, and areas for improvement in an After-Action Report (AAR). Plans, policies, and procedures should be updated to incorporate and address the outcomes outlined in each report.

After-Action Review Process	
☐	**Designate a staff member**(s) to conduct the After-Action Review process and solicit information for the AAR through: ▪ Post-incident/exercise discussions and evaluations. ▪ Surveys and feedback forms from the Incident Management Team, staff, residents, responsible parties, and emergency supply vendors, and local emergency management providers.

After-Action Review Process	
☐	**Describe the event**, be it a real-world incident or an exercise. Include as much detail as possible. Questions to consider: ▪ When and where did the event occur? How long did the response last? ▪ What was the nature and magnitude of the event? (For exercises, what is the summary of exercise activities?) ▪ How did the incident impact residents, services, and the facility/facilities?
☐	Select the **focus areas** for the AAR based on areas needing improvement.
☐	Under each focus area, describe **areas for improvement**. Questions to consider: ▪ What gaps, barriers, or challenges emerged? ▪ What resources were needed that were not available? ▪ What disruptions to services occurred? ▪ How well did personnel understand their roles and responsibilities?
☐	Identify next steps for **improving future responses**. If possible, develop an improvement plan outlining priority levels, responsible parties, and estimated timelines for implementation. Provide additional training to cover areas of weakness.

After Action Report Template

Event	Event Date
[Incident/Exercise Name]	[Date]
Event Description	
[Brief description of incident/exercise]	
Strengths	
▪ [Placeholder] ▪ [Placeholder] ▪ [Placeholder]	
Areas for Improvement	
▪ [Placeholder] ▪ [Placeholder] ▪ [Placeholder]	

Improvement Plan

Issue/Area for Improvement	Corrective Action	Responsible Party	Start Date	Completion Date

Resource Management

Resource Considerations

Before a disaster occurs, it is important to have send-receive agreements in place; have lists of vendors and service providers; and have all necessary information about site generator systems on hand. This information is vital to the internal facility response, can help first responders, and can set accountability. When determining which resources may be necessary for facility preparedness, consult the considerations below:

Generators

- What reporting processes are in place in the event that a generator fails inspection, is not properly maintained, or fails a test?
  - Facility has current protocols in place to engage Gen Tech in the event of emergency generator failure. Gen Tech is capable of providing the facility with an appropriately sized mobile generator set. The time to produce the generator will depend on its current location, but the time will not exceed 2 hours. Empire will provide electricians to connect the mobile generator to the facility emergency panel at the time of delivery.
- What positions are routinely trained on the process of establishing emergency power to the building?
  - The emergency generator and transfer switches are designed and set to automatically (7 seconds or less) establish emergency power in the event of a loss of adequate electrical power to the facility. The transfer switches can also be operated manually by a properly trained individual if necessary.
  - Who is responsible for performing this task?
    - The Plant Operations Dir trains all Maintenance personnel on the proper procedures for establishing emergency power.
- What procedures are in place to troubleshoot generator system failures?
  - In light of safety concerns, only a factory trained technician or licensed electrician are authorized to adequately troubleshoot and/or repair the emergency generator.
- How long can emergency power be sustained before having to replenish fuel if tank is full?
  - The facility generator operates on Diesel Fuel, and therefore, it can sustain emergency power indefinitely as long as the fuel service remains operational.
- What systems, capabilities, and/or resources will be impacted if power is lost and emergency power is unable to be secured (e.g., food, water, ventilation)?
  - All heating, cooling, mechanical ventilation, refrigeration, hot water systems, laundry systems, some cooking equipment, EMR, oxygen manifold and mobile

concentrators, fire alarm system once backup battery expires, lighting, emergency lighting and exit signs once backup batteries expire, most computer systems, internet/wifi and the main switchboard. Facilities with sewage lift stations, sewage grinders, macerating pumps, sump pumps, ejector pumps and fire pumps (electrical and pneumatic types) will lose service.

- Equipment/services that will remain operational without electrical service are some cooking equipment, cell phone communications, two way radios, portable oxygen tanks, battery work lamps and lanterns, cold water services, all plumbing system components other than pumps, sewer systems, natural draft ventilation, fire protection sprinkler system and hood mounted fire suppression system. **(Multistory facilities that rely on fire pumps to feed the sprinkler system on upper floors will lose this service.)*

Fuel

- Is the emergency fuel source municipal fuel or local/on-site fuel?
  - Generator: Botini Fuel, on-site storage tank
- What is the current onsite fuel storage capacity?
  - Generator tank holds 1600 gallon of fuel.

Potable Water

- Where is potable water stored on site?
  - Emergency water supply stored in lower level supply rooms. Additionally, facility has an emergency water hookup located along the fire road on the North side of the build near the maintenance office. This hookup supplies the entire facility water system once a truck is connected. The facility is contracted with Troncillito Water for this service.
- What potential barriers are there to reaching the potable water during an emergency?
  - No barriers noted
- Will potable water storage be safe from contamination by flood waters or severe storms?
  - Yes
- Who manages the potable water storage? - Dietary and Plant Operations

Transportation

- Which types of vehicles are immediately available to the facility? **None are currently available**.
  - NA.
- Are facility-owned vehicles maintained?
  - NA
- Where can facility-owned vehicles access fuel?
  - NA
  - NA
- How many and which staff can operate facility-owned vehicles?
  - NA
  - Where are copies of operator licenses kept?
    - NA

Medication/Pharmacy Services during Emergency Conditions:

Medication/treatments will be supplied by ProCare.
The agreement between the facility and ProCare is on file with the Administrator.

PROCEDURE

1. Medications/treatments will be obtained from ProCare in accordance with the policies and procedures outlined in this manual.

2. Should any problems arise with the Pharmaceutical Services provided, the contact person will be the Supervising Pharmacist at ProCare.

3. Medication/treatments may be obtained from an alternate pharmacy provided that the pharmacy can provide medication/treatments in accordance with all facility policies and procedures and State and Federal codes, rules and regulations.

Medication Procurement
EMERGENCY SITUATIONS

In an emergency situation defined by the Commissioner's Ruling Public Health Law Section 3321: Any health care facility which is licensed by the Department as a class 3 institutional dispenser or any retail pharmacy which is licensed by the State, and which health care facility or retail pharmacy is also duly registered with the United States Drug Enforcement Administration (DEA), is exempt from the licensing requirements for the sale of a controlled substance stock by a pharmacy to a pharmacy provided such sale is solely to meet the immediate needs of the pharmacy receiving the controlled substance.

An immediate need exists when the facility or retail pharmacy is not capable of preparing a controlled substance medication or does not have a controlled substance in stock and immediate administration or dispensing of the drug is necessary for proper treatment.

This ruling shall only apply to transfers or sales of stocks of controlled substances. Transfers or sales of other prescription medications are governed by the State Education Law.

A pharmacy, under the direct supervision of the pharmacist, may sell or transfer schedule III, IV or V controlled substances to another authorized pharmacy pursuant to a written request submitted by the purchasing pharmacy or facility on business stationery. All such requests shall indicate the name and address of the requesting pharmacy, the name and address of the pharmacy furnishing the controlled substance, the DEA registration number of both pharmacies, date of the request, and the name, strength, dosage form and quantity of the controlled substance being requested.

Schedule II controlled substances shall be ordered only on an official DEA 222 order form or any successor form and/or methodology authorized by the U.S. DEA. All controlled substance requests must be signed and dated by both the furnishing and the requesting pharmacist.

The pharmacy (vendor) furnishing the requesting pharmacy (vendee) shall provide the vendee pharmacy with an itemized list of the drugs sold or transferred and shall include the name and address of the vendor pharmacy, the name and address of the vendee pharmacy, DEA numbers of both pharmacies, date of the sale or transfer and name, strength, dosage form and quantity of controlled substances being sold or transferred. Upon receipt of the controlled substance, the vendee pharmacist shall sign and date the itemized list of drugs sold or transferred.

The vendor pharmacy and the vendee pharmacy shall maintain all required records of such transfers and request in a separate file or in such a manner as will make them readily available for inspection by authorized representatives of the Bureau of Narcotic Enforcement, New York State Health Department and/or the United States Drug Enforcement Administration or other law enforcement officials authorized by law to inspect such records.

PROCEDURE

1. In the event that a controlled substance ordered for the resident is not available or not normally stocked in the facility pharmacy and cannot be changed to an equivalent controlled substance on hand in the pharmacy, the supervising pharmacist/designee obtains the ordered controlled substance from Omni Care or back up retail pharmacy.
2. The supervising pharmacist/designee calls Omni Care first to ensure that they have the ordered controlled substance on hand. If the ordered controlled substance is not available at Omni Care, the back up pharmacy is called.
3. For all Schedule III, IV and V controlled substances, the supervising pharmacist/designee completes an Emergency controlled substance Request Form (4F.16.A-E) which includes: the facility pharmacy name and address, the name and address of the pharmacy furnishing the controlled substance, DEA Registration number of both pharmacies, date of the request and the name, strength, dosage form and quantity of the controlled substance being requested.
4. For all Schedule II controlled substances, the supervising pharmacist/designee completes a DEA 222 order form. The form must be signed and dated by both the furnishing and receiving pharmacies.
5. Upon courier delivery of the requested controlled substance, the supervising pharmacist/designee verifies the contents against the manifest/invoice. The manifest/invoice includes: an itemized list of the controlled substance(s), name and address of the vendor pharmacy, name and address of the facility pharmacy, DEA numbers of both pharmacies, date of the sale or transfer, name, strength, dosage form and quantity of the controlled substance(s).
6. After reconciliation of the controlled substance(s), the supervising pharmacist/designee signs and dates the invoice/manifest and keeps a copy.
7. A copy of the manifest/invoice is maintained in the facility pharmacy in a separate binder.

Emergency Medication Box

POLICY

An emergency medication box will be available at each nursing unit. The box will contain medications that may be necessary for resident therapy during an emergency.

PROCEDURE

1. The contents of each Emergency Box are recommended by the Facility Quality Assurance Committee and approved by the Medical Director, Director of Nursing and Consultant Pharmacist.

2. The Emergency Box will not contain any controlled substances.

3. The Emergency Box is maintained in the medication room of each nursing unit and kept locked at all times.

4. The Special Unit ER Box and the IV Solution Supply is kept on the sub-acute/designated unit.

5. The contents of the Emergency Box are identical on all nursing units, with the exception of the kit stored on the first aid unit of the facility, in which additional injectable medications are stored.

6. A list of Emergency Box and Special Unit ER Box contents is attached to the top of each box. An expiration date for the entire box is marked on the lock of the box. This indicates the date that the first item contained in the box expires.

7. In the event the Emergency Box/Special unit ER Box/IV solution supply is used:

    a. The Emergency Boxes are only used for emergency situation and is signed out accordingly by the nurse.
    b. The pharmacy is contacted and informed what was used, on which, and that replenishment is needed.

Emergency Medication Service

Medication/treatments will be supplied by ProCare. ProCare has 24 hour services available via on call at the local pharmacy and/or its sister sites.

The agreement between the facility and ProCare is on file with the Administrator.

The facility is equipped with emergency medication kits (E-Kits) in dedicated locations available 24/7. Such E-Kits provide critical medications. Please refer to E-Kit policy.

PROCEDURE

1. The facility can reach a pharmacist any time of the day.

2. Medications/treatments will be obtained from ProCare in accordance with the policies and procedures outlined in this manual. Each medication unless otherwise specified is filled for a 30 day cycle.

3. For medication orders, the facility can call the pharmacy directly during normal business hours (8 AM to 9:30 PM) at 315-800-6400. Should any problems arise with the Pharmaceutical Services provided, the contact person will be the Supervising Pharmacist at ProCare.

4. After hours "Emergency Service" will be described as the need for a medication that is not contained in the Emergency Box and must be administered for any emergency or STAT new orders:

    a. after hours a pharmacist can be reached at 954-982-7100
    b. pharmacist will call back within 1 hour

5. Medication/treatments may be obtained from an alternate pharmacy provided that the pharmacy can provide medication/treatments in accordance with all facility policies and procedures and State and Federal codes, rules and regulations.

Glossary

Term	Definition
Activation	To begin the process of mobilizing a response team, or to set in motion an emergency operations (response) or recovery plan, process, or procedure in response to incident or exercise.
Automatic Sprinkler	Ceiling sprinklers are located throughout the facility and are activated by heat, thereby setting off the water flow and the alarm.
Defend-in-Place	The ability of a facility to safely retain their residents in an incident-related situation (e.g., flood, severe weather, wildfire). This is also known as “hunkering down” during an event.
Demobilization	The orderly, safe, and efficient return of an incident resource to its original location and status.
Evacuation	Organized, phased, and supervised dispersal or removal of people from dangerous or potentially dangerous areas, and their reception and care in safe areas.
Evacuation Holding Area	Temporary refuge for residents and staff during a facility evacuation, and if needed, point of embarkation for transport for longer-term evacuations.
Evacuee	A person removed or moving from areas threatened or struck by a disaster.
Fire Alarm	Loud ringing of bells, which may be activated by detectors, sprinklers, or manually, to alert residents and staff. When the bells sound, one of the systems has been activated and an emergency is occurring.
Fire Doors	These doors cut off a wing or a portion of a wing from adjoining areas to prevent drafts, which carry smoke, and retards the spread of fire.
Hazard	Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.

Term	Definition
Hazard Vulnerability Analysis	A systematic approach to identifying all hazards that may affect an organization and/or its community, assessing the risk (probability of hazard occurrence and the consequence for the organization) associated with each hazard and analyzing the findings to create a prioritized comparison of hazard vulnerabilities. The consequence, or "vulnerability," is related to both the impact on organizational function and the likely service demands created by the hazard impact.
Incident Action Plan	An oral or written plan, containing objectives that reflect the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods.
Incident Command System	A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.
Incident Management	The broad spectrum of activities and organizations providing effective and efficient operations, coordination, and support applied at all levels of government, utilizing both governmental and nongovernmental resources to plan for, respond to, and recover from an incident, regardless of cause, size, or complexity.
Incident Management Team	The Incident Management Team is comprised of pre-designated personnel who are assigned to plan and execute response and recovery operations. Incident Management Team activation is designed to be flexible and scalable depending on the type, scope, and complexity of the incident. As a result, the Incident Commander may decide to activate the entire team or select positions, based on the extent of the emergency.
Lockdown	A security measure taken during an emergency to prevent people from leaving a facility, and to prevent an active threat (one or more persons) from entering a facility.

Term	Definition
Mitigation	Activities providing a critical foundation in the effort to reduce the loss of life and property from natural and/or manmade disasters by avoiding or lessening the impact of a disaster and providing value to the public by creating safer communities. Mitigation seeks to fix the cycle of disaster damage, reconstruction, and repeated damage. These activities or actions, in most cases, will have a long-term sustained effect.
Operational Period	The time scheduled for executing a given set of operation actions, as specified in the Incident Action Plan. Operational periods can be of various lengths, although usually they last 12-24 hours.
Preparedness	A continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action in an effort to ensure effective coordination during incident response. Preparedness focuses on the following elements: planning; procedures and protocols; training and exercises; personnel qualification and certification; and equipment certification.
Receiving Facility	A facility that has entered into agreement with another facility (nursing home, adult care facility, hospital, etc.), offering to host residents and staff for some part of an emergency response.
Response	Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes.
Recovery	The development, coordination, and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private-sector, non-governmental, and public assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post incident reporting; and development of initiatives to mitigate the effects of future incidents.
Secure Area	An area that has been checked and verified to be clear of fire/danger, with windows and doors closed, equipment shut down, and hallways free of obstacles.

Term	Definition
Shelter-in-Place	NYSDOH defines shelter-in-place as the protective action strategy of keeping a small number of residents in their present location when the risks of relocation or evacuation exceed the risks of remaining in current location. Can only be done for coastal storms. Requires pre-approval from NYSDOH prior to each hurricane season and pre-authorization at the time of the incident. Please refer to the 2019 Evacuation Plan.
Situational Awareness	Is the ability to identify, process, and comprehend the essential information about an incident to inform the decision-making process in a continuous and timely cycle and includes the ability to interpret and act upon this information.
Smoke Detector	Smoke detectors are located on ceilings throughout the facility and respond to smoke thereby setting off the alarm.
Threat	Natural or manmade occurrence, individual, entity, or action that has or indicates the potential to harm life, information, operations, the environment, and/or property.

For all Hazard Annexes on the following pages the NYSDOH Regional Office is to be notified during normal business hours. **For events that occur on nights, weekends or holidays, notify the NYSDOH Duty Officer at 914 654 7067**.