Long Term Care
Preparedness Toolkit
BASE PLAN

March 2019

Alabama Nursing Home Association

www.anha.org

Contents

Introduction

The Alabama Long Term Care (LTC) Preparedness Toolkit was developed to assist with emergency preparedness planning for this specialized health care population. LTC facilities, as they are referred to in the toolkit, include nursing homes, skilled nursing facilities, and assisted living facilities. This toolkit was originally created by the Minnesota Dept. of Health, Care Providers of Minnesota, Aging Services of Minnesota, and regional representation from the Health Care Preparedness Program who developed this tool to assist LTC facilities in emergency preparedness. The toolkit was revised with permission by members of the Alabama Nursing Home Association to assist Alabama facilities in preparing for disasters.

See Appendix A for CMS Emergency Preparedness Checklist for Effective Healthcare Facility Planning

This toolkit can be used by LTC facility owners, administrators, and staff. Information includes sample templates, forms, and suggested resources to develop and/or enhance facility emergency preparedness plans within LTC throughout Alabama. It should not be viewed as a static document but one that provides a foundation for an All Hazards approach to planning, preparedness, and response activities. It is recommended that not one person at any facility be charged in preparing this plan. Rather, it is suggested that an internal committee be formed from various disciplines within the facility to work on this plan. This toolkit serves as a base template that can be customized to the needs of each facility. The tools in this document are important items you will need to address prior to an event occurring.

Preface

This Toolkit was developed as a service to Alabama Nursing Home Association members. While this document reflects a compilation of management skills and plans for emergency and disaster related incidents and was developed by individuals experienced in disaster and emergency preparedness, it is not intended to be the only approved standard of practice or to dictate an exclusive course of conduct. Other plans of management for emergency and disaster related incidents may be appropriate, taking into account the needs of the facility, patient acuity, available resources, and locational limitations.

Overview of All Hazards Approach to Planning

Recent catastrophic events such as Hurricane Harvey and Hurricane Irma as well as other events have shown that better planning is needed for all types of health care facilities. Because different types of events present different challenges to health care entities, an all hazards approach to planning is proven to be most efficient and most beneficial. An all hazards response plan must be based on the hazards that are most likely to affect a facility and it is important in directing how a response may unfold and what the correct response actions would be. In order to identify the most likely hazards, a hazard vulnerability analysis must be completed (see section 3 for more information on the Hazard Vulnerability Analysis information).

All Hazards

Hazards may be thought of as extreme events. Hazard vulnerability analysis is often based on an "all hazards approach." This means that one begins with a list of all possible disasters, regardless of their likelihood, geographic impact, or potential outcome. The list may be the result of a committee brainstorming session, research, or other methodology, and should be as comprehensive as possible.

It may be helpful to divide the potential hazards into categories to focus the thought process. Typical categories may include natural hazards, technological hazards, and man made events. These are certainly not requirements and should not be considered to be constraining. There is overlap between the categories as well. For example, a transportation accident may be considered a technological hazard rather than a man made event.

Once the complete hazards listing is developed, look at it critically for items that might be appropriately grouped together as one hazard category. Organize the list into categories.

Finally, a prioritization process should be undertaken to determine the course of emergency planning. The realistic factors of time and money play a role in decisions of preparedness, and facilities must choose to apply their limited resources where they will have the most impact. To work toward this end, each identified hazard will be evaluated for its probability of occurrence, risk to the organization, and the organization's current level of preparedness.

Probability

Disasters, by nature, are not predictable. Still, familiarity with the geographic area and research will identify those for which the facility must be most prepared. It is important to consider both expected occurrences as well as unlikely scenarios.

Regularly occurring natural disasters are typically well known within a community. The community will often be able to provide data that include hundred-year flood plains, weather information for the locale, etc. The weather bureau may also be able to provide input. In addition, community emergency planning agencies may have already done a community-based hazard vulnerability analysis. This may not provide a complete solution, but it will provide a start.

Nursing homes and long-term care facilities have become increasingly dependent on technology to provide their normal services. As a result, a failure of a given technological system can put a facility into an internal state of disaster. Beyond the walls of a facility itself, technology in the community can fail or lead to an incident creating victims in need of medical care or otherwise affecting the health care facility. External transportation failures can lead to unavailability of supplies, which can also be disastrous. In order to determine the probability of these events, examine the internal technology in the facility and the availability of backup systems to compensate for failure. Service records and system failure reports can be used to evaluate the likelihood that these incidents may occur. Types of industry in the community should also be considered in this assessment for a technological disaster with broad community impact.

Establishing the probability of occurrence of these events is only part objective and statistical—the remainder can best be considered intuitive or highly subjective. Each hazard should be evaluated in terms that will reflect its likelihood. The tool presented in this document, for example, uses the qualitative terms of *high, medium, low,* or *no probability of occurrence*. A factor may be used, but is not required, to quantitatively assess the probability.

Risk

Risk is the potential impact that any given hazard may have on the organization. Risk must be analyzed to include a variety of factors, which may include, but are not limited to the following:

Threat to human life
Threat to health and safety
Property damage
Systems failure
Economic loss
Loss of community trust/goodwill
Legal ramifications
Cybersecurity

The threat to human life and the lesser threat to health and safety are considered to be so significant that they are given separate consideration on the hazard vulnerability analysis document. Consider each possible disaster scenario to determine if either of these human impact threats is a factor.

The remaining three categories on the analysis tool classify risk factors as to their disruption to the organization in high, moderate, or low classification. From the bulleted list above, property damage, systems failure, economic loss, loss of community trust, and legal ramifications are all considered together to determine the level of risk.

Property damage in a disaster situation may be a factor more often than not, although the degree of damage may vary. Seismic activity may virtually destroy a building, or render it uninhabitable. In the most severe scenario of this type, the property damage will also include equipment and supplies within the facility. Other hazards may impact only a portion of the building, for example, flooding only in the basement. Perhaps severe weather resulted only in a few broken windows.

Systems failure may have been the cause of the emergency in the first place. A major utility failure may require backup equipment or service that is significantly less convenient, or may not be sustainable for a lengthy time. Even though an alternate system is available, the failure will typically cause a facility to implement emergency plans. Systems failure, however, is not necessarily an isolated occurrence. It can be the result of another hazard, such as flooding damage to an emergency generator.

In any disaster, economic loss is a possibility that deserves consideration. If a facility cannot provide services because of disaster, revenue will be affected. It may result from damage to the physical plant or equipment, inability to access the facility due to transportation or crowd control issues, or a negative public relations impact. Long term care entities are businesses like any other, and economic disruptions can be managed for only a limited time. Each hazard must be analyzed for its adverse financial impact.

An issue of loss of goodwill has the potential for legal ramifications in the aftermath of a disaster. If errors were made in the management of the emergency, if lives were lost or injuries occurred, the facility could face legal action. It is advisable to consult risk management and/or the facilities legal counsel if questions exist in this area.

According to the Department of Homeland Security, Cyberspace and its underlying infrastructure are vulnerable to a wide range of risk stemming from both physical and cyber threats and hazards. Sophisticated cyber actors and nation-states exploit vulnerabilities to steal information and money and are developing capabilities to disrupt, destroy, or threaten the delivery of essential services. For more information visit https://www.dhs.gov/topic/cybersecurity.

Preparedness

Finally, an evaluation of the organization's current level of preparedness to manage any given disaster should be undertaken. This process should involve the input of community agencies. The health care facility will not be responding to an emergency in a vacuum, and there may be community resources to support the facility.

Long term care facilities have done disaster planning for many years and are well prepared to manage many types of emergencies. However, the scope of current emergency planning has expanded and the typical organization will find at least some hazards from the all hazards list for which improvements are needed. The current status of emergency plans and the training status of staff members to respond to any given hazard is a factor to consider in evaluating preparedness.

The health care organization may carry insurance to compensate for losses suffered because of some emergencies. Backup systems may also be thought of as insurance protecting against certain occurrences. The availability of insurance coverage or backup systems should be factored into the determination of the current preparedness status.

The hazard vulnerability analysis tool in this document evaluates the organization's preparedness level as good, fair, or poor. An alternative way of approaching this issue is to evaluate each hazard based on the amount of improvement needed, for example, slight, moderate, or major. Both systems will yield similar results.

Planners within the organization should evaluate this section critically and realistically. Failure to do so may result in a false sense of security, which may result in an increased impact on some of the risk factors discussed above. Appropriate evaluation of preparedness will direct the organization's effort and resources earmarked for emergency management.

Plain Language

Utilization of plain language decreases staff confusion and ensures transparency for residents and visitors. The linked toolkit offers suggestions for how to utilize plain language in emergency overhead paging.

There are several organizations that have plain language tool kits. Some of them are:

Minnesota Hospital Association. (2011). Plain Language Emergency Overhead Paging. St. Paul, MN. https://www.mnhospitals.org/Portals/0/Documents/ptsafety/overhead-paging-toolkit-2011.pdf

South Carolina Hospital Association. (2016). Plain Language Emergency Codes Implementation Toolkit. https://www.scha.org/files/documents/plainlanguage_toolkit_16.pdf

Florida Hospital Association. (2014). Overhead Emergency Codes. https://www.jointcommission.org/assets/1/6/EM-2014_RECOMMENDATIONS_FOR_HOSPITAL_EMERGENCY_CODES_FINAL_(2).pdf

Hazard Vulnerability Analysis (HVA) Tool

The hazard vulnerability analysis (HVA) tool is simply that -- a tool. It is provided as a resource and a starting point for organizations to evaluate their vulnerability to hazards. It may be modified or changed in any way that is appropriate for individual facility use.

This document uses a quantitative method to evaluate vulnerability, which is also not required. The facility may find a qualitative method equally as effective.

Using this tool, each potential hazard is evaluated as described above and scored as appropriate in the areas of probability, risk, and preparedness. The factors are then multiplied to give an overall total score for each hazard. Note that a hazard with no probability of occurrence for a given organization is scored as zero and will automatically result in a zero for the total score.

Listing the hazards in descending order of the total scores will prioritize the hazards in need of the facility's attention and resources for emergency planning. It is recommended that each organization evaluate this final prioritization and determine a score below which no action is necessary. The focus will then be on the hazards of higher priority. Establishing a cutoff value, however, does introduce risk to the organization for those hazards falling below. The facility has determined that there is some probability and risk of the event occurring, and has chosen to exclude it from the planning process. It must be noted that the acceptance of all risk is at the discretion of the organization.

Hazard Vulnerability Analysis Instructions

Evaluate every potential event in each of the three categories of probability, risk, and preparedness. Add additional events as necessary.

Issues to consider for probability include, but are not limited to:

Known risk
Historical data
Manufacturer/vendor statistics

Issues to consider for risk include, but are not limited to:

- Threat to life and/or health
- Disruption of services
- Damage/failure possibilities
- Loss of community trust
- Financial impact
- Legal issues

Issues to consider for preparedness include, but are not limited to:

- Status of current plans
- Training status
- Insurance
- Availability of back-up systems
- Community resources

Multiply the ratings for each event in the area of probability, risk and preparedness. The total values, in descending order, will represent the events most in need of organization focus and resources for emergency planning. Determine a value below which no action is necessary. Acceptance of risk is at the discretion of the organization.

Facilities are to review and update their HVA annually. HVA will have changes, additions and may even have hazards removed.

Sample HVA Tool

Note: an electronic HVA can also be accessed through your regional health care coalition. Below is a screenshot of what the electronic HVA looks like. Kaiser Permanente has a HVA as well and can be accessed at https://asprtracie.hhs.gov/technical-resources/resource/250/kaiser-permanente-hazard-vulnerability-analysis-hva-tool.

EVENT	PROBABILITY	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*	*Interruption of services*	*Preplanning*	*Time, effectiveness, resources*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*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= Low 2 = Moderate 3 = High*	*0 = N/A 1= High 2 = Moderate 3 = Low or none*	*0 = N/A 1= High 2 = Moderate 3 = Low or none*	*0 = N/A 1= High 2 = Moderate 3 = Low or none*	*0 - 100%*
Tornado								0%
Severe Thunderstorm								0%
Snow Fall								0%
Blizzard								0%
Ice Storm								0%
Temperature Extremes								0%
Proximity to Airport								
Proximity to Train Tracks								
Proximity to MOA								
Proximity to Downtown								
Drought								0%
Flood, External								0%
Wild Fire								0%
Landslide								0%
Dam Inundation								0%
Volcano								0%
Epidemic								0%
AVERAGE SCORE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

See Appendix B for Hazard Vulnerability Analysis Tool

Emergency Operations Plan Tool

The following tools serve as specific components that will allow your organization to plan and prepare to meet the needs of both your residents and staff in the event of an incident.

Each tool will be preceded by a descriptor of the tool and instructions where necessary. These tools when taken as a whole are the basis of an Emergency Operations Plan (EOP).

Once the EOP has been developed, it is also the role of the team to be sure that this plan is shared with appropriate staff and that internal training is conducted. This training should be incorporated into regularly scheduled trainings as staff changes do occur and keeping current on any material requires periodic review.

For an EOP to maintain viability and usefulness, it needs to be updated on a scheduled basis. As each facility grows and changes, the EOP also needs to be modified to reflect those changes. Once these tools are completed, your EOP will be well on the way to serving each facility's need to care for staff and residents.

Incident Command System

In any emergency response, it is critical that clear lines of authority (chain of command) exist within the facility. This ensures that there is timely and efficient decision-making and communication. It is important to define a chain of command, designate a facility incident commander, and clarify their authority and decision-making ability. This is an important aspect of the disaster plan.

Disaster planning needs to start at the top of the organization. Bring the leaders of the organization into the planning process from the very beginning to identify and agree upon the best course of action for the health care facility, its residents and staff. Organization leaders should discuss the financial and clinical implications of the various proposed response strategies. This may include items such as closing to new admissions or agreeing to be a "surge" or overflow setting for the local hospital. Medical and administrative priorities need to match, and your facility's leadership team needs to be clear about its role and authority.

Incident Command Systems (ICS) can be used at organizations both large and small — it can even be used by just one person. If you have a small organization, the same person may fill multiple spots on the ICS organizational chart. Assure through practice and exercise that one designated person is not disproportionately overburdened with her or his roles in an emergency. It is recommended that, at a minimum, frontline staff obtain the basics of ICS by taking ICS 100, ICS 200, and ICS 700. These courses and more can be found at: Federal Emergency Management Agency Training Website at https://www.fema.gov/training-0.

Benefits of Utilizing Incident Command in Health Care

Common terminology and 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 verbiage that may not be clearly understood by all planning and response partners. Common terminology helps to define the 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.

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. This will be clearly demonstrated in subsequent sections that detail the incident management team along with their roles and responsibilities.

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.

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 California Association of Health Care Facilities Nursing Home Incident Command System. https://www.cahfdisasterprep.com/nhics. The State of Alabama Emergency Operations Plan can be found at https://alabamaema.files.wordpress.com/2017/11/alabama-eop-11-basic-plan-final.pdf.

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.

Pre-designated incident locations and 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 helicopter landing zones, staging areas, command posts, 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.

Resource management

Resources are assets that are used in the response. Examples include personnel, equipment, food, communications, supplies, vehicles, etc. When making requests for assistance from other health care facilities, local emergency management, regional health care coalitions and other state partners have a clear picture of current and needed resources. This level of

awareness allows those providing the support to provide the necessary assets through a clear understanding of current capability.

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

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.

Basic ICS Job Action Overview

The organization chart is the base to ICS and is utilized when a response to any incident is necessary. Specific personnel placed in the various roles are determinant on the skills and position with the organization.

Incident Commander: Leads the response, appoints section leaders, approves plans and key actions (CEO, administrator, Director of Nursing (DON), nursing supervisor.)

Operations Section: Handles key actions including first aid, search and rescue, fire suppression, securing the site (DON, Department supervisors, nursing supervisor, direct care staff.)

Planning Section: Gathers information, thinks ahead, makes and revises action plans and keeps all team members informed and communicating. (Safety committee, Continuity of operations planning team, etc.)

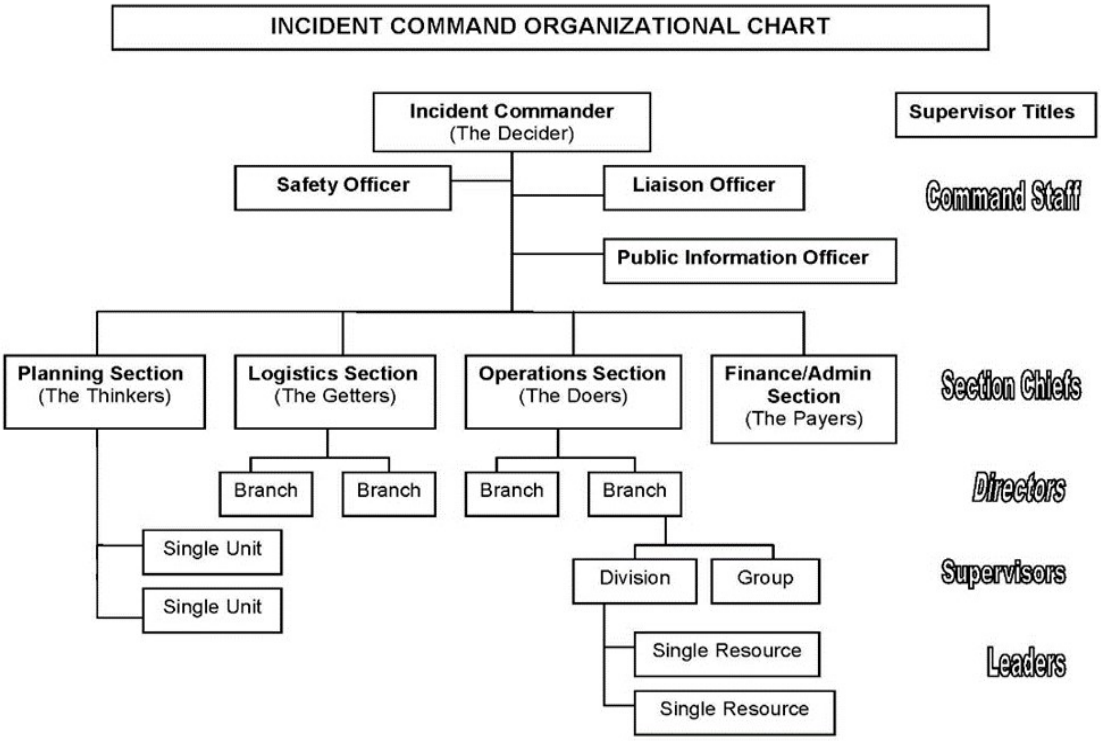
Logistics Section: Finds, distributes, and stores all necessary resources (maintenance supervisor, purchasing, human resources director)

Finance Section: Tracks all expenses, claims, activities, and personnel time and is the record keeper for the incident (controller, accounts department, payroll.)

Public Information Officer: Provides reliable information to staff, visitors and families, the news media and concerned others as approved by the Incident Commander. (Social Worker, Administration Personnel)

Safety Officer: Ensures safety of staff, residents, and visitors; monitors and corrects hazardous conditions. Has authority to halt any operation that poses immediate threat to life and health.

Liaison Officer: Serves as the primary point of contact for supporting agencies assisting the facility. (Social Worker, Administration Personnel)



Depending on the size of the facility, one person may occupy multiple positions within the section. You do not need to activate all positions – only activate what you need for the incident. This is your basic Incident Command. If part of a larger system i.e.: health organization, you will need to know where your ICS fits within that organization's structure.

See Appendix C for ICS Organization Chart and Job Action Sheets

An online version of the Heath Care Incident Command system (HICS) specifically designed with the Long Term Care facility in mind is located at Southern Maine Regional Resource Center at http://www.smrrc.org/hics.htm.

The following table is a list of persons that can be used to fill a role in the ICS Organization Chart:

Incident Command Position	**Facility Role**
Incident Commander	Administrator/CEO
Medical Director/Specialist	Medical Director/Nurse Consultant
Public Information Officer	Administrator/Media Relations
Liaison Officer	Community Specialist/Assistant Administrator
Safety Officer	Maintenance
Operations Section Chief	Director of Nursing/Nursing Supervisor
Resident Services Branch Director	Director of Staff Development
Nursing Unit Leader	Nursing Supervisor/Charge Nurse
Admit/Transfer and Discharge Unit Leader	Nursing Supervisor/Charge Nurse/Admissions
Infrastructure Branch Director	Housekeeping supervisor
Dietary Unit Leader	Dietary supervisor
Environmental Unit Leader	Housekeeping
Physical Plant/Security Leader	Maintenance
Planning Section Chief	Assistant administrator
Situation Unit Leader	Admissions
Documentation Unit Leader	Medical Records
Logistics Section Chief	Chief Finance Officer/Assistant Administrator
Services Branch Director	Accounts Manager
Communications Unit Leader	Maintenance
IT/IS Unit Leader	IT/IS staff
Supply Unit Leader	Purchasing
Staffing/Scheduling Unit Leader	Human Resources/Staffing
Transportation Unit Leader	Maintenance/Activity Staff/Rehab
Finance/Admin Section Chief	Chief Finance Officer/Accounting
Time Unit Leader	Payroll/Billing
Claims Unit Leader	Risk Manager/Quality Manager

Organization Information and Contact Information

For an EOP to be functional, it is dependent on current and accurate information. Key to any response is the ability to know who to notify and how to get in touch with these personnel. For this reason, having current and accurate organizational information along with current information regarding key staff is essential. An effective response cannot occur without personnel. The following information needs to be maintained and updated periodically so

timely communications and response can occur. The following information is broken out into three separate areas:

- **Organizational Information:** contains the contact information for facility ownership and leadership.
- **Emergency Contact Roster-Internal:** contains the contact information for supervisors/leaders within the organization.
- **External Contact Information-External:** contains emergency contacts, contractors, and outside support services

See Appendix D for Contact lists

Facility-Specific Information

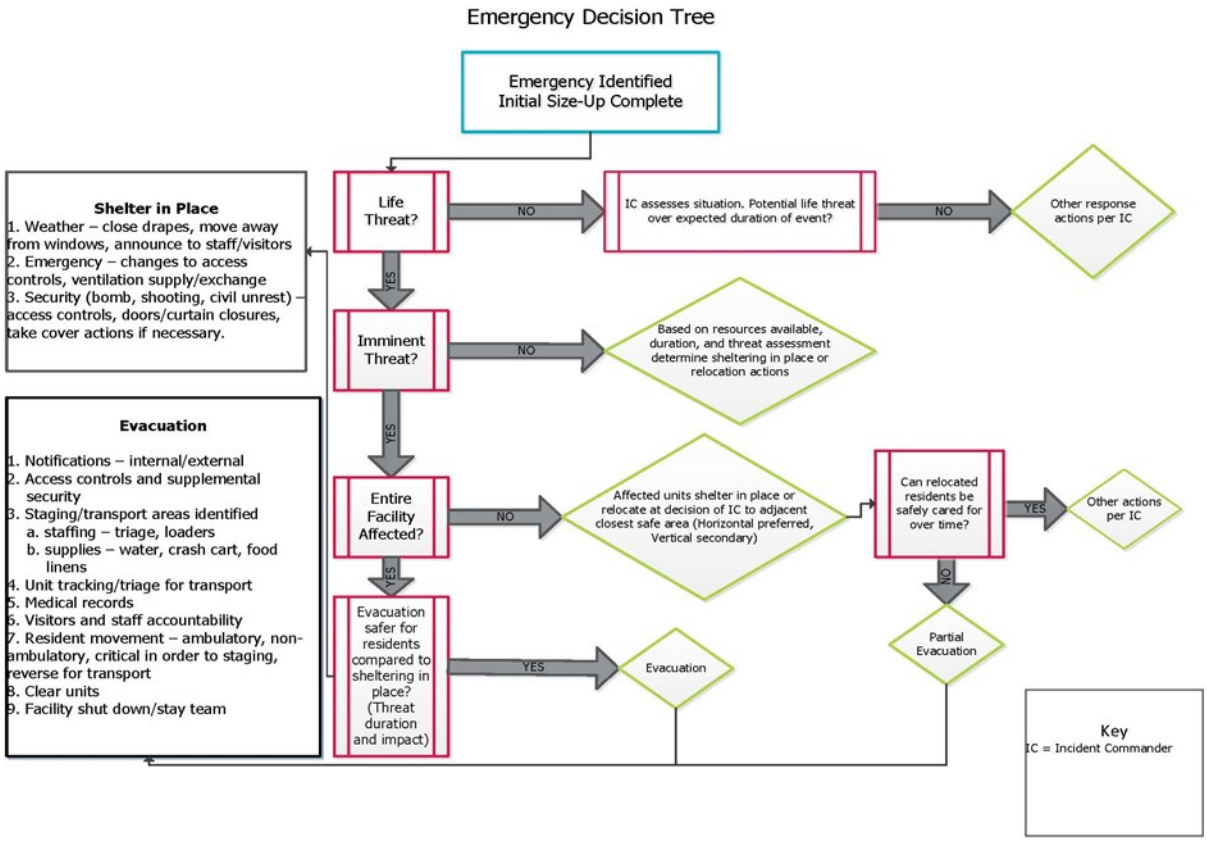
This information is made up of the location and characteristics of the facility and the people associated with it. As with any response, it is important to understand the physical features of a facility in order to maintain safety and efficiency. It is also important to understand the occupancy and certain specific information regarding the occupants. The facility-specific information provides descriptions of the facility and some baseline information regarding staff and residents. The information contained should be reviewed and updated annually.

See Appendix E for Facility Specific Information

Decision Making

During an unplanned event knowing what needs to be done to ensure the safety of the residents as well as the staff can be extremely stressful. The facility should have a clearly delineated decision making tree.

Sample Decision Making Tree

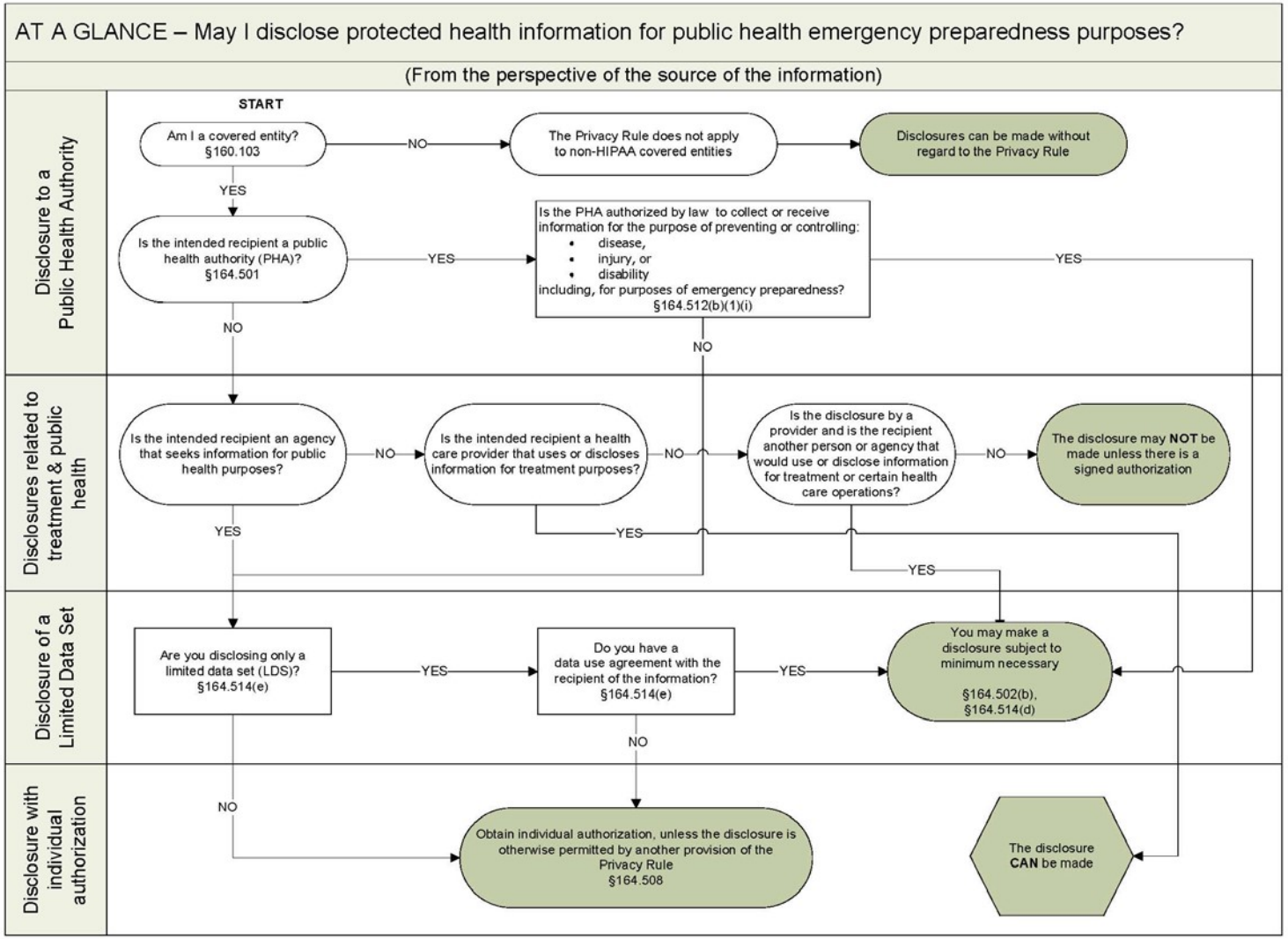


HIPAA in Emergent Situations

During emergent situations, the decision to share private patient/resident health care information is difficult. To ensure that there is continuity of care there may be situations where it is necessary to waive HIPAA.

See Appendix F for HIPAA Waiver toolkit.

Disclosure of private health information decision tree



Ethical Guidelines

The Institute of Medicine's Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations offers a useful framework which fundamentally relies on the principle of justice.

Ethical Values:

Fairness – who receives what and at what point
Professional Duty – do no harm, do not abandon Stewardship
– allocating scarce resources; utilitarianism Ethical Process
Elements:

Transparency – communication to stakeholders
Consistency – nondiscrimination
Proportionality – elevating response during emergency Accountability
– acting upon duty to respond
During an emergency the following events require incorporation of sound ethical considerations:

- Triaging—Workforce members should be prepared to prioritize which residents to evacuate first prior to or during a crisis.
- Allocation of Resources—Workforce members should know what resources are available during a crisis, where supplies are stored, and have the tools needed to determine how scarce resources will be issued.
- Standards of Care—Workforce members should be prepared to adjust their standards of care during an emergency. Considerations include ensuring individuals are trained to provide care normally outside of their professional practice.

Evacuation Plan

While evacuation is typically not preferred, there may be times when this option is safest for the residents and staff. Due to the varied abilities of nursing home residents, evacuation can be a daunting task without appropriate consideration and planning ahead of time. Prior planning regarding how residents will be transported, who will provide the transportation, what specialty types of vehicles will be needed and where they will come from all need to be prearranged in order to maximize the safety of residents and staff. Evacuation planning also includes determining what supplies, food, water, medications, and other physical items will be needed in order to maintain safety. Pre-determined locations should be identified where residents can be taken that will adequately meet their needs. Identifying pre-determined locations and having discussions ahead of time will ensure a smooth transition. Two sample memoranda are provided to serve as templates (See Appendix I). Additionally, it should be noted that having an evacuation agreement with more than one facility would be appropriate.

Traditionally, facilities often choose the closest like facility with which to partner. However, a second facility some distance away may be prudent in the event that the closest facility may be similarly affected and unable to handle the transfer request.

The following pages are specifically dedicated to looking at evacuation needs. If additional evacuation and shelter-in-place planning resources are desired, please refer to the Minnesota Department of Health website.

Transportation Plan

The transportation plan should describe how the residents will be transported to the sheltering facilities. It should include as an attachment any contracts or Memorandums of Agreement with transportation companies, churches or ambulance services, or other transportation modality. The transportation plan should include:

The number and types of vehicles required.
How the vehicles will be obtained.
Who will provide the drivers.
Medical support to be provided for the patient or resident during transportation. The following support needs should be considered:

- Residents who are independent in ambulation.
- Residents who require assistance with ambulation.
- Residents who are non-ambulatory.
- Residents with cognitive impairments.
- Residents with equipment/prosthetics (equipment/prosthetics should accompany residents and should be securely stored in the designated mode of transportation).

Estimation of the time to prepare residents for transportation.
Estimation of the time for the facility to prepare for evacuation.
Estimation of time for the patient or resident to reach the sheltering facility.
Detailed route to be taken to each sheltering facility if possible.
Description of what items must be sent with the patient or resident such as:

- The patient's medical record, which contains medications the patient is taking, dosage, frequency of medication administration, special diets, special care, etc.
- A three-day supply of medications (if possible).
- Special medical supplies the patient may need.
- Other items such as clothing, incontinence diapers, etc.

The medical records should be provided to the receiving facility and remain with the receiving facility until the patient or resident is transferred back to the sending facility or to another facility.
Records should be maintained of which residents are transported to which facilities.

Evacuation Destination Information

The Sheltering Plan should describe where the residents will be transported. The receiving facility should be appropriate for the level of care required for the residents being evacuated. The plan should include as an attachment any contract, memorandum of agreement, or transfer agreement the facility has with a receiving facility. The following should also be included in the plan:

Sleeping plan
Feeding plan
Medication plan
Accommodations for relocated staff
Number of relocated residents that can be accommodated at each receiving facility

Staffing Plan

The Staffing Plan should include how the relocated residents will be cared for at the sheltering facility as well as the number and type of staff that is needed at the evacuating facility to help evacuate the residents. The Staffing Plan should include:

Description of how care will be provided to relocated residents
Identification of number and type of staff needed to evacuate the facility and to accompany residents to the sheltering facility
Plan for relocating facility staff

- A contingency plan if facility staff cannot make it into the shelter due to their own family's needs.

Attachments and Documents

The following documents should be included as attachments to the Evacuation Plan:

Sheltering agreements between the facility and the receiving facility (must be update annually)
Transportation agreements between the facility and ambulance companies, bus services, churches, etc. (must be updated annually)
Documentation of any coordination between law enforcement, fire departments, etc.

See Appendix G for evacuation plans, checklists and transportation agreements.

Sheltering in Place

In certain situations, such as a tornado or chemical incident, your facility may be better off to stay and shelter in place. The facility needs to plan for sheltering in place. In an emergency,

your facility may be without telephone or other communications, electric power, or water and sewer service for several days. The facility must be able to exist on its own for at least 72 hours without outside assistance. Your plan should include provisions for resident care (monitoring of medical conditions), facility safety and security, food, water, medications, contact with first responders (fire, police, EMS, etc.), public health, transportation, staff, lighting, temperature control, waste disposal, and medical supplies.

The sheltering in place plan is not to be specific to the event requiring sheltering, instead, the plan should contain the following:

- Plan in place describing how three days of non-perishable meals are kept on hand for residents and staff. The Plan should include special dietary requirements.
- Plan in place describing how 96 hours of potable water is stored and available to residents and staff.
- Plan in place identifying 96 hours of necessary medications that are stored at the facility and how necessary temperature control and security requirements will be met.
- Plan in place to identify staff that will care for the residents during the event including any transportation needs that the staff might have and how the facility will meet those needs.
- Plan in place for an alternative power source, such as an onsite generator, and describe how 96 hours of fuel will be maintained and stored. Alternate power source plan provides for necessary testing of the generator.
- Plan in place describing how the facility will dispose of or store waste and biological waste until normal waste removal is restored.
- Emergency Communications Plan in place, such as for cell phones, hand held radios, pager, satellite phone, laptop computer for instant messaging, HAM radio, etc.
- Adequate planning considerations given to the needs of residents, such as dialysis patients.
- Adequate planning considerations given to residents on oxygen.
- Adequate planning considerations given to residents using durable medical equipment such as masks, nasal cannulas, colostomy equipment, g-tube, etc.

See Appendix H for Facility Shelter in Place plan, Supply and Equipment lists, and checklists.

Memorandums of Understanding

Health care facilities should consider memorandums of understanding (MOUs) with organizations that can provide them resources and services during emergencies and disasters. MOUs are established between hospitals, other health care providers and/or emergency response agencies to identify their agreements to collaborate, communicate, respond and

support one another during a disaster or other public health emergency. Understandings regarding the incident command structure, patient and resource management, processes and policies in place for requesting and sharing of staff, equipment and consumable resources, as well as payment, are generally addressed in a local mutual aid MOU.

MOUs help facilities demonstrate and document compliance with Joint Commission and State and Federal expectations for collaborative planning and disaster response. MOUs are also a documentation asset when seeking federal reimbursement through FEMA after a disaster.

MOUs are also used by facilities to document agreements with other organizations and agencies to provide transportation, consumables (e.g., water, food), equipment, personnel and many other resources and services that may be needed during a disaster event. These MOUs help to document a facility's ability to respond and to sustain operations.

Examples include MOUs with:

- Local hospitals for patient transfer, supplies, equipment, pharmaceuticals, and personnel.
- Local nurse registry agencies, temporary agencies, and security personnel providers.
- Other local health care providers including clinics and long term care facilities for personnel, supplies, equipment, and transportation.
- Vendors and suppliers for health care and non-health care resources, including linen and fuel.
- County government for services including transportation and security; for supplies; and for assistance in managing the treatment and transportation of staff and patients.
- Third party payors to suspend lag time for payments

See Appendix I for MOU templates

Recovery Plan

Disaster and crisis planning are primarily focused on preparing and responding, however, another critical component is the recovery phase. At this point the worst of the immediate and acute crisis has passed, and a facility can focus on returning to standard operations. From a facilities standpoint, recovery often means taking a look at the infrastructure of the facility and making determinations if the facility is still operable and capable of taking care of the residents. Recovery should be coordinated with others such as local emergency management, financial personnel, public health, food delivery services, utilities, etc. In other words, recovery involves taking a complete look not just at the physical structure, but also those types of needs that support the safe and effective operation of your facility.

See Appendix J for consideration checklists for re-opening

Staff Care Plan

During a crisis or disaster, additional help is often needed. One way to assist in making it easier for staff to stay at or report in to work, is to have a staff care plan. A staff care plan includes pre-determined arrangements for staff members' family and loved ones. Having this information available allows staff to feel comforted that arrangements are made for their loved ones and often increases the likelihood that staff will remain at or report in to work.

See Appendix K for Staff Care Plan documentation

Exercise, Evaluation and Improvement Planning

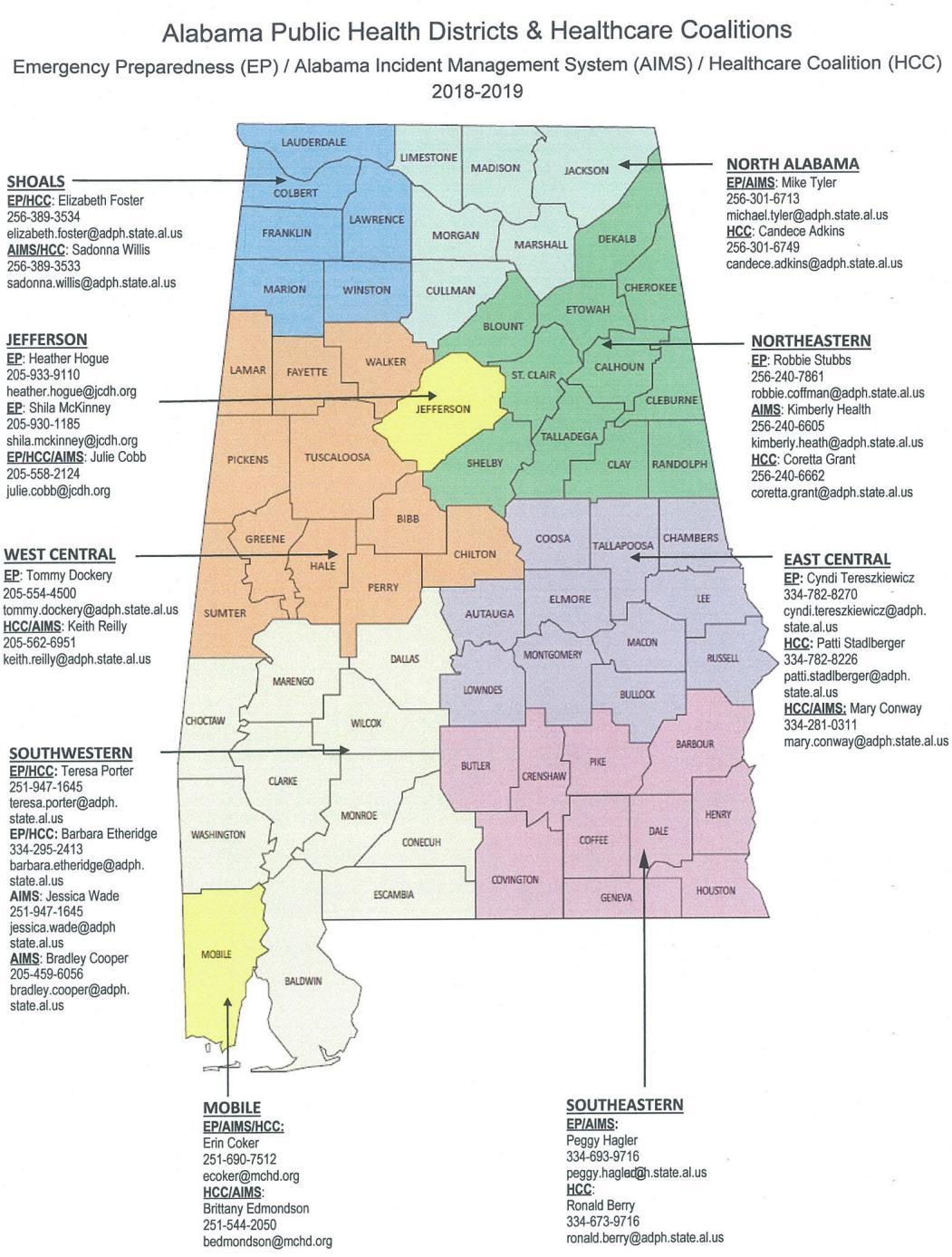
For any plan to be useful, it needs to be tested periodically to determine if it works or if weaknesses appear once the plan is tested. Unless the plan is tested routinely, it is not truly a functional piece of work, which is the goal of having an emergency operations plan. Finding out during a crisis that the plan has real weaknesses is not the time to face that kind of risk. For this reason, there should be an exercise plan which includes both an evaluation piece and improvement planning.

The Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Requirements state that LTC facilities must offer training on emergency procedures at least once annually and must complete at least two exercises annually: one full-scale exercise that is community- or facility-based and one additional exercise of the facility's choice. See link for requirements: CMS Emergency Preparedness Requirements by Provider Type.

See Appendix L for Exercise, Evaluation, and Improvement Planning Checklist

Regional Resources and Support Agencies

The following map will assist health care facilities in determining to which region they belong.



List of Appendixes and Annexes

Appendix/Annex	Description
Appendix A	CMS Emergency Preparedness Checklist for Effective Health Care Facility Planning
Appendix B	Facility Hazard Vulnerability Analysis
Appendix C	Organization Chart/Job Action Sheets/ICS Quick Start Guide
Appendix D	Facility Contact Lists
Appendix E	Facility Specific Information
Appendix F	HIPPA Waiver Toolkit
Appendix G	Evacuation Plan and Checklists, Transportation Agreements
Appendix H	Facility Shelter in Place Plan, Supply and Equipment Lists, and Checklists
Appendix I	MOU Templates
Appendix J	Recovery Checklists
Appendix K	Staff Care Plan Documentation
Appendix L	Exercise, Evaluation, and Improvement Planning Checklist and AAR/IP
Appendix M	Important Resources
Appendix N	Active Shooter Resources
Appendix O	Alabama Long Term Care Survey Tools and Information
Annex A	Apartment Evacuation Policy
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Annex E	Chemical Spills
Annex F	Communications
Annex G	Electrical Power Outage Policy
Annex H	Elevator Policy
Annex I	Emergency Notification of Administrator
Annex J	Fire Policy
Annex K	Health and Humidity Policy

The attachments contained within the Appendixes and Annexes are considered templates. To make the documents facility specific, facilities will need to adapt the templates.

Acronyms

Acronym	Description
AAR	After Action Report
ADPH	Alabama Department of Public Health
ANHA	Alabama Nursing Home Association
BT	Bioterrorism
CDC	Centers for Disease Control and Prevention
COOP	Continuity of Operations Plan
DOC	Department Operations Center
EM	Emergency Management
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
FEMA	Federal Emergency Management Agency
HICS	Hospital Incident Command System
HHS	Health and Human Services
HPP	Hospital Preparedness Program or Health Care Preparedness Program
HSEEP	Homeland Security Exercise & Evaluation Program
HSEM	Homeland Security & Emergency Management
HVA	Hazard Vulnerability Analysis
HVAC	Heating, Ventilation & Air Conditioning
IAP	Incident Action Plan
IC	Incident Command or Infection Control
ICS	Incident Command System
IMT	Incident Management Team
IMS	Incident Management System
IP	Improvement Plan
IT	Information Technology
JAS	Job Action Sheets
LTC	Long-term Care
MOU	Memo of Understanding
OSHA	Occupational Safety and Health Administration

PFA	Psychological First Aid
PHPC	Public Health Preparedness Consultant
PICEs	Potential Injury Creating Events
PIO	Public Information Officer
POC	Point of Contact
PPE	Personal Protective Equipment
RHPC	Regional Healthcare Preparedness Coordinator

Appendix A: CMS Emergency Preparedness Checklist

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/SandC_EPChecklist_Persons_LTCFacilities_Ombudsmen.pdf

http://www.health.state.mn.us/oep/healthcare/ltc/appendixa.pdf

Appendix B: Hazard Vulnerability Analysis (HVA) Tool

Kaiser Permanente has developed a Hazard Vulnerability Analysis tool which is available for download as a planning resource. Individuals or organizations using this tool are solely responsible for any hazard assessment and compliance with applicable laws and regulations.

Download the Kaiser Permanente HVA Tool at https://asprtracie.hhs.gov/technical-resources/resource/250/kaiser-permanente-hazard-vulnerability-analysis-hva-tool.

Appendix C: ICS Organization Chart and Job Action Sheets

Long Term Care Organization Chart:

Depending on the size of the facility, one person may occupy multiple positions within the section. You do not need to activate all positions – only activate what you need for the incident. This is your basic Incident Command, if part of a larger system i.e.: health organization, you will need to know where your ICS fits within that organizations structure

These titles are universal and not subject to local change.

Incident Management System Basic Job Action Sheets

Customize these sheets as needed based on the type and number of staff at your facility. Note: more than one person could be assigned management duties and staff that will be assigned the duties must be trained on these responsibilities. You should develop Management Duties vs. Staff Duties for each area. The managers all report to the “Incident Commander.” All duties to be performed are disaster-specific, so some items might not be applicable to your situation.

Incident Command

POSITION ASSIGNED TO:	
Reporting to:	CEO/Other Oversight Management Structure
Command Center Location	
Telephone:	

Mission: Organize and direct the facility's emergency operations. Give overall direction for facility operations and make evacuation and sheltering in place decisions.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Assume role of Incident Commander and activate the Nursing Home Incident Command System (NHICS)
		Notify your usual supervisor of the incident activation of NHICS.
		Determine the following prior to the initial NHICS team meeting. (This will comprise the first components of the facility's Incident Action Plan).
		1. Nature of the problem (incident type, injury/illness type, etc.) 2. Safety of staff, residents and visitors 3. Risks to personnel and need for protective equipment 4. Risks to the facility 5. Need for decontamination 6. Estimated duration of incident 7. Need for modifying daily operations 8. NHICS team required to manage the incident 9. Need to open up the facility's Incident Command Center (ICC) location 10. Overall community response actions being taken 11. Need to communicate with state licensing agency 12. Status of local, county, and state Emergency Operations Centers (EOC)
		Determine need for and appropriately appoint Command Staff and Section Chiefs, or Branch/Unit/Team leaders as needed; distribute corresponding Job Action Sheets and position identification.
		Assign clerical personnel to function as the ICC recorder(s). Document all key activities, actions, and decisions on a continual basis.

Time Completed	Initials	Action
		Communicate to Command Staff and Section Chiefs how personnel time is to be recorded. Determine if Finance/Administration has any special preferences for submission at this time.
		Define and document specific existing or potential safety risks and hazards, which Section or Branch may be affected, and steps to mitigate the threat. This is the first step in an ongoing process continued by the Safety Officer and included in the subsequent briefing meetings.
		Receive status reports from and develop an Incident Action Plan with Section Chiefs and Command Staff to determine appropriate response and recovery levels. During initial briefing/status reports, the following information may be needed: • Initial facility damage survey report across sections. • Evaluate the need for evacuation. As appropriate to the incident, verify transportation plans. • Obtain resident census and status and request a projection report for 4, 8, 12, 24 & 48 hours from time of incident onset. Adjust projections as necessary. Assign to Planning Section Chief. • Identify the operational period and ICC shift change. • As appropriate to the incident, authorize a resident prioritization assessment for the purposes of designating appropriate early discharge (e.g. dialysis, vent –dependent). • Ensure that appropriate contact with outside agencies has been established and facility status and resource information provided through the Liaison Officer. • Seek information from Section Chiefs regarding on-hand resources of medical equipment, supplies, medications, food, and water as indicated by the incident. • Assess generator function and fuel supply. • Review security and facility surge capacity as appropriate, especially if serving as a host site or in case the local emergency management office requests beds.

Time Completed	Initials	Action
		Oversee and approve revision of the Incident Action Plan developed by the Planning Section Chief. Ensure that the approved plan is communicated to all Command Staff and Section Chiefs.
		Communicate facility and incident status and the Incident Action Plan to CEO or designee, or to other executives and/or Board of Directors members on a need-to-know basis.
		Draft initial message for Public Information Officer (PIO) for notification to family members, responsible parties, and/or other interested persons regarding facility and resident status.

Ongoing

Time Completed	Initials	Action
		Ensure staff, resident, and media briefings are being conducted regularly.
		Evaluate overall nursing home operational status, and ensure critical issues are addressed.
		Ensure incident action planning for each operational period and a reporting of the Incident Action Plan at each shift change and briefing.
		Review /revise the Incident Action Plan with the Planning Section Chief for each operational period.
		Ensure continued communications with local, regional, and state response coordination centers through the Liaison Officer and others.
		Authorize resources as needed or requested by Section Chiefs.
		Set up routine briefings with Section Chiefs to receive status reports and update the action plan regarding the continuance and termination of the action plan.
		Approve media releases submitted by PIO.
		Observe all staff, volunteers, and residents for signs of stress and inappropriate behavior. Report concerns to Human Resources. Provide for staff rest periods and relief.

Liaison Officer

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Function as the incident contact person in the nursing home for representatives from other agencies, such as the local emergency management office, police, and the licensing agency.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Notify your usual supervisor of your NHICS assignment.
		Obtain briefing from Emergency Incident Commander and note time for next meeting.
		Establish contact with local, county and/or state emergency organization agencies to share information on current status, appropriate contacts, and message routing.
		Communicate information obtained and coordinate with Public Information Officer.
		Obtain initial status and information from the Planning Section Chief to provide as appropriate to external stakeholders and local and/or county Emergency Operations Center (EOC)EOC, upon request: • Resident Care Capacity – The number of residents that can be received and current census. • Nursing Home's Overall Status – Current condition of facility structure, security, and utilities. • Any current or anticipated shortage of critical resources including personnel, equipment, supplies, medications, etc. • Number of residents and mode of transportation for residents requiring transfer to hospitals or receiving facilities, if applicable.

Time Completed	Initials	Action
		• Any resources that are requested by other facilities (e.g., personnel, equipment, supplies). • Media relations efforts being initiated, in conjunction with the PIO.
		Establish communication with other nursing homes as appropriate, the local EOC, and/or local response agencies (e.g., public health department). Report current facility status.
		Keep local EOC liaison officer updated as to critical issues and unmet resource needs.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		Attend all command briefings and Incident Action Planning meetings to gather and share incident and facility information. Contribute interfacility information and community response activities and provide Liaison goals to the Incident Action Plan.
		Request assistance and information as needed through the facility's network or from the local and/or regional EOC.
		Obtain the following information from the Planning Section Chief and be prepared to report to appropriate authorities the following data: • Number of new residents admitted and level of care needs. • Current resident census • Number of residents hospitalized, discharged home, or transferred to other facilities • Number dead
		Communicate with Logistics Section Chief on status of supplies, equipment and other resources that could be mobilized to other facilities, if needed or requested.

Public Information Officer

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Serve as the conduit for information to internal and external stakeholders, including staff, visitors and families, and the news media, as approved by the Incident Commander.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Notify your usual supervisor of your NHICS assignment.
		Obtain briefing from Emergency Incident Commander and note time for next briefing.
		Decide where a media briefing area might be located if needed (away from the facility's Incident Command Center and the resident care activity areas). Coordinate designation of such areas with Safety Officer.
		Contact external Public Information Officers from community and governmental agencies and/or their designated websites to determine public information and media messages developed by those entities to ensure consistent messages from all entities.
		Develop public information and media messages to be reviewed and approved by the Incident Commander before release to families, news media, and the public. Identify appropriate spokespersons to contact families or to deliver press briefings as needed.
		Assess the need to activate a staff and/or family member "hotline" for recorded information concerning the incident and facility status and establish the "hotline" if needed.
		Attend all command briefings and incident action planning meetings to gather and share incident and nursing home information.

Time Completed	Initials	Action
		Monitor incident/response information through the internet, radio, television and newspapers.
		Establish communication with other nursing homes as appropriate, local Emergency Operations Center (EOC), and/or local response agencies (e.g., public health department). Report current facility status.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		Coordinate with the Operations regarding: • Receiving and screening inquiries regarding the status of individual residents. • Release of appropriate information to appropriate requesting entities.
		Continue to attend all Command briefings and incident action planning meetings to gather and share incident and nursing home information. Contribute media and public information activities and goals to the Incident Action Plan.
		Continue dialogue with external community and governmental agencies to get public information and media messages. Coordinate translation of critical communications into languages for residents as appropriate.
		Continue to develop and revise public information and media messages to be reviewed and approved by the Incident Commander before release to the news media and the public.
		Develop regular information and status update messages to keep staff informed of the incident, community, and facility status. Assist in the development and distribution of signage as needed.

Safety Officer

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Ensure safety of staff, residents, and visitors, monitor and correct hazardous conditions.

Have authority to halt any operation that poses immediate threat to life and health.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Read this entire Job Action Sheet and review emergency organizational chart.
		Put on position identification (garment, vest, cap, etc.).
		Notify your usual supervisor of your NHICS assignment.
		Determine safety risks of the incident to personnel, the physical plant, and the environment. Advise the Incident Commander and Section Chiefs of any unsafe condition and corrective recommendations.
		Communicate with the Logistics Chief to procure and post non-entry signs around unsafe areas.
		Ensure the following activities are initiated as indicated by the incident/situation: • Evaluate building or incident hazards and identify vulnerabilities • Specify type and level of Personal Protective Equipment to be utilized by staff to ensure their protection, based upon the incident or hazardous condition • Monitor operational safety of decontamination operations if needed

Time Completed	Initials	Action
		• Contact and coordinate safety efforts with the Operations to identify and report all hazards and unsafe conditions to the Operations Section Chief.
		Work with Incident Command staff in designating restricted access areas and providing signage.
		Assess nursing home operations and practices of staff, and terminate and report any unsafe operation or practice, recommending corrective actions to ensure safe service delivery.
		Ensure implementation of all safety practices and procedures in the facility.
		Initiate environmental monitoring as indicated by the incident or hazardous condition.
		Attend all command briefings and Incident Action Planning meetings to gather and share incident and facility safety requirements.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		Continue to assess safety risks of the incident to personnel, the facility, and the environment. Advise the Incident Commander and Section Chiefs of any unsafe condition and corrective recommendations.
		Ensure proper equipment needs are met and equipment is operational prior to each operational period.
		Continue to attend all command briefings and incident action planning meetings to gather and share incident and facility information. Contribute safety issues, activities and goals to the Incident Action Plan.

Operations

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Organize and direct activities relating to the Operations Section. Carry out directives of the Incident Commander. Coordinate and supervise the branches within the Operations Section. Oversee the direct implementation of resident care and services, dietary services, and environmental services. Contribute to the Incident Action Plan.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Notify your usual supervisor of your NHICS assignment.
		Obtain briefing from Emergency Incident Commander and designate time for next meeting.
		Assess need to appoint Branch Directors: • Resident Services • Infrastructure
		Transfer the corresponding Job Action Sheets to Branch Director. If a Branch Director is not assigned, the Planning Chief keeps the Job Action Sheet and assumes that function.
		Brief Branch Directors on current situation and develop the section's initial projection/status report. Establish the Operations Section chain of command and designate time and location for next section briefing. Share resident census and condition information gained at initial Command briefing. Communicate how personnel time is to be recorded.
		Establish Operations Section Center (in proximity to Incident Command area, if possible).
		Serve as primary contact with nursing home Medical Director.

Time Completed	Initials	Action
		Meet with Resident Services Branch Director and Nursing Services Unit Leader and communicate with Medical Director to plan and project resident care needs.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		From information reported by Branch Directors, inform Incident Command of facility's internal factors which may contribute to the decision to evacuate or shelter in place: • Resident acuity • Physical structure
		Implement resident evacuation at the direction of the Incident Commander with support of Branch Directors and other Section Chiefs.
		Meet regularly with the Incident Commander, Command Staff and other Section Chiefs to update status of the response and relay important information to Operations Section's Staff.
		As the incident requires, in preparation for movement of residents within the facility or to a staging area, work with Logistics to assist in the gathering and placement of transport equipment (wheelchairs, canes, stretchers, walkers, etc).
		Designate times for briefings and updates with Branch Directors to develop and update section's projection/status report.
		Coordinate personnel needs with Logistics .
		Coordinate supply and equipment needs with Logistics
		Provide situation reports and projections to the Planning Section within stated time frames.
		Coordinate financial issues with the Finance/Administration Section.

Time Completed	Initials	Action
		Ensure that this Section's branches are adequately staffed and supplied.
		Observe all staff, volunteers, and residents for signs of stress and inappropriate behavior. Report concerns to Human Resources. Provide for staff rest periods and relief.

Planning

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Gather and analyze incident-related information. Obtain status and resource projections from all section chiefs for long range planning and conduct planning meetings. From these projections, compile and distribute the facility's Incident Action Plan. Coordinate and supervise the units within the Planning Section.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Notify your usual supervisor of your NHICS assignment.
		Obtain briefing from Emergency Incident Commander and designate time for next meeting.
		Assess need for the following Unit Leaders and appoint as needed: • Situation Status • Documentation
		Transfer the corresponding Job Action Sheets to Unit Leader. If a unit leader is not assigned, the Planning Chief keeps the Job Action Sheet and assumes that function.
		Brief all unit leaders on current situation and develop the section's initial projection/status report. Designate time and location for next section briefing. Communicate how personnel time is to be recorded.
		Establish a Planning/Information Section Center.
		Facilitate and conduct incident action planning meetings with Command Staff, Section Chiefs, and other key personnel as needed to plan for the next operational period.

Time Completed	Initials	Action
		Coordinate preparation and documentation of the Incident Action Plan and distribute copies to the Incident Commander and all Section Chiefs.
		Call for status and resource projection reports from all Section Chiefs for scenarios 4, 8, 24 & 48 hours from time of incident onset. Adjust time for receiving these reports as necessary.
		Direct Situation Unit Leader to document and update projection/status reports from all sections.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		Meet regularly with the Incident Commander, Command Staff and other Section Chiefs to update status of the response and relay important information to Planning Section's Staff.
		Ensure that personnel and equipment are being tracked.
		Designate times for briefings and updates with group supervisors to develop and update section's projection/status report.
		Ensure that this Section's groups are adequately staffed and supplied.
		Observe all staff, volunteers, and residents for signs of stress and inappropriate behavior. Report concerns to Human Resources. Provide for staff rest periods and relief.

Logistics

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Organize and direct those operations associated with maintenance of the physical environment, and adequate levels of personnel, food, and supplies to support the incident objectives. Coordinate and supervise the branches within the Logistics Section. Contribute to the Incident Action Plan.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Notify your usual supervisor of your NHICS assignment.
		Obtain briefing from Emergency Incident Commander and designate time for next meeting.
		Assess need to appoint Branch Directors and/or Unit Leaders and distribute corresponding Job Action Sheets. Refer to Nursing Home Incident Command System organizational chart. Transfer the corresponding Job Action Sheets to persons appointed.
		If a function is not assigned, the Logistics Chief keeps the Job Action Sheet and assumes that function.
		Brief Branch Directors on current situation and develop the section's initial projection/status report. Establish the Logistics Section chain of command and designate time and location for next section briefing. Communicate how personnel time is to be recorded.
		Establish Logistics Center.
		Maintain communications with Operations Section Chief and Branch Directors to assess critical issues and resource needs.
		Ensure resource ordering procedures are communicated to appropriate Sections and their requests are timely and accurately processed.
Time Completed	Initials	Action
		Attend damage assessment meeting with Incident Commander, Environmental Services Unit Leader, and the Safety Officer.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		From information reported by Branch Directors, inform Incident Command of facility's internal factors which may contribute to the decision to evacuate or shelter in place: • Transportation and Status of Destination Locations • Supplies • Access to Staff
		Meet regularly with the Incident Commander, Command Staff and other Section Chiefs to update status of the response and relay important information to Logistics Section's Staff.
		Obtain needed material and fulfill resource requests with the assistance of the Finance/Administration Section Chief and Liaison Officer.
		Ensure the following resources are obtained and tracked: • Staff • Resident care supplies • Communication hardware • Food and water
		Obtain information and updates regularly from Branch Directors and Unit Leaders.
		Ensure that this Section's groups are adequately staffed and supplied.
		Observe all staff, volunteers, and residents for signs of stress and inappropriate behavior. Report concerns to Human Resources. Provide for staff rest periods and relief.

Finance/Administration

POSITION ASSIGNED TO:	
Reporting to:	Incident Command
Command Center Location	
Telephone:	

Mission: Monitor the utilization of financial assets and the accounting for financial expenditures.

Supervise the documentation of expenditures and cost reimbursement activities. Coordinate and supervise the units within the Finance/Admin Section. Contribute to the Incident Action Plan.

Intermediate: Operational Period 0-2 Hours

Time Completed	Initials	Action
		Receive appointment from Incident Commander. Obtain Job Action Sheet.
		Notify your usual supervisor of your NHICS assignment.
		Obtain briefing from Incident Commander and designate time for next meeting.
		Assess need for the following Unit Leaders and appoint as needed:
		1. Procurements
		2. Cost
		3. Employee Time
		4. Compensation/Claims
		5. Business Continuity
		Transfer the corresponding Job Action Sheets to Unit Leaders. If a unit leader is not assigned, the Finance/Admin Chief keeps the Job Action Sheet and assumes that function.
		Brief unit leaders on current situation and develop the section's initial projection/status report. Designate time for next section briefing. Communicate how personnel time is to be recorded.

Time Completed	Initials	Action
		Discuss with Employee Time Unit Leader how to document facility-wide personnel work hours worked relevant to the emergency.
		Assess the need to obtain cash reserves in the event access to cash is likely to be restricted as an outcome of the emergency incident.
		Participate in Incident Action Plan preparation, briefings, and meetings as needed: • Provide cost implications of incident objectives • Ensure Incident Action Plan is within financial limits established by Incident Command • Determine if any special contractual arrangements/agreements are needed
		Identify and document insurance company requirements for submitting damage/claim reports.
		Document all key activities, actions, and decisions on a continual basis.

Ongoing

Time Completed	Initials	Action
		Coordinate emergency procurement requests with Logistics.
		Maintain cash reserves on hand.
		Consult with state and federal officials regarding reimbursement regulations and requirements; ensure required documentation is prepared accordingly.
		Meet regularly with the Incident Commander, Command Staff and other Section Chiefs to update status of the response and relay important information to Finance/Admin Section Staff.
		Approve and submit to Incident Command a "cost-to-date" incident financial status report every 8 hours (prepared by the Cost Unit Leader, if appointed) summarizing financial data relative to personnel, supplies, and miscellaneous expenses.

Time Completed	Initials	Action
		Ensure that required financial and administrative documentation is properly prepared.
		Process invoices received.
		Maintain routine, non-incident related administrative oversight of financial operations.
		Observe all staff, volunteers, and residents for signs of stress and inappropriate behavior. Report concerns to Human Resources. Provide for staff rest periods and relief.

Department Considerations for Jobs

Other departments within the organization will have personnel assigned within the ICS structure depending on their roles, talents, and current need. There are items each department should consider as they assign personnel:

Dietary/Food Services Unit Leader

Name: _____ Date: _____

Title: _____ Reports to: _____

Management Duties

Time Completed	Initials	Item
		Oversee kitchen management
		Notify staff if there will be an evacuation
		Ensure gas appliances are turned off before departure
		Contact dietary/food service staff whom need to report to duty
		Supervise movement and separation of food stores to designated area(s)
		Supervise loading of food in the event of an evacuation
		Supervise closing of the kitchen
		Ensure preparation of food and water to be transported to the receiving facility
		Ensure disposable utensils, cups, straws, napkins are packed
		Ensure adequate food is available and packed for staff going to receiving facility
		Brief Commander as needed

Housekeeping Unit Leader

Name: _____ Date: _____

Title: _____ Reports to: _____

Staff Duties as assigned by Manager

Time Completed	Initials	Item
		Brief supervisor as needed
		Ensure cleanliness of resident's environment
		Ensure provision of housekeeping supplies for three days
		Clear corridors of any obstructions such as carts, wheelchairs, etc
		Ensure adequate cleaning supplies and toilet paper is available
		Check equipment (wet/dry vacuums, etc.)
		Secure facility (close windows, lower blinds, etc.)
		Perform clean-up, sanitation and related preparations
		Assist with moving residents to departure areas as needed
		Ensure adequate supplies of linens, blankets, and pillows
		Ensure emergency linens are available for soaking up spills and leaks
		Supervise loading of laundry and housekeeping supplies into transportation vehicles

Infrastructure and Maintenance Services Unit Leader

Name: _____ Date: _____

Title: _____ Reports to: _____

Staff Duties as assigned by Manager

Time Completed	Initials	Item
		Brief supervisor as needed
		Ensure communications equipment is operational and extra batteries are available
		Check and ensure safety of surrounding areas (secure loose outdoor equipment and furniture)
		Secure exterior doors and windows
		Check/fuel emergency generator and switch to alternative power as necessary
		Alert Department Heads of equipment supported by emergency generator
		If pump or switch on emergency generator is controlled electrically, install manual pump or switch
		Ensure readiness of buildings and grounds
		Call fire department if applicable
		Conduct inventory of vehicles, tools and equipment and report to administrative service
		Fuel vehicles
		Identify shut off valves and switches for gas, oil, water, and electricity and post charts to inform personnel
		Close down/secure facility in event of evacuation
		Ensure all needed equipment is in working order

Time Completed	Initials	Item
		Document and report repairs/supplies needed for the building
		Ensure emergency lists are posted in appropriate areas
		Monitor fuel supplies and generators
		Be watchful for potential fire hazards, water leaks, water intrusion, or blocked facility access
		Determine need for additional security.*
		Ensure supplies and equipment are safe from theft.*
		Identify and mitigate outdoor threats to facility. *

* If your facility does not have dedicated Security Staff- otherwise, these duties would be assigned to Security.

Nursing Department Unit Leader

Name: _____ Date: _____

Title: _____ Reports to: _____

Time Completed	Initials	Item
		Brief supervisor as needed
		Ensure delivery of resident medical needs
		Assess special medical situations
		Coordinate oxygen use
		Relocate endangered residents
		Ensure availability of medical supplies
		Secure patient records

Time Completed	Initials	Item
		Maintain resident accountability and control
		Supervise residents and their release to relatives, when approved
		Ensure proper control of arriving residents and their records
		Screen ambulatory residents to identify those eligible for release
		Maintain master list of all residents, including their dispositions
		Contact pharmacy to determine: • Cancellation of deliveries • Availability of backup pharmacy • Availability of 3-days of medical supplies
		Assist with patient transportation needs
		Supervise emergency care
		Use Medication Administration Records (MAR) to verify patient/resident locations
		Ensure adequate medications and medical supplies are available
		Periodically check medications and medical supplies
		Review and prioritize patient/resident care requirements
		Coordinate staffing needs
		Supervise patient/resident transfer from the building

Patient Services Unit Leader

Name: _____ Date: _____

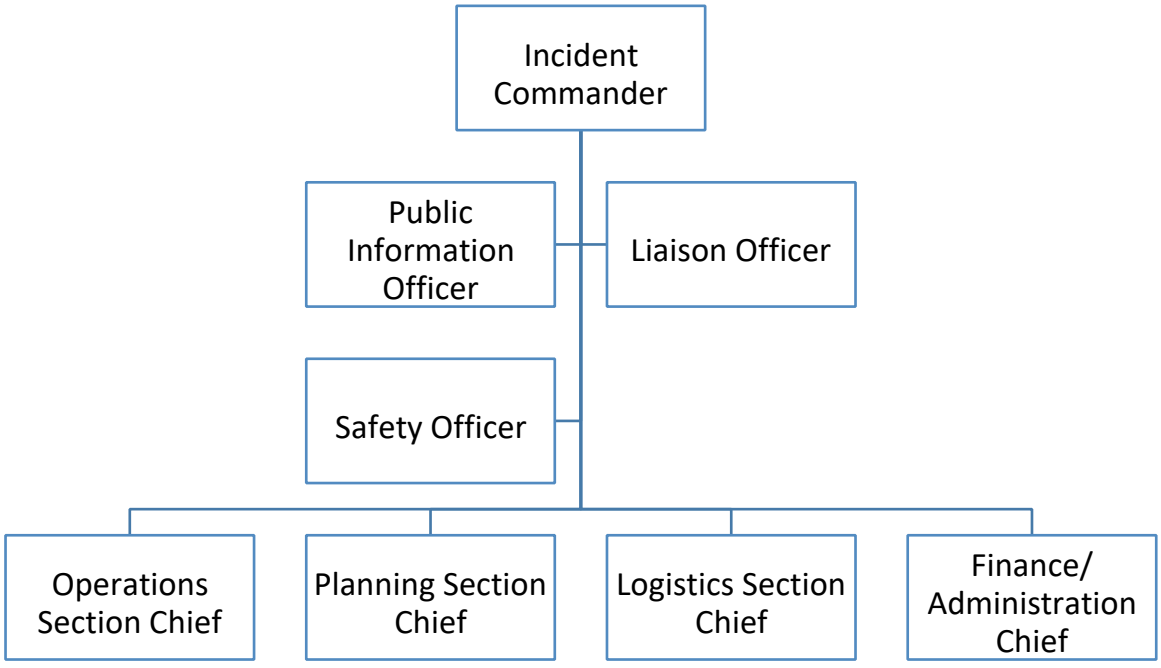
Title: _____ Reports to: _____

Time Completed	Initials	Item
		Brief supervisor as needed
		Notify resident families/responsible parties of disaster situation and document this notification
		Coordinate information release with senior administrator
		Monitor telephone communication
		Answer telephones and direct questions/requests to appropriate areas
		Order supplies as directed (Coordinate with Nursing/Medical Services)
		Cancel special activities (i.e., trips, activities, family visits, etc.), deliveries and services
		Make arrangements for emergency transportation of residents
		Contact additional staff when authorized
		Monitor and document costs associated with the incident
		Secure non-patient records
		Supervise and/or assist in clearing hallways, exits
		Coordinate movement of residents
		Assist in transport of residents from rooms to departure areas
		Assist in transfer of residents to transportation vehicles
		Ensure adequate trained staff is available for emotional needs of patient and staff
		Ensure appropriate staff are available to provide bedside treatments

HICS Incident Action Plan (IAP) Quick Start

HICS: Combined HICS 201-202-203-204-215A

Incident Name:	
Operational Period:	
Situation Summary	



HICS 201, 203

Incident Name:	
Operational Period:	
Current Hospital Incident Management Team (fill in additional positions as appropriate)	
Health and Safety Briefing Identify potential incident health and safety hazards and develop necessary measures (remove hazard, provide personal protective equipment, warn people of the hazard) to protect responders from those hazards.	

Appendix C: ICS Organization Chart and Job Action Sheets

Incident Objectives	

Appendix D: Facility Contact Lists

Organizational Information

Organization: _____

Address: _____

City: _____ **State:** _____ **Zip code:**

Phone Number: (___)_____ **Fax:** (___)_____

Owner of LTC Community/Organization

Name: _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone Number: (____)_____ **Fax:** _____( )

Cell Phone Number: (___)_____

E-mail: _____

Administrator/Executive Director

Name: .

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone Number: (___)_____ **Fax:** _____( )

Cell Phone Number: (____)_____

E-mail: _____

Emergency Contact Roster - Internal

Emergency Contact Roster will be placed:

1.

2.

Training provided to notify staff where the rosters are and when to utilize

Facility Command Center Location:

Alternate Facility Command Center Location:

Command Center Telephone Number(s):

Administrator

Name: _____

Work #: _____

Cell #: _____

Home #: _____

Email: _____

Other: _____

Medical Director

Name: _____

Work #: _____

Cell #: _____

Home #: _____

Email: _____

Other: _____

Director of Nursing

Name: _____

Work #: _____

Cell #: _____

Home #: _____

Email: _____

Other: _____

Director of Environmental Services

Name: _____

Work #: _____

Cell #: _____

Home #: _____

Email: _____

Other: _____

Plant Maintenance Supervisor

Name: _____

Work #: _____

Cell #: _____

Home #: _____

Email: _____

Other: _____

Dietary/Food Services Director

Name: _____

Work #: _____

Cell #: _____

Home #: _____

Email: _____

Other: _____

Security Director

Name: _____

Work #: _____

Cell #: _____

Home #: _____

Email: _____

Other: _____

Safety Director

Name: _____

Work #: _____

Cell #: _____

Home #: _____

Email: _____

Other: _____

Public Information Officer

Name: _____

Work #: _____

Cell #: _____

Home #: _____

Email: _____

Other: _____

Behavioral Health/Social Work

Name: _____

Work #: _____

Cell #: _____

Home #: _____

Email: _____

Other: _____

Others

Name: _____

Work #: _____

Cell #: _____

Home #: _____

Email: _____

Other: _____

Emergency Contact Roster - External

Organization	Point of Contact
Fire	
Law Enforcement	
Emergency Medical Services	
City Emergency Manager (If applicable)	
County Emergency Management	
Local Emergency Room or Hospital	
Regional Hospital Resource Center	
Local Public Health Office	
Alabama Department of Public Health – Health Provider Standards	
Alabama Department of Health – Office of Emergency Preparedness	
Alabama Department of Senior Services	
Alabama Nursing Home Association	

Physicians

Name	Office #	Cell	Pager

Appendix E: Facility Specific Information

Building Information

Facility Name and Address: _____
_____
_____
_____

Number of Floors: _____

Water Source: _____

Sewer and Septic: _____

Location of Sprinkler: _____

System Control Panel: _____

Location of Power Shutoff: _____

Location of Generator: _____

Closest Major Highway/Road: _____

Closest Railroad:
_____

Other Modes of Potential
Transportation i.e. Harbor: _____

Any Known Hazards
(i.e. propane tanks, high voltage concerns): _____

Are you within 10 miles of a nuclear facility: YES NO _____

Are you within 50 miles of a nuclear facility: YES NO _____

Do you have any locked units: YES NO _____

ATTACH A FLOOR PLAN OF THE BUILDING IF POSSIBLE

Personnel Information

Average number of staff per shift:

Days: _____

Evenings: _____

Overnights: _____

Average number of staff in each department:

Department	**Number of Staff**
Administration	
Nursing	
Dietary	
Housekeeping	
Maintenance	
Recreation	
Social Services	
Human Resources	

Resident Information	**Census Number**	**Date Updated/Initials**
Licensed Bed Number		
Average Census		
Average Number of Ambulatory Residents		
Average Number of Non-Ambulatory Residents		
Any Ventilator or Life Support Residents		

Facility Preparation List

Physical Plant Risk Assessment is completed _____ (indicate frequency – quarterly, biannually, annually).

Physical Plant Risk Assessment Schedule: _____

_____

Photographs of buildings needed for insurance purposes have been taken on _____ and are located _____

(Include all sides of the building including roof areas)

Date Completed	Initials	Item
		Clearly marked gas and water shut-off valves with legible instructions how to shut off each
		Available tools to facilitate prompt gas shut-off
		Check gas shut off-valves and generators to insure proper operation
		Evaluate heating, ventilating, and air conditioning function and control options
		Assess ducted and non-ducted return air systems
		Preventive maintenance of HVAC system
		Location of ramp used to evacuate residents to buses or other vehicles
		Community's evacuation plan in area accessible to the public (if applicable)

Appendix F: HIPAA Waiver Toolkit

HIPAA Waivers for Disasters

Is the HIPAA Privacy Rule suspended during a national or public health emergency?

1. No.

2. CAUTION: State law may be much stricter than federal law
   a. Pre-emption analysis needs to be done regarding all of the exceptions below.
   b. The stricter law to protect privacy (whether federal or state) pre-empts.
   c. Thus in some states, the exceptions listed below will not be legal.

3. The Secretary of HHS may waive certain provisions of the Rule under the Project Bioshield Act of 2004 (PL 108-276) and Section 1135(b)(7) of the Social Security Act.

4. What provisions may be waived?
   a. If the President declares an emergency or disaster and the Secretary declares a public health emergency, the Secretary may waive sanctions and penalties against a covered hospital that does not comply with certain provisions of the HIPAA Privacy Rule.
   b. Following are the waivable provisions:
      i. Patient's right to agree or object
         1. The requirements to obtain a patient's agreement to speak with family members or friends involved in the patient's care (45 CFR 164.510(b)).
         2. The requirement to honor a request to opt out of the facility directory (45 CFR 164.510(a)). ii. Notice: The requirement to distribute a notice of privacy practices (45 CFR 164.520).

      iii. Restrictions by patients:
         1. The patient's right to request privacy restrictions (45 CFR 164.522(a)).

5. The patient's right to request confidential communications (45 CFR 164.522(b)) When and to what entities does the waiver apply?

   a. If the Secretary issues such a waiver, it only applies:

      i. In the emergency area and for the emergency period identified in the public health emergency declaration. ii. To hospitals that have instituted a disaster protocol. The waiver would apply to all patients at such hospitals.

      iii. For up to seventy-two hours from the time the hospital implements its disaster protocol.

iv. In a pandemic infectious disease, the waiver is in effect until the termination of the declaration of the public health emergency.

b. When the Presidential or Secretarial declaration terminates, a hospital must then comply with all the requirements of the Privacy Rule for any patient still under its care, even if seventy-two hours has not elapsed since implementation of its disaster protocol.

c. Regardless of the activation of an emergency waiver, the HIPAA Privacy Rule permits disclosures for treatment purposes and certain disclosures to disaster relief organizations. For instance, the Privacy Rule allows covered entities (CEs) to share protected health information (PHI) with the American Red Cross so it can notify family members of the patient's location (45 CFR 164.510(b)(4)).

6. **Resource**: *See* Public Health Uses and Disclosures at https://www.hhs.gov/hipaa/for-professionals/faq/public-health-uses-and-disclosures/index.html

Does the HIPAA Privacy Rule permit CEs to disclose protected health information, without individuals' authorization, to public officials responding to a bioterrorism threat or other public health emergency?

1. Yes.
   a. The Rule recognizes that various agencies and public officials will need PHI to deal effectively with a bioterrorism threat or emergency.
   b. To facilitate the communications that are essential to a quick and effective response to such events, the Privacy Rule permits CEs to disclose needed information to public officials in a variety of ways.

2. CEs may disclose PHI, without the individual's authorization, to a **public health authority** acting as authorized by law in response to a bioterrorism threat or public health emergency (*see* 45 CFR 164.512(b)), public health activities).

3. The Privacy Rule also permits a CE to disclose PHI to **public officials** who are reasonably able to prevent or lessen a serious and imminent threat to public health or safety related to bioterrorism (*see* 45 CFR 164.512(j)), to avert a serious threat to health or safety).

4. In addition, disclosure of PHI, without the individual's authorization, is permitted:
   a. Where the circumstances of the emergency implicates law enforcement activities (*see* 45 CFR 164.512(f));
   b. National security and intelligence activities (*see* 45 CFR 164.512(k)(2)); or
   c. Judicial and administrative proceedings (*see* 45 CFR 164.512(e)).

5. **Resource**: *See* Disclosures in Emergency Situations

Can healthcare information be shared in a severe disaster?

1. Yes
2. Providers and health plans covered by the HIPAA Privacy Rule can share patient information in all of the following ways:
    a. **Treatment:** Healthcare providers can share patient information as necessary to provide treatment, which includes.
        i. Sharing information with other providers (including hospitals and clinics); ii. Referring patients for treatment (including linking patients with available providers in areas where the patients have relocated); and
        iii. Coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate health services).
    b. Providers can also share patient information to the extent necessary to seek **payment** for these healthcare services.
    c. **Notification**: Healthcare providers can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death.
        i. The healthcare provider should get verbal permission from individuals, when possible; but if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.
        ii. Thus, when necessary, the hospital may notify the police, the press, or the public at large to the extent necessary to help locate, identify, or otherwise notify family members and others as to the location and general condition of their loved ones.
        iii. In addition, when a healthcare provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.
    d. **Imminent Danger**: Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public—consistent with applicable law and the provider's standards of ethical conduct.
    e. **Facility Directory**: Healthcare facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition.

3. Of course, the HIPAA Privacy Rule does not apply to disclosures if they are not made by entities covered by the Privacy Rule. Thus, for instance, the HIPAA Privacy Rule does not restrict the American Red Cross from sharing patient information.

4. **Resource**: *See* Disclosures Required by Law

When does the Privacy Rule allow CEs to disclose PHI to law enforcement officials?

1. The Privacy Rule is balanced to protect an individual's privacy while allowing important law enforcement functions to continue.

    a. The Rule permits CEs to disclose PHI to law enforcement officials, without the individual's written authorization, under specific circumstances.
    b. For a complete understanding of the conditions and requirements for these disclosures, providers need to review the exact regulatory text at the citations provided.

2. Disclosures for **law enforcement purposes** are permitted as follows:

    a. To comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, or a grand jury subpoena.
        i. The Rule recognizes that the legal process in obtaining a court order and the secrecy of the grand jury process provides protections for the individual's private information.

3. *See* 45 CFR 164.512(f)(1)(ii)(A)-(B).

    a. To respond to an **administrative request**, such as an administrative subpoena or investigative demand or other written request from a law enforcement official.
        i. Because an administrative request may be made without judicial involvement, the Rule requires all administrative requests to include or be accompanied by a written statement that the information requested is relevant and material, specific and limited in scope, and de-identified information cannot be used 2) *See* 45 CFR 164.512(f)(1)(ii)(C).
    b. To respond to a request for PHI for purposes of identifying or locating a **suspect, fugitive, material witness or missing person**; but the CE must limit disclosures of PHI to name and address, date, and place of birth, social security number, ABO blood type and Rh factor, type of injury, date and time of treatment, date and time of death, and a description of distinguishing physical characteristics.
        i. Other information related to the individual's DNA, dental records, body fluid or tissue typing, samples, or analysis cannot be disclosed under this provision, but may be disclosed in response to a court order, warrant, or written administrative request

ii. *See* 45 CFR 164.512(f)(2).

4. This same limited information may be reported to law enforcement:

   a. About a **suspected perpetrator** of a crime when the report is made by the victim who is a member of the CEs workforce (45 CFR 164.502(j)(2)).

   b. To **identify or apprehend** an individual who has admitted participation in a violent crime that the CE reasonably believes may have caused serious physical harm to a victim, provided that the admission was not made in the course of or based on the individual's request for therapy, counseling, or treatment related to the propensity to commit this type of violent act (45 CFR 164.512(j)(1)(ii)(A), (j)(2)-(3)).

5. To respond to a request for PHI about a **victim of a crime**, and the victim agrees.

   a. If, because of an emergency or the person's incapacity, the individual cannot agree, the CE may disclose the PHI if law enforcement officials represent that the PHI is not intended to be used against the victim, is needed to determine whether another person broke the law, the investigation would be materially and adversely affected by waiting until the victim could agree, and the CE believes in its professional judgment that doing so is in the best interests of the individual whose information is requested (45 CFR 164.512(f)(3)).

6. Where **child abuse victims or adult victims of abuse, neglect, or domestic violence** are concerned, other provisions of the Rule apply:

   a. Child abuse or neglect may be reported to any law enforcement official authorized by law to receive such reports and the agreement of the individual is not required (45 CFR 164.512(b)(1)(ii)).

   b. Adult abuse, neglect, or domestic violence may be reported to a law enforcement official authorized by law to receive such reports (45 CFR 164.512(c)): i. If the individual agrees; ii. If the report is required by law; or

   iii. If expressly authorized by law, and based on the exercise of professional judgment, the report is necessary to prevent serious harm to the individual or others, or in certain other emergency situations (*see* 45 CFR 164.512(c)(1)(iii)(B)).

   iv. Notice to the individual of the report may be required (*see* 45 CFR 164.512(c)(2)).

7. To report PHI to **law enforcement** when required by law to do so.

   a. *See* 45 CFR 164.512(f)(1)(i).

   b. For example, state laws commonly require healthcare providers to report incidents of gunshot or stab wounds, or other violent injuries; and the Rule permits disclosures of PHI as necessary to comply with these laws.

8. To alert law enforcement to the **death** of the individual.
    a. When there is a suspicion that death resulted from criminal conduct (*see* 45 CFR 164.512(f)(4)).
    b. Information about a decedent may also be shared with medical examiners or coroners to assist them in identifying the decedent, determining the cause of death, or to carry out their other authorized duties (45 CFR 164.512(g)(1)).

9. To report PHI that the CE in good faith believes to be evidence of a **crime** that occurred on the CEs premises (45 CFR 164.512(f)(5)).

10. When responding to an **off-site medical emergency**, as necessary to alert law enforcement about criminal activity, specifically, the commission and nature of the crime, the location of the crime or any victims, and the identity, description, and location of the perpetrator of the crime.
    a. *See* 45 CFR 164.512(f)(6).
    b. This provision does not apply if the CE believes that the individual in need of the emergency medical care is the victim of abuse, neglect, or domestic violence.

11. When consistent with **applicable law and ethical standards**:
    a. To a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public (45 CFR 164.512(j)(1)(i)); or
    b. To identify or apprehend an individual who appears to have escaped from lawful custody (45 CFR 164.512(j)(1)(ii)(B)).

12. For certain other **specialized governmental law enforcement purposes**, such as:
    a. To federal officials authorized to conduct intelligence, counter- intelligence, and other national security activities under the National Security Act (45 CFR 164.512(k)(2)) or to provide protective services to the President and others and conduct related investigations (45 CFR 164.512(k)(3));
    b. To respond to a request for PHI by a correctional institution or a law enforcement official having lawful custody of an inmate or others if they represent such PHI is needed to provide healthcare to the individual; for the health and safety of the individual, other inmates, officers, or employees or others at a correctional institution or responsible for the transporting or transferring inmates; or for the administration and maintenance of the safety, security, and good order of the correctional facility, including law enforcement on the premises of the facility (45 CFR 164.512(k)(5)).

13. Except when required by law, the disclosures to law enforcement summarized above are subject to a **minimum necessary** determination by the CE (45 CFR 164.502(b), 164.514(d)).
    a. When reasonable to do so, the covered entity may rely upon the representations of the law enforcement official (as a public officer) as to what information is the minimum necessary for their lawful purpose (45 CFR 164.514(d)(3)(iii)(A)).
    b. Moreover, if the law enforcement official making the request for information is not known to the CE, the CE must verify the identity and authority of such person prior to disclosing the information (45 CFR 164.514(h)).

14. **Resource**: *See* Disclosures for Law Enforcement Purposes

DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES (45 CFR 164.512(b))

Background

1. The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to PHI to carry out their public health mission.

2. The Rule also recognizes that public health reports made by CEs are an important means of identifying threats to the health and safety of the public at large, as well as individuals.

3. The Rule permits CEs to disclose PHI without authorization for specified public health purposes.

How the Rule Works

1. General Public Health Activities.
    a. The Privacy Rule permits CEs to disclose PHI, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability (*see* 45 CFR 164.512(b)(1)(i)). This would include, for example,
        i. The reporting of a disease or injury;
        ii. Reporting vital events, such as births or deaths; and
        iii. Conducting public health surveillance, investigations, or interventions.

b. Also, CEs may, at the direction of a public health authority, disclose PHI to a foreign government agency that is acting in collaboration with a public health authority (*see* 45 CFR 164.512(b)(1)(i)).
c. CEs who are also a public health authority may use, as well as disclose, PHI for these public health purposes (*see* 45 CFR 164.512(b)(2)).
    i. A "public health authority" is an agency or authority of the United States government, a State, a territory, a political subdivision of a State or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency (*see* 45 CFR 164.501).
    ii. Examples of public health authorities include:
        1. State and local health departments;
        2. The Food and Drug Administration (FDA);
        3. The Centers for Disease Control and Prevention (CDC);
        and 4. The Occupational Safety and Health Administration (OSHA).

2. Generally, CEs are required reasonably to limit the PHI disclosed for public health purposes to the minimum amount necessary to accomplish the public health purpose.
    a. CEs are not required to make a minimum necessary determination for public health disclosures that are made pursuant to an individual's authorization, or for disclosures that are required by other law (*see* 45 CFR 164.502(b)).
    b. For disclosures to a public health authority, CEs may reasonably rely on a minimum necessary determination made by the public health authority in requesting the PHI (*see* 45 CFR 164.514(d)(3)(iii)(A)).
    c. For routine and recurring public health disclosures, CEs may develop standard protocols, as part of their minimum necessary policies and procedures, that address the types and amount of PHI that may be disclosed for such purposes (*see* 45 CFR 164.514(d)(3)(i)).

3. Other Public Health Activities.

    a. The Privacy Rule recognizes the important role that persons or entities other than public health authorities play in certain essential public health activities.
    b. Accordingly, the Rule permits CEs to disclose PHI, without authorization, to such persons or entities for the public health activities discussed below.
    c. **Child abuse or neglect**. CEs may disclose PHI to report known or suspected child abuse or neglect, if the report is made to a public health authority or other

appropriate government authority that is authorized by law to receive such reports.

i. For instance, the social services department of a local government might have legal authority to receive reports of child abuse or neglect, in which case, the Privacy Rule would permit a CE to report such cases to that authority without obtaining individual authorization. ii. Likewise, a CE could report such cases to the police department when the police department is authorized by law to receive such reports (*see* 45 CFR 164.512(b)(1)(ii)).

d. **Quality, safety, or effectiveness of a product or activity regulated by the FDA.** CEs may disclose PHI to a person subject to FDA jurisdiction, for public health purposes related to the quality, safety, or effectiveness of an FDA-regulated product or activity for which that person has responsibility. Examples of purposes or activities for which such disclosures may be made include, but are not limited to:

i. Collecting or reporting adverse events (including similar reports regarding food and dietary supplements), product defects or problems (including problems regarding use or labeling), or biological product deviations;

ii. Tracking FDA-regulated products;

iii. Enabling product recalls, repairs, replacement, or lookback (which includes locating and notifying individuals who received recalled or withdrawn products or products that are the subject of lookback); and iv. Conducting post-marketing surveillance.

v. The "person" subject to the jurisdiction of the FDA does not have to be a specific individual.

1. Rather, it can be an individual or an entity, such as a partnership, corporation, or association.
2. CEs may identify the party or parties responsible for an FDA-regulated product from the product label, from written material that accompanies the product (known as labeling), or from sources of labeling, such as the Physician's Desk Reference.
3. *See* 45 CFR 164.512(b)(1)(iii).

e. **Persons at risk of contracting or spreading a disease**. A CE may disclose PHI to a person who is at risk of contracting or spreading a disease or condition if other law authorizes the CE to notify such individuals as necessary to carry out public health interventions or investigations.

i. For example, a CE may disclose PHI as needed to notify a person that (s)he has been exposed to a communicable disease if the CE is legally authorized to do so to prevent or control the spread of the disease.

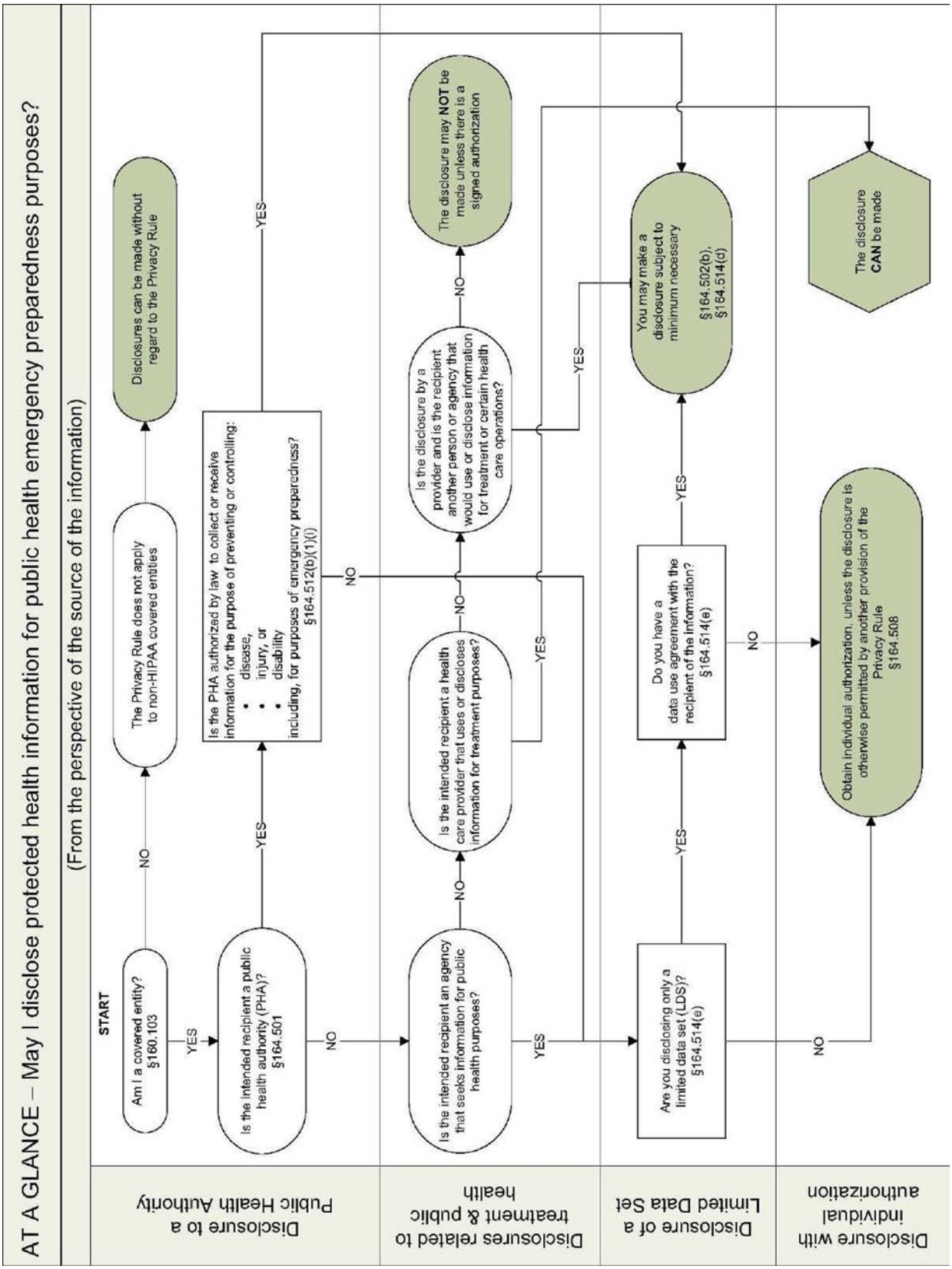
ii. *See* 45 CFR 164.512(b)(1)(iv).

f. Workplace medical surveillance.

i. A CE who provides a healthcare service to an individual at the request of the individual's employer, or provides the service in the capacity of a member of the employer's workforce, may disclose the individual's PHI to the employer for the purposes of workplace medical surveillance or the evaluation of work-related illness and injuries to the extent the employer needs that information to comply with OSHA, the Mine Safety and Health Administration (MSHA), or the requirements of State laws having a similar purpose. ii. The information disclosed must be limited to the provider's findings regarding such medical surveillance or work-related illness or injury. iii. The CE must provide the individual with written notice that the information will be disclosed to his or her employer (or the notice may be posted at the worksite if that is where the service is provided) (*see* 45 CFR 164.512(b)(1)(v)).

Resources and Frequently Asked Questions

1. Privacy Rule FAQs
2. General information on Privacy of Health Information/HIPAA


AT A GLANCE – May I disclose protected health information for public health emergency preparedness purposes?
(From the perspective of the source of the information)
Disclosure to a Public Health Authority
Disclosures related to treatment & public health
Disclosure of a Limited Data Set
Disclosure with individual authorization
START
Am I a covered entity? §160.103
NO
The Privacy Rule does not apply to non-HIPAA covered entities
Disclosures can be made without regard to the Privacy Rule
YES
Is the intended recipient a public health authority (PHA)? §164.501
YES
Is the PHA authorized by law to collect or receive information for the purpose of preventing or controlling:
• disease,
• injury, or
• disability
including, for purposes of emergency preparedness? §164.512(b)(1)(i)
YES
NO
Is the intended recipient an agency that seeks information for public health purposes?
NO
Is the intended recipient a health care provider that uses or discloses information for treatment purposes?
NO
Is the disclosure by a provider and is the recipient another person or agency that would use or disclose information for treatment or certain health care operations?
NO
The disclosure may NOT be made unless there is a signed authorization
YES
YES
YES
Are you disclosing only a limited data set (LDS)? §164.514(e)
YES
Do you have a data use agreement with the recipient of the information? §164.514(e)
YES
You may make a disclosure subject to minimum necessary §164.502(b), §164.514(d)
NO
NO
Obtain individual authorization, unless the disclosure is otherwise permitted by another provision of the Privacy Rule §164.508
The disclosure CAN be made

Appendix G: Evacuation Plan and Checklists. Transportation Agreements

Estimated Number and Types of Vehicles Needed to Evacuate

Vehicle	Supplied By	Date of Contact	MOU Signed Date / Initials	Next Review Date
Ambulance				
Ambulance				
Bus				
Bus				
Bus				
Bus				
Medi-van/care cab				
Medi-van/care cab				
Medi-van/care cab				
Other (Describe)				
Other (Describe)				
Other (Describe)				

Transportation Agreement/Contract Contacts

(Include copies of agreement in the plan)

Company Name	
Contact Person	
Office	
Cell	
Type and # of vehicles	

Evacuation Logistics

Based on your residents' needs, levels of mobility, cognitive abilities, and health status, your LTC community should develop evacuation logistics as part of your Disaster Plan. The following table is an example of such a logistics plan.

Evacuation Plan

Transportation

- **Residents who are independent in ambulation**: will be accompanied by a designated staff member to the designated mode of transportation.
- **Residents who require assistance with ambulation:** will be accompanied by designated staff member to the designated mode of transportation.
- **Residents who are non-ambulatory:** will be transferred by designated staff members via the designated mode of transportation.
- **Residents with cognitive impairments:** will be accompanied by an assigned staff member via the designated mode of transportation.
- **Residents with equipment/prosthetics:** equipment/prosthetics should accompany residents and should be securely stored in the designated mode of transportation.

Medical Records

At a minimum, each resident will be evacuated with the Critical Resident Information.

Medications

Each resident will be evacuated with a minimum of a 3-day supply of medications. If medications require refrigeration, indicate plan to keep medications cool.

Estimated Evacuation Time

Calculate based on the number of residents and estimated time for each based on assistance required.

Resident Tracking

Indicate who is responsible for keeping the log of residents' locations post-evacuation (some situations may require residents going to numerous locations).

Resident Justification

Indicate who is responsible for making a final check and head count of residents to ensure all residents have been evacuated.

Evacuation Checklists

Preparedness: Items potentially needed for evacuation

Check off	Item
	Appropriate ramp to load residents on buses or other vehicles
	First aid kit(s)
	Medical record of some type for residents
	Special legal forms, such as signed treatment authorization forms, do not resuscitate orders, and advance directives
	Clothing with each resident's name on their bag
	Water supply for trip- staff and residents (one gallon/resident/day)
	Emergency drug kit
	Non-prescription medications
	Prescription medications and dosages labeled), to include physician order sheet
	Communications devices: cell phones, walkie-talkies (to communicate among vehicles), 2 way radios, pager, Blackberry, satellite phone, laptop computer for instant messaging, CB radio (bring all you have)
	Air mattresses or other bedding (blankets, sheets, pillows)
	Facility checkbook, credit cards, pre-paid phone cards
	Cash, including quarters for vending machines, laundry machines, etc
	Copies of important papers: insurance policies, titles to land and vehicles, etc.
	List of important phone numbers
	Emergency prep box: trash bags, baggies, yarn, batteries, flashlights, duct tape, string, wire, knife, hammer and nails, pliers, screwdrivers, fix-a-flat, jumper cables, portable tire inflator, tarps, batteries, etc.
	Non perishable food items- staff and residents
	Disposable plates, utensils, cups, straws
	Diet cards
	Rain ponchos
	Battery operated weather radio and extra batteries, to include hearing aid batteries and diabetic pump batteries
	Hand sanitizer
	Incontinence products
	Personal wipes

Check off	Item
	Toiletry items (comb, brush, shampoo, soap, toothpaste, toothbrush, lotion, mouthwash, deodorant, shaving cream, razors, tissues)
	Denture holders/cleansers
	Toilet Paper
	Towels
	Latex Gloves
	Plastic Bags
	Bleach sterilizing cleaner
	Coolers
	Lighters
	Office supplies, such as markers, pens, pencils, tape, scissors, stapler, note pads, etc.
	Laptop computer with charger; Flash drives or CDs with medical records
	Maps – County and State
	Insect Repellant
	Vehicle Emergency Kit (Safety Triangles, road flares, engine oil, transmission fluid, funnels, jumper cables, tow rope or chain, tool kit, etc.)

Response: Prior to Evacuation

Date/Time Completed	Initials	Item
		Determination made of number of residents that must be transported by ambulance, van, car, bus or other method
		Transport services contacted and necessary transportation arranged.
		Receiving facilities contacted and arrangements made for receipt of residents.
		Contact made with facility's medical director and/or the patient's physician
		Necessary staff contacted for assistance in transporting residents and caring for residents at the receiving facility.
		County Emergency Management Agency contacted and informed of the status of the evacuation.
		Roster made of where each patient will be transferred and notify next of kin when possible.
		Residents readied for transfer, with the most critical residents to be transferred first. Include:

Date/Time Completed	Initials	Item
		a. change of clothes
		b. 3 day supply of medications
		c. 3 day supply of medical supplies
		d. patient's medical chart to include next of kin
		e. patient identification, such as a picture, wrist band, identification tag, or other identifying document to ensure residents are not misidentified
		Adequate planning considerations given to needs of residents, such as dialysis patients.
		Adequate planning considerations given to residents on oxygen.
		Adequate planning considerations given to residents using durable medical equipment such as masks, nasal cannulas, colostomy equipment, g-tube, etc.

Sample Resident Profile

Resident Name: _____ AKA _____

DOB _____HT _____WT _____M/F _____

Assistive Devices Used *(Circle all that apply)*

Dentures *Partial or Full*

Cane

Walker

Wheelchair

Eyeglasses

Hearing Aid

Oxygen *Indicate Concentration* _____

Resident Current Photo

Emergency Contact Information

Name: _____Relationship _____

Address: _____Phone _____

Physician

Name: _____

Address: _____ Phone _____

Pertinent Medical Information:

_____
_____
_____
_____

Medications:

Name _____Dosage _____

Name _____Dosage _____

Name _____Dosage _____

Name _____Dosage _____

Name _____Dosage _____

Name _____Dosage _____

Allergies:

_____
_____

Medical Devices:

_____
_____

Pet _____Name _____

Age _____

Sheltering Facility Agreement/Contract Contacts

(Include copies of agreement in the plan)

Company Name	
Contact Person	
Office	
Cell	
Pager	
Will Accept # and Type of Residents	

Appendix H: Facility Shelter-in-Place Plan. Supply and Equipment Lists, and Checklists

Shelter-in-Place Checklists

This checklist is not disaster-specific, so all items will not necessarily be applicable depending on the nature of the disaster

Preparedness

Date Completed	Initials	Item
		Plan in place describing how three days of non-perishable meals are kept on hand for residents and staff. The Plan should include special diet requirements.
		Plan in place describing how 72 hours of potable water is stored and available to residents and staff.
		Plan in place identifying 72 hours of necessary medications that are stored at the facility and how necessary temperature control and security requirements will be meet.
		Plan in place to identify staff that will care for the residents during the event and any transportation requirements that the staff might need and how the facility will meet those needs.
		Plan in place for an alternative power source to the facility such as an onsite generator and describe how 72 hours of fuel will be maintained and stored.
		Alternate power source plan provides for necessary testing of the generator.
		Plan in place describing how the facility will dispose of or store waste and biological waste until normal waste removal is restored.
		Emergency Communications Plan in place, such as for cell phones, hand held radios, pager, Blackberry, satellite phone, laptop computer for instant messaging, HAM radio, etc.
		Adequate planning considerations given to needs of residents, such as dialysis patients.
		Adequate planning considerations given to residents on oxygen.
		Adequate planning considerations given to residents using durable medical equipment such as masks, nasal cannulas, colostomy equipment, g-tube, etc.

Shelter-in-Place Supply and Equipment Checklist

Check	Item
	Emergency Placards
	Non perishable food items- staff and residents
	Disposable plates, utensils, cups and straws
	Battery operated weather radio and extra batteries
	Hand sanitizer
	Drinking water (one gallon per day per person)
	Ice
	Backup generators
	Diesel fuel to supply generators for power and for cooling systems
	Backup supply of gasoline so staff can get to and from work
	Extra means for refrigeration
	Food (staff and residents)
	Medicines – Specific Lists could be made to indicate specific medications and needed quantity
	Medical Supplies- Specific Lists could be made to indicate specific types of medical supplies needed.
	Medical equipment-Specific Lists could be made to indicate specific type and quantity of medical equipment such as oxygen tanks.
	Battery operated weather radio, flashlights and battery operated lights
	Extra batteries, to include hearing aid batteries and diabetic pump batteries
	Toiletry items for staff and residents (comb, brush, shampoo, soap, toothpaste, toothbrush, lotion, mouthwash, deodorant, shaving cream, razors, tissues)
	Hand sanitizer
	Incontinence products
	Personal wipes
	Denture holders/cleansers
	Toilet paper
	Towels
	Latex gloves
	Plastic bags
	Bleach/sterilizing cleaner
	Plastic sheeting for covering broken windows, etc.

	Duct tape
	Hammers
	Nails
	Coolers
	Lighters
	Extension Cords
	Office supplies, such as markers, pens, pencils, tape, scissors, stapler, note pads, etc. – Think of the thinks you would need to do business – Office in a box
	Laptop computer with charger; Flash drives or CDs with medical records, portable printer if possible

Response

Notes: Some actions are dependent upon the nature of the disaster.

Date / Time Completed	Initials	Item
		Condition of residents being monitored continuously, particularly those with respiratory problems, and provide oxygen or suitable assistance.
		Windows and exterior doors are closed
		Air intake vents and units in bathrooms, kitchen, laundry, and other rooms closed
		Heating, cooling, and ventilation systems that take in outside air, both central and individual room units turned off. (Units that only re-circulate inside air may have to be kept running during very cold or very hot weather to avoid harm to residents)
		Food, water, and medications covered and protected from airborne contamination and from contact with waste materials, including infectious waste.
		Contact with emergency authorities regarding the hazard and internal conditions.
		Contact public health authorities for advice regarding the need for decontamination, and the means for doing it.
		Standby vehicles with pre-filled fuel tanks stationed on the highest point of ground nearby. (Flooding or High Water)
		Trained staff available who can remain at the facility for at least 72 hours, especially to manage non-ambulatory residents or others with additional needs.
		Support teams available on standby with communications equipment in order to assist in getting additional supplies.

		Medical equipment, medicines, refrigerators, stoves, food and water, supplies, beds, desks and chairs moved to a second floor location or raised off the floor to ensure protection against possible flooding.

Appendix I: MOU Templates

Sample Memoranda of Agreements

Agreement to Provide Facilities for Temporary Shelter

(Sample MOU use for an alternate site)

THIS AGREEMENT (Agreement) is entered into as of this _____ day of ____ 20 _____ by and between, (the FACILITY) and _____ , (the SHELTER) for the provision of physical facilities to serve as a temporary shelter for the residents of the FACILITY in the event of the need for emergency evacuation of the FACILITY.

RECITALS

A. The FACILITY is a [type of facility], with census at full capacity of [number of residents]
B. The SHELTER is a [describe], that has the capacity to temporarily accommodate [number of residents], and the Facility's staff who care for those residents.

AGREEMENT

In consideration of the mutual promises in this Agreement, The FACILITY and the SHELTER agree as follows:

1. **Nature of Services.** The SHELTER is not a nursing facility, health care facility, or residential facility licensed by the State of Alabama.
   1.1. The SHELTER will provide the following physical facilities to the FACILITY on a temporary basis:
      1.1.1. Space sufficient to accommodate ___ beds, sleeping arrangements, residents, and the FACILITY staff who provide care for the residents.
      1.1.2. Restrooms
      1.1.3. Electricity to provide light and to supply power to necessary medical devices and/or equipment to care for the residents.
      1.1.4. A potable water source or space to accommodate water reserves.
   1.2. The SHELTER's physical facilities will only include the aforementioned services and do not include:
      1.2.1. Staffing
      1.2.2. Supplies
      1.2.3. Medical care
      1.2.4. Food or water (other than city services)

1.2.5. Clothing

1.2.6. Beds or linen

1.2.7. Transportation

1.3. The FACILITY will be responsible for providing food, clothing, beds, linen, appropriate medical and other supplies, transportation, appropriate equipment, staff, and medication (if appropriate) or arranging for these services and provisions.

2. **Availability of SHELTER.** As part of the emergency nature of the services required by the FACILITY, the SHELTER agrees to be available as provided in the AGREEMENT at any time, 24hours/day, seven days/week.

2.1. The FACILITY will designate a contact person (or designee) who will notify the SHELTER of the need for its services.

2.2. The SHELTER will designate a contact person (or designee) who will ensure that the SHELTER is available for use by the FACILITY in the case of an emergency at any time, 24 hours/day, seven days/week.

2.3. In the alternative, the SHELTER and the FACILITY will agree on a designated contact person or designee who will have access to the SHELTER in the event of an emergency at any time, 24 hours/day, seven days/week.

2.4. In the event of an emergency, the services of the SHELTER will be necessary only until it has been deemed safe for the residents to return to the FACILITY, or the residents have been placed in an alternative setting.

2.5. The FACILITY agrees to make a good faith effort to utilize the SHELTER only as long as necessary and make a good faith effort to transfer residents to alternative placement as quickly as safely possible.

3. **Insurance coverage.** The SHELTER agrees to maintain premises liability insurance.

4. **Indemnification.** The SHELTER and the FACILITY agree to indemnify and hold each other harmless for all claims and damages for all negligent acts or omissions arising out of or as a result of the performance of this AGREEMENT.

5. **Fees.** The FACILITY agrees to pay the SHELTER at a rate of $_____.00 per month to maintain the SHELTER in a position to accommodate all the terms of this AGREEMENT.

5.1. The FACILITY agrees to reimburse the SHELTER for additional expenses incurred during the use of its facilities.

6. **Entire Agreement.** This Agreement contains the entire Agreement between parties.

6.1. Any amendments to this Agreement must be made in writing and signed by both parties.

7. **Applicable Law.** This Agreement and any disputes relating to it shall be construed under Alabama law.

7.1. If any of the provisions in this Agreement are determined to be in violation of State or Federal law, said provisions shall be interpreted so as to be in compliance with such law or said provisions shall fall out of this Agreement, but otherwise, the Agreement shall be unaffected and shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the date stated above.

[NAME OF FACILITY]

By: _____

Its: Administrator _____

[NAME OF SHELTER]

By: _____

Its: _____

Sample Mutual Aid Transfer Agreement Between LTC Facilities

"The following long-term care community agree to accept residents from other facilities (specify) in the event of a disaster. A disaster is any event, natural, man-made or technological, that the community determines that a partial or full evacuation is necessary.

"This transfer would not exceed the receiving community's total bed capacity on a long-term basis.

"All facilities involved in a transfer during a disaster will be responsible for contacting the Alabama Department of Public Health and the Alabama Medicaid Agency for decisions regarding Medicare/Medicaid reimbursement and any other issue.

"The facilities involved in transferring residents during a disaster will mutually determine the beds available, whether special needs and resident choice can be accommodated.

"All employees of the transferring community will remain employees of the transferring community for the purpose of worker's compensation insurance.

"The receiving community will distribute community policies and procedures and information on emergency plans to employees of the transferring community. The receiving community will assign all employees to work with the transferring community personnel.

"Medical records will be evacuated as discussed in each community's emergency plan.

"This agreement will renew automatically annually unless prior written 30-day notice is given."

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the date stated above.

[NAME OF FACILITY]

By: _____

Its: Administrator _____

[NAME OF SHELTER]

By: _____

Its: _____

Appendix J: Recovery Checklists

Recovery Checklist: Prior to Re-opening

Date Completed	Initials	Item
		Recovery operations coordinated with county emergency management agency.
		Recovery operations coordinated with local jurisdictions/agencies to restore normal operations.
		Recovery operations coordinated with authorities to perform search and rescue if necessary
		Recovery operations coordinated with applicable jurisdiction to reestablish essential services.
		Crisis counseling for provided residents/families as needed.
		Local and state authorities provided with a master list of displaced, injured or deceased residents.
		Next-of-kin notified of displaced, injured or deceased residents.
		Insurance agent contacted.
		Hazard evaluation conducted prior to re-entry, to include potential structural damage, environmental concerns and items that can affect staff, volunteers, residents and appropriate personnel.
		Inventory taken of damaged goods.
		Protective measures taken for undamaged property, supplies and equipment.
		Access- safe access and egress assured for staff, deliveries, and ambulances.
		Building declared safe for occupancy by appropriate regulatory agency.
		Building- Fire-fighting services available including sprinklers, standpipes, alarms, etc.
		Building- Pest control/containment procedures in effect.
		Building- Adequate environmental control systems in place.
		Internal communication system functional and adequate.
		Internal Communications- Emergency call system functional and adequate.
		Internal Communications- Fire alarms system(s) functional and adequate.

Date Completed	Initials	Item
		Internal Communications- Notifications made to staff regarding status of communication system(s).
		External Communications- functional to call for assistance (to fire, police, etc.).
		External Communications- Notifications made to staff regarding status of communication system(s).
		Dialysis Patients- water supply and other system components adequate and functional.
		Dietary- adequate facilities, personnel & supplies onsite.
		Dietary- adequate refrigeration for storage of food and dietary supplies.
		Dietary- food approved for re-use by appropriate agency if applicable
		Electrical Systems- Main switchboard, utility transfer switches, fuses and breakers operational.
		Electrical Systems- transformers reviewed.
		Electrical Systems- emergency generators, backup batteries and fuel available where needed. Transfer switches in working order. Sufficient fuel available for generators.
		Equipment & supplies located in flooded or damaged areas approved or not approved for reuse.
		Equipment & supplies- including oxygen- adequate available onsite.
		Equipment & supplies- plan in place to replenish.
		Equipment & supplies- equipment inspected and cleared prior to patient use.
		Equipment & supplies- ability to maintain patient care equipment that is in use.
		Equipment & supplies-flashlights and batteries (including radio and ventilator batteries) available.
		Facilities/Engineering- Cooling Plant operational
		Facilities/Engineering-Heating Plant operational
		Facilities/Engineering- Distribution System (ductwork, piping, valves and controls, filtration, etc.) operational.
		Facilities/Engineering- Treatment Chemicals (Water treatment, boiler treatment) operational.
		Infection Control- Procedures in place to prevent, identify, and contain infections and communicable diseases.
		Infection Control-Procedures and mechanisms in place to isolate and prevent contamination from unused portions of facility.

Date Completed	Initials	Item
		Infection Control- adequate staff and resources to maintain a sanitary environment.
		Infection Control- process in place to segregate discarded, contaminated supplies, medications, etc. prior to reopening of facility.
		Information Technology /Medical Records – systems or backup systems in place.
		Management- adequate management staff available
		Personnel- adequate types and numbers available.
		Security- adequate staff available.
		Security- adequate systems available.
		Waste Management- System in place for trash handling.
		Waste Management- System in place for handling hazardous and medical waste.
		Water systems- potable water for drinking, bathing, dietary service, patient services.
		Water systems- sewer system adequate
		Water systems- available and operational for fire suppression

Recovery Checklist: Re-opening the Facility

Date Completed	Initials	Item
		Repairs and maintenance complete
		Emergency exits, fire extinguishers, carbon monoxide detectors, smoke alarms and other critical systems are working
		Back-up generator working
		Air conditioning/heat working
		Adequate, rested staff available
		Counselors available to staff and residents
		Adequate medical, clinical, personal care, food and water, and building supplies delivered and available
		Residents' families notified of re-opening
		Local authorities (police and fire) notified
		State authorities ADPH – Provider Services notified
		Check to see if other services in community are up and running such as local hospital and pharmacy

Appendix K: Staff Care Plan Documentation

Disaster Family Care Plan (Staff)

Name: _____

Department: _____

Location/Shift: _____

In the event of a major emergency in which I will not be able to go home and care for my family or pets, please call the individual(s) listed below and provide them with the instructions regarding the emergency.

Alternate Caregiver #1:
Name: _____

Address: _____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

Alternate Caregiver #2:
Name: _____

Address: _____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

Location of children or other dependents:

Name	**School/Daycare Facility**	**Telephone/Cell Phone Numbers**	**Medications**	**Allergies**

Other pertinent information:

_____

Signature and Date

Appendix L: Exercise, Evaluation, and Improvement Planning Checklist. AARIP

Exercise, Evaluation, and Improvement Planning Checklist

Plans, policies and procedures are tested at least annually in one or more exercises that are evaluated and result in corrective actions for plan improvement.

Emergency Response Plan

Date	Initials	Tasks
		Review and update your facilities Hazard and Vulnerabilities Assessment (HVA) annually.
		Review your Emergency Operations Plan (EOP) for updating to meet your current needs and identify gaps annually.
		Review and update all Memorandums of Understanding (MOU) with response services such as sheltering facilities, transportation, and emergency medical services (EMS), annually.

		Distribute the EOP to your staff and identify where it is located in your facility. Include distribution and coordination with appropriate emergency response partners.

Providing Trained Staff

Date	Initials	Tasks
		Identify staff for emergency roles and responsibilities. Update their personal contact information as needed.
		Have your staff update their personal family emergency plans annually.
		Conduct training seminars and workshops annually to familiarize staff with the EOP especially the Evacuation Plan part of the EOP.
		Plan an announced staff notification drill then conduct unannounced drills once each quarter. After each drill, evaluate the numbers contacted and how quickly they responded and try to improve on the next drill.
		Identify the equipment and methods used for communication with your staff, patients, and emergency responders during an incident.
		Update emergency response contact information: phone numbers, and contracted sheltering facilities annually.

Appendix L: Exercise, Evaluation, and Improvement Planning Checklist. AAR-IP

Test all equipment

Date	Initials	Tasks
		Phones, computer systems, alarms, general addressing systems, 2-way radios, 800 MHz radios, ham radios (all that apply)
		Facility power generators, emergency lighting systems, flashlights

Conduct exercises to demonstrate plans and procedures in an exercise or real response

Date	Initials	Tasks

		Identify equipment, plans, or procedures that need to be tested or demonstrated
		Identify staff who would gain experience in their response role.
		Plan one or more drills for testing equipment, notification procedures, and other standard operating procedures annually.
		Plan a seminar to share the EOP and any policy, plan, or procedural changes with your staff.
		Plan a workshop to bring together key staff to develop or improve a procedure or plan.
		Plan a tabletop discussion exercise to demonstrate how your all-hazard plans, policies, or procedures would apply to a specific type of incident and for your staff to gain experience. Evaluate and improve your plan.
		Plan a functional exercise to demonstrate a part of your plan, test a procedure, and give additional experience to your staff. Evaluate and improve your plan
		Hold a full-scale exercise with your response staff and/or with other response partners to test your planned response to a specific type of incident. Evaluate and improve your plan.
		Develop a one-year or multiple-year training and exercise plan to provide a timeline for accomplishing your training goals
		Track the completion of corrective actions from your exercise after action reports in a facility-wide improvement plan.

Appendix M: Important Resources

Important Contact Information and Resources

Alabama Emergency Management County Emergency Manager Listing: This link will provide county by county listings of emergency management based on your location.
https://ema.alabama.gov/county-ema-directory/

Alabama Healthcare Planning Disaster Guide:
http://www.adph.org/cep/assets/alhealthcaredisastplanguide.pdf

Alabama Incident Management System (AIMS):
https://al.aimslive.org/Session/New?ReturnUrl=%2f

Centers for Medicare and Medicaid Services Emergency Preparedness Requirements
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html
Includes the following:

- Facility Transfer Agreement - Example
- 17 Facility- Provider Supplier Types Impacted
- Frequently Asked Questions (FAQs) Round One
- Frequently Asked Questions (FAQs) Round Two Revised 6-1-17
- Frequently Asked Questions (FAQs) Round Three Revised 6-1-17
- Frequently Asked Questions (FAQs) Round Four
- Frequently Asked Questions Round Four Definitions
- Frequently Asked Questions (FAQs) Round Five
- General Presentation - Overview of EP
- Advanced Copy-Emergency Prep Interpretive Guidelines
- Surveyor Tool- EP Tags
- CMS Online Training for Emergency Preparedness

TRACIE
The Department of Health and Human Services ASPR **TRACIE (**Technical Resources, Assistance Center, and Information Exchange) is a healthcare preparedness information gateway that provides access to information and resources to improve preparedness and resiliency.
https://asprtracie.s3.amazonaws.com/documents/cms-ep-rule-resources-at-your-fingertips.pdf

Alabama Emergency Management Agency
https://ema.alabama.gov/

Centers for Medicare and Medicaid Services (CMS) State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_z_emergprep.pdf

Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Basic Training Surveyor Course
https://surveyortraining.cms.hhs.gov/pubs/CourseMenu.aspx?cid=0CMSEmPrep_ONL

Appendix N: Active Shooter Resources

Incorporating Active Shooter Incident Planning Into Health Care Facility Emergency Operations Plans
https://www.phe.gov/preparedness/planning/Documents/active-shooter-planning-eop2014.pdf

IAEMSC Active Shooter Planning and Response in a Healthcare Facility
https://iaemsc.org/index.php?option=com_content&view=article&id=129:active-shooter-planning-and-response-in-a-healthcare-facility&catid=26&Itemid=353

PSQH Protecting your Patients: Violence and Active Shooters
https://www.psqh.com/analysis/protecting-patients-violence-active-shooters/

Active Shooter Planning And Response In A Healthcare Setting
https://www.fbi.gov/file-repository/active_shooter_planning_and_response_in_a_healthcare_setting.pdf/view

NAME OF FACILITY: _____

DATE OF SURVEY: _____ LONG TERM CARE FACILITIES PROVIDER NUMBER: _____

		EMERGENCY PREPAREDNESS REQUIREMENTS			LONG TERM CARE FACILITIES
Tag #	Title	Tag Text (Regulatory Text)	MET	NOT MET	REMARKS
E0001	Establishment of the Emergency Program (EP)	The facility must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.*			483.73
E0004	Develop and Maintain EP Program	[The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.			483.73(a)
E0006	Maintain and Annual EP Updates	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			483.73(a)(1)-(2)
E0007	EP Program Patient Population	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**			483.73(a)(3)
E0009	Process for EP Collaboration	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. **			483.73(a)(4)

		EMERGENCY PREPAREDNESS REQUIREMENTS			LONG TERM CARE FACILITIES
Tag #	Title	Tag Text (Regulatory Text)	MET	NOT MET	REMARKS
E0013	Development of EP Policies and Procedures	(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.			483.73 (b)
E0015	Subsistence needs for staff and patients	[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.			483.73 (b)(1)
E0018	Procedures for Tracking of Staff and Patients	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For LTC at §483.73(b), ICF/IIDs at §483.475(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [LTC or ICF/IID] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [LTC or ICF/IID] must document the specific name and location of the receiving facility or other location.			483.73 (b)(2)
E0020	Policies and Procedures including Evacuation	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.			483.73 (b)(3)

Tag #	Title	EMERGENCY PREPAREDNESS REQUIREMENTS Tag Text (Regulatory Text)	MET	NOT MET	LONG TERM CARE FACILITIES REMARKS
E0022	Policies and Procedures for Sheltering	(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility].			483.73(b)(4)
E0023	Policies and Procedures for Medical Docs.	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.			483.73(b)(5)
E0024	Policies and Procedures for Volunteers	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.			483.73(b)(6)
E0025	Arrangement with other Facilities	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] *[For LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.			483.73(b)(7)

Tag #	Title	EMERGENCY PREPAREDNESS REQUIREMENTS Tag Text (Regulatory Text)	MET	NOT MET	LONG TERM CARE FACILITIES REMARKS
E0026	Roles under a Waiver Declared by Secretary	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.			483.73(b)(8)
E0029	Development of Communication Plan	(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.			483.73(c)
E0030	Names and Contact Information	[(c) The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.			483.73(c)(1)
E0031	Emergency Officials Contact Information	[(c) The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.			483.73(c)(2)

		EMERGENCY PREPAREDNESS REQUIREMENTS			LONG TERM CARE FACILITIES
Tag #	Title	Tag Text (Regulatory Text)	MET	NOT MET	REMARKS
E0032	Primary/Alternate Means for Communication	[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.			483.73(c)(3)
E0033	Methods for Sharing Information	[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).			483.73(c)(4)-(6)
E0034	Sharing Information on Occupancy/Needs	[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.			483.73(c)(7)
E0035	LTC and ICF/IID Family Notifications	[(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.			483.73(c)(8)

		EMERGENCY PREPAREDNESS REQUIREMENTS			LONG TERM CARE FACILITIES
Tag #	Title	Tag Text (Regulatory Text)	MET	NOT MET	REMARKS
E0036	Emergency Prep Training and Testing	(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).			483.73 (d)
E0037	Emergency Prep Training Program	(1) Training program. The facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.			483.73 (d) (1)
E0039	Emergency Prep Testing Requirements	(2) Testing. *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			483.73 (d) (2)

		EMERGENCY PREPAREDNESS REQUIREMENTS			LONG TERM CARE FACILITIES
Tag #	Title	Tag Text (Regulatory Text)	MET	NOT MET	REMARKS
E0041	LTC Emergency Power	§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [LTC facility] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.			483.73(e)
		*[For LTC at §483.73(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12–2 to NFPA 99, issued August 11, 2011. (iii) TIA 12–3 to NFPA 99, issued August 9, 2012. (iv) TIA 12–4 to NFPA 99, issued March 7, 2013. (v) TIA 12–5 to NFPA 99, issued August 1, 2013. (vi) TIA 12–6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12–1 to NFPA 101, issued August 11, 2011. (ix) TIA 12–2 to NFPA 101, issued October 30, 2012. (x) TIA 12–3 to NFPA 101, issued October 22, 2013. (xi) TIA 12–4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.			

		EMERGENCY PREPAREDNESS REQUIREMENTS			LONG TERM CARE FACILITIES
Tag #	Title	Tag Text (Regulatory Text)	MET	NOT MET	REMARKS
E0042	Integrated Health Systems	(e) [or (f)]Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:] (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.			483.73 (f)

ADPH E-Tag Descriptions

E-0001

Under this condition/requirement, facilities are required to develop an emergency preparedness program that meets all of the standards specified within the condition/requirement. The emergency preparedness program must describe a facility's comprehensive approach to meeting the health, safety, and security needs of their staff and patient population during an emergency or disaster situation. The program must also address how the facility would coordinate with other healthcare facilities, as well as the 6 whole communities during an emergency or disaster (natural, man-made, facility). The emergency preparedness program must be reviewed annually. A comprehensive approach to meeting the health and safety needs of a patient population should encompass the elements for emergency preparedness planning based on the "all hazards" definition and specific to the location of the facility. For instance, a facility in a large flood zone, or tornado prone region should have included these elements in their overall planning in order to meet the health, safety and security needs of the staff and of the patient population. Additionally, if the patient population has limited mobility, facilities should have an approach to address these challenges during emergency events. The term "comprehensive" in this requirement is to ensure that facilities do not only choose one potential emergency that may occur in their area, but rather consider a multitude of events and be able to demonstrate that they have considered this during their development of the emergency preparedness plan.

E-0004

Facilities are required to develop and maintain an emergency preparedness plan. The plan must include all of the required elements under the standard. The plan must be reviewed and updated at least annually. The annual review must be documented to include the date of the review and any updates made to the emergency plan based on the review. The format of the emergency preparedness plan that a facility uses is at its discretion. An emergency plan is one part of a facility's emergency preparedness program. The plan provides the framework, which includes conducting facility-based and community- based risk assessments that will assist a facility in addressing the needs of their patient populations, along with identifying the continuity of business operations which will provide support during an actual emergency. In addition, the emergency plan supports, guides, and ensures a facility's ability to collaborate with local emergency preparedness officials. This approach is specific to the location of the facility and considers particular hazards most likely to occur in the surrounding area. These include, but are not limited to:

• Natural disasters • Man-made disasters, • Facility-based disasters that include but are not limited to: Care-related emergencies; • Equipment and utility failures, including but not limited to power, water, gas, etc.; • Interruptions in communication, including cyber-attacks; • Loss of all or portion of a facility; and • Interruptions to the normal supply of essential resources, such as water, food, fuel (heating, cooking, and generators), and in some cases, medications and medical supplies (including medical gases, if applicable). When evaluating potential interruptions to the normal supply of essential services, the facility should take into account the likely durations of such interruptions. Arrangements or contracts to re-establish essential utility services during an emergency should describe the timeframe within which the contractor is required to initiate services after the start of the emergency, how they will be procured and delivered in the facility's local area, and that the contractor will continue to supply the essential items throughout and to the end of emergencies of varying duration.

E-0006

Facilities are expected to develop an emergency preparedness plan that is based on the facility-based and community-based risk assessment using an "all-hazards" approach. Facilities must document both risk assessments. An example consideration may include, but is not limited to, natural disasters prevalent in a facility's geographic region such as wildfires, tornados, flooding, etc. An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to the location of the facility considering the types of hazards most likely to occur in the area. Thus, all-hazards planning does not specifically address every possible threat or risk but ensures the facility will have the capacity to address a broad range of related emergencies. Facilities are encouraged to utilize the concepts outlined in the 11National Preparedness System, published by the United States Department of Homeland Security's Federal Emergency Management Agency {FEMA), as well as guidance provided by the Agency for Healthcare Research and Quality {AHRQ). "Community" is not defined in order to afford facilities the flexibility in deciding which healthcare facilities and agencies it considers to be part of its community for emergency planning purposes. However, the term could mean entities within a state or multi-state region. The goal of the provision is to ensure that healthcare providers collaborate with other entities within a given community to promote an integrated response. Conducting integrated planning with state and local entities could identify potential gaps in state and local capabilities that can then be addressed in advance of an emergency. Facilities may rely on a community-based risk assessment developed by other entities such as public health agencies,

emergency management agencies, and regional health care coalitions or in conjunction with conducting its own facility-based assessment. If this approach is used, facilities are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure that the facility's emergency plan is in alignment. When developing an emergency preparedness plan, facilities are expected to consider, among other things, the following: • Identification of all business functions essential to the facility's operations that should be continued during an emergency; • Identification of all risks or emergencies that the facility may reasonably expect to confront; • Identification of all contingencies for which the facility should plan; • Consideration of the facility's location; • Assessment of the extent to which natural or man-made emergencies may cause the facility to cease or limit operations; and, • Determination of what arrangements may be necessary with other health care facilities, or other entities that might be needed to ensure that essential services could be provided during an emergency. In situations where the facility does not own the structure(s) where care is provided, it is the facility's responsibility to discuss emergency preparedness concerns with the landlord to ensure continuation of care if the structure of the building and its utilities are impacted. For LTC facilities and ICF/IIDs, written plans and the procedures are required to also include missing residents and clients, respectively, within their emergency plans. Facilities must develop strategies for addressing emergency events that were identified during the development of the facility- and community-based risk assessments. Examples of these strategies may include, but are not limited to, developing a staffing strategy if staff shortages were identified during the risk assessment or developing a surge capacity strategy if the facility has identified it would likely be requested to accept additional patients during an emergency. Facilities will also want to consider evacuation plans. For example, a facility in a large metropolitan city may plan to utilize the support of other large community facilities as alternate care sites for its patients if the facility needs to be evacuated. The facility is also expected to have a backup evacuation plan for instances in which nearby facilities are also affected by the emergency and are unable to receive patients Hospices must include contingencies for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

E-0007

The emergency plan must specify the population served within the facility, such as inpatients and/or outpatients, and their unique vulnerabilities in the event of an emergency or disaster. A facility's emergency plan must also address persons at-risk, except for plans of ASCs, hospices, PACE organizations, HHAs, CORFs, CMHCs, RHCs/FQHCs and ESRD facilities. As defined by the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006, members of at-risk populations

may have additional needs in one or more of the following functional areas: maintaining independence, communication, transportation, supervision, and medical care. In addition to those individuals specifically recognized as at-risk in the PAHPA (children, senior citizens, and pregnant women), "at-risk populations" are also individuals who may need additional response assistance including those who have disabilities, live in institutionalized settings, are from diverse cultures and racial and ethnic backgrounds, have limited English proficiency or are non-English speaking, lack transportation, have chronic medical disorders, or have pharmacological dependency. At-risk populations would also include, but are not limited to, the elderly, persons in hospitals and nursing homes, people with physical and mental disabilities as well as others with access and functional needs, and infants and children. Mobility is an important part in effective and timely evacuations, and therefore facilities are expected to properly plan to identify patients who would require additional assistance, ensure that means for transport are accessible and available and that those involved in transport, as well as the patients and residents are made aware of the procedures to evacuate. For outpatient facilities, such as Home Health Agencies (HHAs), the emergency plan is required to ensure that patients with limited mobility are addressed within the plan. The emergency plan must also address the types of services that the facility would be able to provide in an emergency. The emergency plan must identify which staff would assume specific roles in another's absence through succession planning and delegations of authority. Succession planning is a process for identifying and developing internal people with the potential to fill key business leadership positions in the company. Succession planning increases the availability of experienced and capable employees that are prepared to assume these roles as they become available. During times of emergency, facilities must have employees who are capable of assuming various critical roles in the event that current staff and leadership are not available. At a minimum, there should be a qualified person who "is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility." In addition to the facility- and community-based risk assessment, continuity of operations planning generally considers elements such as: essential personnel, essential functions, critical resources, vital records and IT data protection, alternate facility identification and location, and financial resources. Facilities are encouraged to refer to and utilize resources from various agencies such as FEMA and Assistant Secretary for Preparedness and Response (ASPR) when developing strategies for ensuring continuity of operations. Facilities are encouraged to refer to and utilize resources from various agencies such as FEMA and ASPR when developing strategies for ensuring continuity of operations.

E-0009

While the responsibility for ensuring a coordinated disaster preparedness response lies upon the state and local emergency planning authorities, the facility must document its efforts to contact these officials to engage in collaborative planning for an integrated emergency response. The facility must include this integrated response process in its emergency plan. Facilities are encouraged to participate in a healthcare coalition as it may provide assistance in planning and addressing broader community needs that may also be supported by local health department and emergency management resources. For ESRD facilities,§494.120(c)(2) of the ESRD Conditions for Coverage on Special Purpose Dialysis Facilities describes the requirements for ESRD facilities that are set up in an emergency (i.e., an emergency circumstance facility) which are issued a unique CMS Certification Number (CCN). ESRD facilities must incorporate these specific provisions into the coordination requirements under this standard. Survey Procedures Interview facility leadership and ask them to describe their process for ensuring cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation. • Ask for documentation of the facility's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts. • For ESRD facilities, ask to see documentation that the ESRD facility contacted the local public health and emergency management agency public official at least annually to confirm that the agency is aware of the ESRD facility's needs in the event of an emergency and know how to contact the agencies in the event of an emergency.

E-0013

Facilities must develop and implement policies and procedures per the requirements of this standard. The policies and procedures are expected to align with the identified hazards within the facility's risk assessment and the facility's overall emergency preparedness program. We are not specifying where the facility must have the emergency preparedness policies and procedures. A facility may choose whether to incorporate the emergency policies and procedures within their emergency plan or to be part of the facility's Standard Operating Procedures or Operating Manual. However, the facility must be able to demonstrate compliance upon survey, therefore we recommend that facilities have a central place to house the emergency preparedness program documents (to include all policies and procedures} to facilitate review.

E-0015

Facilities must be able to provide for adequate subsistence for all patients and staff for the duration of an emergency or until all its patients has been evacuated and its operations cease. Facilities have flexibility in identifying their individual subsistence needs that would be required during an emergency. There are no set requirements or standards for the amount of provisions to be provided in facilities, Provisions include, but are not limited to, food, pharmaceuticals and medical supplies. Provisions should be stored in an area which is less likely to be affected by disaster, such as storing these resources above und-level to protect from possible flooding. Additionally, when inpatient facilities determine their supply needs, they are expected to consider the possibility that volunteers. visitors, and individuals from the community may arrive at the facility to offer assistance or seek shelter. Alternate sources of energy depend on the resources available to a facility, such as battery-operated lights, or heating and cooling, in order to meet the needs of a facility during an emergency. Facilities are not required to upgrade their electrical systems, but after review of their risk assessment, facilities may find it prudent to make any necessary adjustments to ensure that occupants health and safety needs are met, and that facilities maintain safe and sanitary storage areas for provisions.

Maintain safe and sanitary storage areas for provisions. This specific standard does not require facilities to have or install generators or any other specific type of energy source. (However, for hospitals at §482. S{e), CAHs at §485.625(e) and LTC facilities at §483.73(e) please also refer to Tag E-0041 for Emergency and Stand-by Power Systems.) It is up to each individual facility, based on its risk assessment, to determine the most appropriate alternate energy sources to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, and alarm systems and sewage and waste disposal. Whatever alternate sources of energy a facility chooses to utilize must be in accordance with local and state laws as well as relevant LSC requirements. Facilities must establish policies and procedures that determine how required heating and cooling of their facility will be maintained during an emergency situation, as necessary, if there were a loss of the primary power source. If a facility determines the best way to maintain temperatures, emergency lighting, fire detection and extinguishing systems and sewage and provisions, such as generator testing and fuel storage, etc. outlined under the NFPA guidelines would not be applicable. Portable generators should be operated, tested, and maintained in accordance with manufacturer, local and/or State requirements. If a facility, however, chooses to utilize a permanent generator to maintain emergency

power, LSC provisions such as 23 generator testing and maintenance will apply and the facility may be subject to LSC surveys to ensure compliance is met. As an example, some ESRD facilities have contracted services with companies who maintain portable emergency generators for the facilities off-site. In the event of an emergency where the facility is unable to reschedule patients or evacuate, the generators are brought to the location in advance to assist in the event of loss of power. Facilities who are not specifically required by the EP Final Rule to have a generator, but are required to meet provision for an alternate sources of energy, may consider this approach for their facility. Facilities are encouraged to confer with local health department and emergency management officials, as well as and healthcare coalitions, where available, to determine the types and duration of energy sources that could be available to assist them in providing care to their patient population during an emergency. As part of the risk assessment planning, facilities should determine the feasibility of relying on these sources and plan accordingly. Facilities are not required to provide onsite treatment of sewage but must make provisions for maintaining necessary services. For example, LTC facilities are already required to meet Food Receiving and Storage provisions at §483.35(i) Sanitary Conditions, which contain requirements for keeping food off the floor and clear of ceiling sprinklers, sewer/waste disposal pipes, and vents can also help maintain food quality and prevent contamination. Additionally, ESRD facilities under current CfCs at §494.40{a)(4) are also required to have policies and procedures for handling, storage and disposal of potentially infectious waste. We are not specifying any required provisions regarding treatment of sewage and necessary services under this tag; however, facilities are required to follow their current facility-type requirements (e.g., CoPs/CfCs, Requirements) which may address these areas. Additionally, we would expect facilities under this requirement to ensure current practices are followed, such as those outlined by the Environmental Protection Agency (EPA) and under State-specific laws. Maintaining necessary services may include, but are not limited to, access to medical gases; treatment of soiled linens; disposal of bio-hazard materials for different infectious diseases; and may require additional assistance from transportation companies for safe and appropriate disposal in accordance with nationally accepted industry guidelines for emergency preparedness.

E-0018

Facilities must develop a means to track patients and on-duty staff in the facility's care during an emergency event. In the event staff and patients are relocated, the facility must document the specific name and location of the receiving facility or other location

for sheltered patients and on-duty staff who leave the facility during the emergency. CMHCs, PRTF's, LTC facilities, lCF/llDs, PACE organizations and ESRD Facilities are required to track the location of sheltered patients and staff during and after an emergency.27 We are not specifying which type of tracking system should be used; rather, a facility has the flexibility to determine how best to track patients and staff, whether it uses an electronic database, hard copy documentation, or some other method. However, it is important that the information be readily available, accurate, and shareable among officials within and across the emergency response systems as needed in the interest of the patient. It is recommended that a facility that is using an electronic database consider backing up its computer system with a secondary source, such as hard copy documentation in the event of power outages. The tracking systems set up by facilities may want to consider who is responsible for compiling/securing patient records and what information is needed during tracking a patient throughout an evacuation. A number of states already have such tracking systems in place or under development and the systems are available for use by health care providers and suppliers. Facilities are encouraged to leverage the support and resources available to them through local and national healthcare systems, healthcare coalitions, and healthcare organizations for resources and tools for tracking patients. Facilities are not required to track the location of patients who have voluntarily left on their own, or have been appropriately discharged, since they are no longer in the facility's care. However, this information must be documented in the patient's medical record should any questions later arise as to the patient's whereabouts. Note: If an ASC is able to cancel surgeries and close {meaning there are no patients or staff in the ASC), this requirement of tracking patients and staff would no longer be applicable. Similarly to ESRD standard practices, if an emergency was imminent and able to be predicted {i.e. inclement weather conditions, etc.) we would expect that ASCs cancel surgeries and cease operations, which would eliminate the need to track patients and staff

E-0020

Facilities must develop policies and procedures that provide for the safe evacuation of patients from the facility and include a!! of the requirements of this standard. RHCs and FQHCs must also place exit signs to guide patients and staff in the event of an evacuation from the facility. Facilities must have policies and procedures which address the needs of evacuees. The facility should also consider in development of the policies and procedures, the evacuation protocols for not only the evacuees, but also staff members and families/patient representatives or other personnel who sought potential refuge at the facility. Additionally, the policies and procedures must address staff responsibilities during

evacuations. Facilities must consider the patient population needs as well as their care and treatment. For example, if an evacuation is in progress and the facility must evacuate, leadership should consider the needs for critically ill patients to be evacuated and accompanied by staff who could provide care and treatment in route to the designated relocation site, in the event trained medical professionals are unavailable by the transportation services. Facilities must consider in their development of policies and procedures, the needs of their patient population and what designated transportation services would be most appropriate. For instance, if a facility primarily cares for critically ill patients with ventilation needs and life-saving equipment, the transportation services should be able to assist in evacuation of this special population and be equipped to do so. Additionally, facilities may also find it prudent to consider alternative methods for evacuation and patient care and treatment, such as mentioned above to have staff members evacuate with patients in given situations. Additionally, facilities should consider their triaging system when coordinating the tracking and potential evacuation of patient/residents/clients. For instance, a triaging system for evacuation may consider the most critical patients first followed by those less critical and dependent on life-saving equipment. Considerations for prioritization may be based on, among other things, acuity, mobility status (stretch bound/wheelchair/ambulatory), and location of the unit, availability of a known transfer destination or some combination thereof. Included within this system should be who (specifically) will be tasked with making triage decisions. Following the triaging system, staff should consider the communication of patient care requirements to the in-taking facility, such as attaching hard copy of standard abbreviated patient health condition/history, injuries, allergies, and treatment rendered. On the same method for communicating this information, a facility could consider color coordination of triage level (i.e. green folder with this information is for less critical patients; red folders for critical and urgent evacuated patients, etc.). Additionally, this hard copy could include family member/representative contact information. Finally, facilities policies and procedures must outline primary and alternate means for communication with external sources for assistance. For instance, primarily methods may be considered via regular telephone services to contact transportation companies for evacuation or reporting evacuation needs to emergency officials; whereas alternate means 31 account for loss of power or telephone services in the local area. In this event, alternate means may include satellite phones for contacting evacuation assistance.

E-0022

Emergency plans must include a means for sheltering all patients, staff, and volunteers who remain in the facility in the event that an evacuation cannot be executed. In

certain disaster situations (such as tornadoes}, sheltering in place may be more appropriate as opposed to evacuation and would require a facility to have a means to shelter in place for such emergencies. Therefore, facilities are required to have policies and procedures for sheltering in place which align with the facility's risk assessment. 33 Facilities are expected to include in their policies and procedures the criteria for determining which patients and staff that would be sheltered in place. When developing policies and procedures for sheltering in place, facilities should consider the ability of their building(s) to survive a disaster and what proactive steps they could take prior to an emergency to facilitate sheltering in place or transferring of patients to alternate settings if their facilities were affected by the emergency. For example, if it is dangerous to evacuate or the emergency affects available sites for transfer or discharge, then the patients would remain in the facility until it was safe to effectuate transfers or discharges. The plan should take into account the appropriate facilities in the community to which patients could be transferred in the event of an emergency. Facilities must determine their policies based on the type of emergency and the types of patients, staff, volunteers and visitors that may be present during an emergency. Based on its emergency plan, a facility could decide to have various approaches to sheltering some or all of its patients and staff.

E-0023

In addition to any existing requirements for patient records found in existing laws, under this standard, facilities are required to ensure that patient records are secure and readily available to support continuity of care during emergency. This requirement does not supersede or take away any requirements found under the provider/supplier's medical records regulations, but rather, this standard adds to such policies and procedures. These policies and procedures must also be in compliance with the Health Insurance Portability and Accountability Act (HIPAA), Privacy and Security Rules at 45 CFR parts 160 and 164, which protect the privacy and security of individual's personal health information.

E-0024

During an emergency, a facility may need to accept volunteer support from individuals with varying levels of skills and training. The facility must have policies and procedures in place to facilitate this support. In order for volunteering healthcare professionals to be able to perform services within their scope of practice and training, facilities must include any necessary privileging and credentialing processes in its emergency preparedness plan policies and procedures. Non-medical volunteers would perform non-medical tasks. Facilities have flexibility in determining how best to utilize volunteers during an emergency

as long as such utilization is in accordance with State law, State scope of practice rules, and facility policy. These may also include federally designated health care professionals, such as Public Health Service (PHS) staff, National Disaster Medical System (NDMS) medical teams, Department of Defense (DOD) Nurse Corps, Medical Reserve Corps (MRC), or personnel such as those identified in federally designated Health Professional Shortage Areas (HPSAs) to include licensed primary care medical, dental and mental/behavioral health professionals. Facilities are also encouraged to integrate State-established volunteer registries, and where possible, State-based Emergency System for Advanced Registration of Volunteer Health Professionals (ESARVHP). Facilities are expected to include in its emergency plan a method for contacting off-duty staff during an emergency and procedures to address other contingencies in the event staff are not able to report to duty which may include, but are not limited to, utilizing staff from other facilities and state or federally-designated health professionals.

E-0025

Facilities are required to have policies and procedures which include prearranged transfer agreements, which may include written agreements or contracted arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. Facilities should consider all needed arrangements for the transfer of patients during an evacuation. For example, if a CAH is required to evacuate, policies and procedures should address what facilities are nearby and outside the area of disaster which could accept the CAH's patients. Additionally, the policies and procedures and facility agreements should include pre-arranged agreements for transportation between the 37 facilities. The arrangements should be in writing, such as Memorandums of Understanding (MOUs) and Transfer Agreements, in order to demonstrate compliance. For RNHCIs, at § 403.748(b)(7), the term "non-medical" is added in order to accommodate the uniqueness of the RNHCI non-medical care

E-0026

Providing care at alternate care sites during emergencies. It is expected that state or local emergency management officials might designate such alternate sites, and would plan jointly with local facilities on issues related to staffing, equipment and supplies at such alternate sites. This requirement encourages providers to collaborate with their local emergency officials in such proactive planning to allow an organized and systematic response to assure continuity of care even when services at their facilities have been severely disrupted. Facility's policies and procedures must specifically address the facility's role in emergencies where the President declares a major disaster or emergency under the

Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency Examples of 1135 waivers include some of the existing CoPs; Licensure for Physicians or others to provide services in the affected State; EMTALA; Medicare Advantage out of network providers and HIPAA. Facilities policies and procedures should address what coordination efforts are required during a declared emergency in which a waiver of federal requirements under section 1135 of the Act has been granted by the Secretary. For example, if due to a mass casualty incident in a geographic location, an 1135 waiver may be granted to waive licensure for physicians in order for these individuals to assist at a specific facility where they do not normally practice, then the facility should have policies and procedures which outline the responsibilities during the duration of this waiver period. For instance, the policies may establish a lead person in charge for accountability and oversight of assisting physicians not usually under contract with the facility. Additionally, facilities should also have in place policies and procedures which address emergency situations in which a declaration was not made and where an 1135 waiver may not be applicable, such as during a disaster affecting the single facility. In this case, policies and procedures should address potential transfers of patients; timelines of patients at alternate facilities, etc. For additional 1135 Waiver information, the SCG Emergency Preparedness Website has resources.

E-0029

Facilities must have a written emergency communication plan that contains how the facility coordinates patient care within the facility, across healthcare providers, and with state and local public health departments. The communication plan should include how the facility interacts and coordinates with emergency management agencies and systems to protect patient health and safety in the event of a disaster. The development of a communication plan will support the coordination of care. The plan must be reviewed annually and updated as necessary. We are allowing facilities flexibility in how they formulate and operationalize the requirements of the communication plan. Facilities in rural or remote areas with limited connectivity to communication methodologies such as the Internet, World Wide Web, or cellular capabilities need to ensure their communication plan addresses how they would communicate and comply with this requirement in the absence of these communication methodologies. For example, if a facility is located in a rural area, which has limited or no Internet and phone connectivity during an emergency, it must address what alternate means are available to alert local and State emergency officials. Optional communication methods facilities may consider include satellite phones, radios and short wave radios.

E-0030

A facility must have the contact information for those individuals and entities outlined within the standard. The requirement to have contact information for "other facilities" requires a provider or supplier to have the contact information for another provider or supplier of the same type as itself. For instance, hospitals should have contact information for other hospitals and CORFs should have contact information for other CORFs, etc. While not required, facilities may also find it prudent to have contact information for other facilities not of the same type. For instance, a hospital may find it appropriate to have the contact information of LTC facilities within a reasonable geographic area, which could assist in facilitating patient transfers. Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership and staff during an emergency event. Facilities which utilize electronic data storage should be able to provide evidence of data back-up with hard copies or demonstrate capability to reproduce contact lists or access this data during emergencies. All contact information must be reviewed and updated as necessary at least annually. Contact information contained in the communication plan must be accurate and current. Facilities must update contact information for incoming new staff and departing staff throughout the year and any other changes to information for those individuals and entities on the contact list. Transplant Centers should be included in the development of the hospitals communication plans. In the case of a Medicare-approved transplant center, a communication plan needs to be developed and disseminated between the hospitals, OPO, and transplant patients. For example, if the transplant program is planning to transfer patients to another transplant center due to an emergency, the communication plan between the hospitals, the OPO, and the patient should include the responsibilities of each of the facility types to ensure continuity of care. During an emergency, should an 44 organ offer become available at the time the patient is at the "transferred hospital," the OPO's emergency preparedness communication plan should address how this information will be communicated to both the OPO and the patient of where their care will be continued.

E-0031

A facility must have the contact information for those individuals and entities outlined within the standard. Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership during an emergency event. Facilities are encouraged but not required to maintain these contact lists both in electronic format and hard-copy format in the event that network systems to retrieve electronic files

are not accessible. All contact information must be reviewed and updated at least annually.

E-0032

Facilities are required to have primary and alternate means of communicating with staff, Federal, State, tribal, regional, and local emergency management agencies. Facilities 46 have the discretion to utilize alternate communication systems that best meets their needs. However, it is expected that facilities would consider pagers, cellular telephones, radio transceivers {that is, walkie-talkies), and various other radio devices such as the NOAA Weather Radio and Amateur Radio Operators' {HAM Radio) systems, as well as satellite telephone communications systems. We recognize that some facilities, especially in remote areas, may have difficulty using some communication systems, such as cellular phones, even in non-emergency situations, which should be outlined within their risk assessment and addressed within the communications plan. It expected these facilities would address such challenges when establishing and maintaining a well-designed communication system that will function during an emergency. The communication plan should include procedures regarding when and how alternate communication methods are used, and who uses them. In addition, the facility should ensure that its selected alternative means of communication is compatible with communication systems of other facilities, agencies and state and local officials it plans to communicate with during emergencies. For example, if State X local emergency officials use the Shared Resources {SHARES) High Frequency {HF) Radio program and facility Y istrying to communicate with RACES, it may be prudent to consider if these two alternate communication systems can communicate on the same frequencies. Facilities may seek information about the National Communication System {NCS), which offers a wide range of National Security and Emergency Preparedness communications services, the Government Emergency Telecommunications Services (GETS), the Telecommunications Service Priority {TSP) Program, Wireless Priority Service (WPS), and SHARES. Other communication methods could include, but are not limited to, satellite phones, radio, and short wave radio. The Radio Amateur Civil Emergency Services (RACES) is an integral part of emergency management operations.

E-0033

Facilities are required to develop a method for sharing information and medical (or for RNHCIs only, care) documentation for patients under the facility's care, as necessary, with other health care providers to maintain continuity of care. Such a system must ensure that information necessary to provide patient care is sent with an evacuated patient to the next care provider and would also be readily available for patients being sheltered in place. White the regulation does not specify timelines for delivering patient care information,

facilities are expected to provide patient care information to receiving facilities during an evacuation, within a timeframe that allows for effective patient 48 treatment and continuity of care. Facilities should not delay patient transfers during an emergency to assemble all patient reports, tests, etc. to send with the patient. Facilities should send all necessary patient information that is readily available and should include at least, patient name, age, DOB, allergies, current medications, medical diagnoses, current reason for admission (if inpatient), blood type, advance directives and next of kin/emergency contacts. There is no specified means (such as paper or electronic) for how facilities are to share the required information. Facilities (with the exception of HHAs, RHCs/FQHCs, and CORFs) are also required to have a means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510 and a means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510{b)(4). Thus, facilities must have a communication system in place capable of generating timely, accurate information that could be disseminated, as permitted under 45 CFR 164.510(b)(4), to family members and others. Facilities have the flexibility to develop and maintain their own system in a manner that best meets its needs. HIPAA requirements are not suspended during a national or public health emergency. However, the HIPAA Privacy Rule specifically permits certain uses and disclosures of protected health information in emergency circumstances and for disaster relief purposes. Section 164.510 "Uses and disclosures requiring an opportunity for the individual to agree to or to object," is part of the "Standards for Privacy of Individually Identifiable Health Information," commonly known as "The Privacy Rule." HIPAA Privacy Regulations at 45 CFR 164.510(b)(4), "Use and disclosures for disaster relief purposes," establishes requirements for disclosing patient information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts for purposes of notifying family members, personal representatives, or certain others of the patient's location or general condition.

E-0034

Facilities except for transplant centers, must have a means of providing information about the facility's needs and its ability to provide assistance to the authority having jurisdiction (local and State emergency management agencies, local and state public health departments, the Incident Command Center, the Emergency Operations Center, or designee). For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTF facilities, and ICF/IIDs, they must also have a means for providing information about their occupancy. Occupancy reporting is considered, but not limited to, reporting the number of patients currently at the facility receiving treatment and care or the facility's occupancy

percentage. The facility should consider how its occupancy affects its ability to provide assistance. For example, if the facility's occupancy is close to 100% the facility may not be able to accept patients from nearby facilities. The types of "needs" a facility may have during an emergency and should communicate to the appropriate authority would include but is not limited to, shortage of provisions such as food, water, medical supplies, assistance with evacuation and transfers, etc. Note: The authority having jurisdiction varies by local, state and federal emergency management structures as well as the type of disaster. For example, in the event of a multi-state wildfire, the jurisdictional authority who would take over the Incident 50 Command Center or state-wide coordination of the disaster would likely be a fire-related agency. We are not prescribing the means that facilities must use in disseminating the required information. However, facilities should include in its communication plan, a process to communicate the required information. Note: As defined by the Federal Emergency Management Administration (FEMA), an Incident Command System (ICS) is a management system designed to enable effective and efficient domestic incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. {FEMA, 2016). The industry, as well as providers/suppliers, use various terms to refer to the same function and we have used the term "Incident Command Center" to mean "Emergency Operations Center" or "Incident Command Post." Local, State, Tribal and Federal emergency preparedness officials, as well as regional healthcare coalitions, can assist facilities in the identification of their Incident Command Centers and reporting requirements dependent on an emergency.

E-0035

LTC facilities and ICF/IIDs are required to share emergency preparedness plans and policies with family members and resident representatives or client representatives, respectively. Facilities have flexibility in deciding what information from the emergency plan should be shared, as well as the timing and manner in which it should be disseminated. While we are not requiring facilities take specific steps or utilize specific strategies to share this information with residents or clients and their families or representatives, we would recommend that facilities provide a quick "Fact Sheet" or informational brochure to the family members and resident or client representatives which may highlight the major sections of the emergency plan and policies and procedures deemed appropriate by the facility. Other options include providing instructions on how to contact the facility in the event of an emergency on the public website or to include the information as part of the facility's check-in procedures. The facility may provide this information to the surveyor during the survey to demonstrate compliance with the requirement.

E-0036

An emergency preparedness training and testing program as specified in this requirement must be documented and reviewed and updated on at least an annual basis. The training and testing program must reflect the risks identified in the facility's risk assessment and be included in their emergency plan. For example, a facility that identifies flooding as a risk should also include policies and procedures in their emergency plan for closing or evacuating their facility and include these in their training and testing program. This would include, but is not limited to, training and testing on how the facility will communicate the facility closure to required individuals and agencies, testing patient tracking systems and testing transportation procedures for safely moving patients to other facilities. Additionally, for facilities with multiple locations, such as multi-campus or multi-location hospitals, the facility's training and testing program must reflect the facility's risk assessment for each specific location. Training refers to a facility's responsibility to provide education and instruction to staff, contractors, and facility volunteers to ensure all individuals are aware of the emergency preparedness program. Testing is the concept in which training is operationalized and the facility is able to evaluate the effectiveness of the training as well as the overall emergency preparedness program. Testing includes conducting drills and/or exercises to test the emergency plan to identify gaps and areas for improvement.

E-0037

Facilities are required to provide initial training in emergency preparedness policies and procedures that are consistent with their roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers. This includes individuals who provide services on a per diem basis such as agency nursing staff and any other individuals who provide services on an intermittent basis and would be expected to assist during an emergency. PACE organizations and CAHs have additional requirements. PACE organizations must also provide initial training to contractors and PACE participants. CAHs must also include initial training on the following: prompt reporting and extinguishing of fires; protection; and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities. Facilities should provide initial emergency training during orientation (or shortly thereafter) to ensure initial training is not delayed. With the exception of CORFs which must complete initial training within the first two weeks of employment, we recommend initial training be completed by the time the staff has completed the facility's new hire orientation program. Additionally, in the case of facilities with multiple locations, such as

multi-campus hospitals, staff, individuals providing services under arrangement, or volunteers should be provided initial training at their specific location and when they are assigned to a new location. Facilities have the flexibility to determine the focus of their annual training, as long as it aligns with the emergency plan and risk assessment. Ideally, annual training should be modified each year, incorporating any lessons learned from the most recent exercises, real-life emergencies that occurred in the last year and during the annual review of the facility's emergency program. For example, annual training could include training staff on new evacuation procedures that were identified as a best practice and documented in the facility "After Action Report (AAR) during the last emergency drill and were incorporated into the emergency plan during the program's annual review. While facilities are required to provide annual training to all staff, it is up to the facility to decide what level of training each staff member will be required to complete each year based on an individual's involvement or expected role during an emergency. There may be core topics that apply to all staff, while certain clinical staff may require additional topics. For example, dietary staff who prepare meals may not need to complete annual training that is focused on patient evacuation procedures. Instead, the facility may provide training that focuses on the proper preparation and storage of food in an emergency. In addition, depending on specific staff duties during an emergency, a facility may determine that documented external training is sufficient to meet some or all of the facility's annual training requirements. For example, staff who work with 56 radiopharmaceuticals may attend external training that teach staff how to handle radiopharmaceutical emergencies. It is up to the facility to decide if the external training meets the facility's requirements. Facilities must maintain documentation of the annual training for all staff. The documentation must include the specific training completed as well as the methods used for demonstrating knowledge of the training program. Facilities have flexibility in ways to demonstrate staff knowledge of emergency procedures. The method chosen is likely based on the training delivery method. For example: computer-based or printed self-learning packets may contain a test to demonstrate knowledge. If facilities choose instructor-led training, a question and answer session could follow the training. Regardless of the method, facilities must maintain documentation that training was completed and that staff are knowledgeable of emergency procedures.

E-0039

Facilities must on an annual basis conduct exercises to test the emergency plan, which for LTC facilities also includes unannounced staff drills using the emergency procedures. Specifically, facilities are required to conduct a tabletop exercise and participate in a full-scale community-based exercise or conduct an individual facility exercise if a community-

based exercise is not available. As the term full- scale exercise may vary by sector, facilities are not required to conduct a full-scale exercise as defined by FEMA or DHS's Homeland Security Exercise and Evaluation Program (HSEEP). For the purposes of this requirement, a full-scale exercise is defined and accepted as any operations-based exercise (drill, functional, or full-scale exercise) that assesses a facility's functional capabilities by simulating a response to an emergency that would impact the facility's operations and their given community. A full-scale exercise is also an operations-based exercise that typically involves multiple agencies, jurisdictions, and disciplines performing functional or operational elements. There is also definition for "community" as it is subject to variation based on geographic setting, (e.g., rural, suburban, urban, etc.), state and local agency roles and responsibilities, types of providers in a given area in addition to other factors. In doing so, facilities have the flexibility to participate in and conduct exercises that more realistically reflect the risks and composition of their communities. Facilities are expected to consider their physical location, agency and other facility responsibilities and needs of the community when planning or participating in their exercises. The term could, however, mean entities within a state or multi-state region. In many areas of the country, State and local agencies (emergency management agencies and health departments) and some regional entities, such as healthcare coalitions may conduct an annual full-scale, community-based exercise in an effort to more broadly assess community-wide emergency planning, potential gaps, and the integration of response capabilities in an emergency. Facilities should actively engage these entities to identify potential opportunities, as appropriate, as they offer the facility the opportunity to not only assess their emergency plan but also better understand how they can contribute to, coordinate with, and integrate into the broader community's response during an emergency. They also provide a collective forum for assessing their communications plans to ensure they have the appropriate contacts and understand how best to engage and communicate with their state and local public health and emergency management agencies and other relevant partners, such as a local healthcare coalition, during an emergency.60 Facilities are expected to contact their local and state agencies and healthcare coalitions, where appropriate, to determine if an opportunity exists and determine if their participation would fulfill this requirement. In doing so, they are expected to document the date, the personnel and the agency or healthcare coalition that they contacted. It is also important to note that agencies and or healthcare coalitions conducting these exercises will not have the resources to fulfill individual facility requirements and thus will only serve as a conduit for broader community engagement and coordination prior to, during and after the full-scale community-based exercise. Facilities are responsible for resourcing their participation and ensuring that all requisite documentation is developed and available to

demonstrate their compliance with this requirement. Facilities are encouraged to engage with their area Health Care Coalitions {HCC) (partnerships between healthcare, public health, EMS, and emergency management) to explore integrated opportunities. Health Care Coalitions (HCCs) are groups of individual health care and response organizations who collaborate to ensure each member has what it needs to respond to emergencies and planned events. HCCs plan and conduct coordinated exercises to assess the health care delivery systems readiness. There is value in participating in HCCs for participating in strategic planning, information sharing and resource coordination. HCC's do not coordinate individual facility exercises, but rather serve as a conduit to provide an opportunity for other provider types to participate in an exercise. HCCs should communicate exercise plans with local and state emergency preparedness agencies and HCCs will benefit the entire community's preparedness. In addition, CMS does not regulate state and local government disaster planning agencies. It is the sole responsibility of the facility to be in compliance. Facilities that are not able to identify a full-scale community-based exercise, can instead fulfill this part of their requirement by either conducting an individual facility-based exercise, documenting an emergency that required them to fully activate their emergency plan, or by conducting a smaller community-based exercise with other nearby facilities. Facilities that elect to develop a small community-based exercise have the opportunity to not only assess their own emergency preparedness plans but also better understand the whole community's needs, identify critical interdependencies and or gaps and potentially minimize the financial impact of this requirement. For example, a LTC facility, a hospital, an ESRD facility, and a home health agency, all within a given area, could conduct a small community-based exercise to assess their individual facility plans and identify interdependencies that may impact facility evacuations and or address potential surge scenarios due to a prolonged disruption in dialysis and home health care services. Those that elect to conduct a community-based exercise should make an effort to contact their local/state emergency officials and healthcare coalitions, where appropriate, and offer them the opportunity to attend as they can provide valuable insight into the broader emergency planning and response activities in their given area. Facilities that conduct an individual facility-based exercise will need to demonstrate how it addresses any risk(s) identified in its risk assessment. For example, an inpatient facility might test their policies and procedures for a flood that may require the evacuation of patients to an external site or to an internal safe "shelter-in-place" location (e.g. foyer, cafeteria, etc.) and include requirements for patients with access and functional needs and potential dependencies on life-saving electricity-dependent medical equipment. An outpatient facility, such as a home health provider, might test its policies and procedures for a flood that may require it to rapidly locate its

on-duty staff, assess the acuity of its patients to determine those that may be able to shelter-in-place or require hospital admission, communicate potential evacuation needs to local agencies, and provide medical information to support the patient's continuity of care. Each facility is responsible for documenting their compliance and ensuring that this information is available for review at any time for a period of no less than three (3) years. Facilities should also document the lessons learned following their tabletop and full-scale exercises and real-life emergencies and demonstrate that they have incorporated any necessary improvements in their emergency preparedness program. Facilities may complete an after action review process to help them develop an actionable after action report (AAR). The process includes a roundtable discussion that includes leadership, department leads and critical staff who can identify and document lessons learned and necessary improvements in an official AAR. The AAR, at a minimum, should determine 1) what was supposed to happen; 2} what occurred; 3) what went well; 4) what the facility can do differently or improve upon; and 5) a plan with timelines for incorporating necessary improvement. Lastly, facilities that are a part of a healthcare system, can elect to participate in their system's integrated and unified emergency preparedness program and exercises. However, those that do will still be responsible for documenting and demonstrating their individual facility's compliance with the exercise and training requirements. Finally, an actual emergency event or response of sufficient magnitude that requires activation of the relevant emergency plans meets the annual exercise requirements and exempts the facility for engaging in the required exercises for one year following the actual event; and facility's must be able to demonstrate this through written documentation. For additional information and tools, please visit the CMS Survey & Certification Emergency Preparedness website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html

E-0041

Emergency and standby power systems CMS requires Hospitals, CAHs and LTC facilities to comply with the 2012 edition of the National Fire Protection Association (NFPA) 101 - Life Safety Code (LSC) and the 2012 edition of the NFPA 99 -Health Care Facilities Code in accordance with the Final Rule (CMS-3277- F). NFPA 99 requires Hospitals, CAHs and certain LTC facilities to install, maintain, inspect and test an Essential Electric System (EES) in areas of a building where the failure of equipment or systems is likely to cause the injury or death of patients or caregivers. An EES is a system which includes an alternate source of power, distribution system, and associated equipment that is designed to ensure continuity of electricity to elected areas and functions during the interruption of normal electrical service. The EES alternate source of power for these facility types is typically a generator.

(Note: LTC facilities are also expected to meet the requirements under Life Safety Code and NFPA 99 as outlined within the LTC Appendix of the SOM}. In addition, NFPA 99 identifies the 2010 edition of NFPA 100 -Standard for Emergency and Standby Power Systems as a mandatory reference, which addresses the performance requirements for emergency and standby power systems and includes installation, maintenance, operation, and testing requirements. 65 In addition to the LSC, NFPA 99 and NFPA 110 requirements, the Emergency Preparedness regulation requires all Hospitals, CAHs, and LTC facilities to implement emergency and standby power systems based upon a facility's established emergency plan, policies, and procedures. Emergency preparedness policies and procedures (substandard (b} of the emergency preparedness requirements} are required to address the subsistence needs of staff and residents, whether the facility decides to evacuate or shelter in place. Subsistence needs include, but are note limited to, food, water, medical, and pharmaceutical supplies, and alternate sources of energy to maintain· temperatures to protect patient/resident health and safety and sanitary storage of provisions; emergency lighting; fire detection, extinguishing, and alarm systems; and sewage and waste disposal. Pharmaceutical supplies, and alternate sources of energy to maintain: temperatures to protect patient/resident health and safety and sanitary storage of provisions; emergency lighting; fire detection, extinguishing, and alarm systems; and sewage and waste disposal. NFPA 99 contains emergency power requirements for emergency lighting, fire detection systems, extinguishing systems, and alarm systems. But, NFPA 99 does not specify emergency power requirements for maintaining supplies, and facility temperature requirements are limited to heating equipment for operating, delivery, labor, recovery, intensive care, coronary care, nurseries, infection/isolation rooms, emergency treatment spaces, and general patient/resident rooms. In addition, NFPA 99 does not require heating in general patient rooms during the disruption of normal power where the outside design temperature is higher than 20 degrees Fahrenheit or where a selected room{s) is provided for the needs of all patients (where patients would be internally relocated), then only that room(s) needs to be heated. Therefore, EES in Hospitals, CAHs and LTC facilities should include consideration for design to accommodate any additional electrical loads the facility determines to be necessary to meet all subsistence needs required by emergency preparedness plans, policies and procedures, unless the facility's emergency plans, policies and procedures required under paragraph (a) and paragraph (b)(l)(i) and (ii) of this section determine that the hospital, CAH or LTC facility will relocate patients internally or evacuate in the event of an emergency. Facilities may plan to evacuate all patients, or choose to relocate internally only patients located in certain locations of the facility based on the ability to meet emergency power requirements in certain locations. For example, a hospital that has the ability to maintain temperature requirements in 50 percent of the

inpatient locations during a power outage, may develop an emergency plan that includes bringing in alternate power, heating and/or cooling capabilities, and the partial relocation or evacuation of patients during a power outage instead of installing additional power sources to maintain temperatures in alt inpatient locations. Or a LTC facility may decide to relocate residents to a part of the facility, such as a dining or activities room, where the facility can maintain the proper temperature requirements rather than the maintaining temperature within the entire facility. It is up to each facility to make emergency power system decisions based on its risk assessment and emergency plan. Emergency generator location NFPA 110 contains minimum requirements and considerations for the installation and environmental conditions that may have an effect on Emergency Power Supply System (EPSS) equipment, including, building type, classification of occupancy, hazard of contents, and geographic location. NFPA 110 requires that EPSS equipment, including 66 generators, to be designed and located to minimize damage {e.g., flooding). NFPA 110 requires emergency power supply systems to be permanently attached, therefore portable and mobile generators would not be permitted as an option to provide or supplement emergency power to Hospitals, CAHs or LTC facilities. Under emergency preparedness, the regulations require that the generator and its associated equipment be located in accordance with the LSC, NFPA 99, and NFPA 110 when a new structure is built or an existing structure or building is renovated. Therefore, new structures or building renovations that occur after November 15, 2016, the effective date of the Emergency Preparedness Final Rule must consider NFPA requirements to ensure that the £PSS equipment is in a location to minimize damage. Emergency generator inspection and testing NFPA 110 contains routine maintenance and operational testing requirements for emergency and standby power systems, including generators. Emergency generators required by NFPA 99 and the Emergency Preparedness Final Rule must be maintained and tested in accordance with NFPA 110 requirements, which are based on manufacture recommendations, instruction manuals, and the minimum requirements of NFPA 110, Chapter 8. Emergency generator fuel NFPA 110 permits fuel sources for generators to be liquid petroleum products {e.g., gas, diesel), liquefied petroleum gas {e.g., propane) and natural or synthetic gas (e.g., natural gas). Generators required by NFPA 99 are designated by Class, which defines the minimum time, in hours, that an EES is designed to operate at its rated load without having to be refueled. Generators required by NFPA 99 for Hospitals, CAHs and LTC facilities are designated Class X, which defines the minimum run time as being "other time, in hours, as required by application, code or user." However, NFPA 110 does require facilities considering seismic events to maintain a minimum 96 hour fuel supply. NFPA 110 also requires that generator installations in locations where the probability of interruption of off-site {e.g., natural gas) fuel supplies is high to maintain onsite storage of an alternate fuel

source sufficient to allow full output of the ESS for the specified class. The Emergency Preparedness Final Rule requires Hospitals, CAHs and LTC facilities that maintain onsite fuel sources {e.g., gas, diesel, propane) to have a plan to keep the EES operational for the duration of emergencies as defined by the facilities emergency plan, policy and procedures, unless it evacuates. This would include maintaining fuel onsite to maintain generator operation or it could include making arrangements for fuel delivery for an emergency event. If fuel is to be delivered during an emergency event, planning should consider limitations and delays that may impact fuel delivery during an event. In addition, planning should ensure that arranged fuel supply sources will not be limited by other community demands during the same emergency event. In instances when a facility maintains onsite fuel sources and plans to evacuate during an emergency, 67 a sufficient amount of onsite fuel should be maintained to keep the EES operational until such time the building is evacuated.

Annex A: Apartment Evacuation Policy & Procedure

PURPOSE: To evacuate all apartment residents to safety in the event of a disaster.

PROCEDURE: In the event it becomes necessary to evacuate the entire building, or a specific wing, the following procedure will be followed:

1. The Administrator or designated person will notify the apartment residents in the event of a disaster.
2. Nursing personnel will direct the C.N.A.'s or staff to evacuate the residents.
3. Nursing staff will knock on the apartment door and notify the tenants/residents on what to do, if no one answers the door, go on to the next apartment and report to the Administrator anyone who was not home.
4. The Administrator will then take the master key to ensure there is no one left in the apartment.
5. The nursing staff will be responsible for bringing the apartment residents files in the event of disaster.
6. A designated person will notify family members what has transpired and where the apartment residents are located.

Annex B: Behavioral Health

The resource linked below, Psychological First Aid Field Operations Guide for Nursing Homes, is a guidance document to assist with providing behavioral health support to persons in nursing homes in the immediate aftermath of a disaster.

Psychological First Aid Field Operations Guide for Nursing Homes

Annex C: Bioterrorism Threats

Reporting Requirements and Contact Information

In the event a bioterrorism (BT) event is suspected, local emergency response systems should be activated. Notification should immediately include local infection control personnel and the LTC community's administration, and prompt communication with the local and state health departments, FBI field office, local police, CDC, and medical emergency services. **Each LTC community should include a list containing the following telephone notification numbers in its readiness plan:**

INTERNAL CONTACTS:

INFECTION CONTROL

ADMINISTRATION/PUBLIC AFFAIRS

EXTERNAL CONTACTS:

LOCAL HEALTH DEPARTMENT

REGIONAL EPIDEMIOLOGIST

STATE HEALTH DEPARTMENT

FBI FIELD OFFICE
BIOTERRORISM EMERGENCY NUMBER, CDC Emergency Response Office 770/488-7100
CDC HOSPITAL INFECTIONS PROGRAM 404/639-6413

Detection of Outbreaks Caused by Agents of Bioterrorism

BT occurs as covert events, in which persons are unknowingly exposed and an outbreak is suspected only upon recognition of unusual disease clusters or symptoms. BT may also occur as announced events, in which persons are warned that an exposure has occurred. A number of announced BT events have occurred in the United States during 1998-1999, but these were determined to have been "hoaxes;" that is, there were no true exposures to BT agents. A healthcare facility's BT Readiness Plan should include details for management of both types of scenarios: suspicion of a BT outbreak potentially associated with a covert event and announced BT events or threats. The possibility of a BT event should be ruled out with the assistance of the FBI and state health officials.

Infection Control Practices for Patient Management

Agents of BT are generally not transmitted from person to person; re-aerosolization of these agents is unlikely. **All** persons, including symptomatic patients with suspected or confirmed BT related illnesses, should be managed utilizing **Standard Precautions**. Standard Precautions are designed to reduce transmission from both recognized and unrecognized sources of infection, and are recommended for all persons receiving care, regardless of their diagnosis or presumed infection status. **For certain diseases or syndromes (e.g., smallpox and pneumonic plague), additional precautions may be needed to reduce the likelihood for transmission.**

Standard Precautions prevent direct contact with all body fluids (including blood), secretions, excretions, nonintact skin (including rashes), and mucous membranes. Standard Precautions routinely practiced by healthcare providers include:

Handwashing

Hands are washed after touching blood, body fluids, excretions, secretions, or items contaminated with such body fluids, whether or not gloves are worn. Hands are washed immediately after gloves are removed, between contacts, and as appropriate to avoid transfer of microorganisms to others and the environment. Either plain or antimicrobial-containing soaps may be used according to policy.

Gloves

Clean, non-sterile gloves are worn when touching blood, body fluids, excretions, secretions, or items contaminated with such body fluids. Clean gloves are put on just before touching mucous membranes and nonintact skin. Gloves are changed between tasks and between procedures on the same person if contact occurs with contaminated material. Hands are washed promptly after removing gloves.

Masks/Eye Protection or Face Shields

A mask and eye protection (or face shield) are worn to protect mucous membranes of the eyes, nose, and mouth while performing procedures and care activities that may cause splashes of blood, body fluids, excretions, or secretions.

Gowns

A gown is worn to protect skin and prevent soiling of clothing during procedures and care activities that are likely to generate splashes or sprays of blood, body fluids, excretions, or secretions. Selection of gowns and gown materials should be suitable for the activity and

amount of body fluid likely to be encountered. Soiled gowns are removed promptly and hands are washed to avoid transfer of microorganisms to others.

Post Exposure Management

The need for decontamination depends on the suspected exposure and in most cases will not be necessary. The goal of decontamination after a potential exposure to a BT agent is to reduce the extent of external contamination of the residents and contain the contamination to prevent further spread.

Decontamination should only be considered in instances of gross contamination. Decisions regarding the need for decontamination should be made in consultation with state and local health departments. Decontamination of exposed individuals prior to receiving them in the healthcare facility may be necessary to ensure the safety of residents and staff while providing care.

When developing BT Readiness Plans, facilities should consider available locations and procedures for patient decontamination.

Depending on the agent, the likelihood for re-aerosolization, or a risk associated with cutaneous exposure, clothing of exposed persons may need to be removed. After removal of contaminated clothing, patients should be instructed (or assisted if necessary) to immediately shower with soap and water. **Potentially harmful practices, such as bathing residents with bleach solutions, are unnecessary and should be avoided.** Clean water, saline solution, or commercial ophthalmic solutions are recommended for rinsing eyes. If indicated, after removal at the decontamination site, patient clothing should be handled only by personnel wearing appropriate personal protective equipment, and placed in an impervious bag to prevent further environmental contamination.

Development of Bioterrorism Readiness Plans should include coordination with the FBI field office. The FBI may require collection of exposed clothing and other potential evidence for submission to FBI or Department of Defense laboratories to assist in exposure investigations.

Prophylaxis and post-exposure immunization

Recommendations for prophylaxis are subject to change. However, up-to-date recommendations should be obtained in consultation with local and state health departments and CDC. Communities should ensure that policies are in place to identify and manage health care workers exposed to infectious residents. In general, maintenance of accurate occupational health records will facilitate identification, contact, assessment, and delivery of post-exposure care to potentially exposed healthcare workers.

Annex D: Bomb Threat Policy and Procedure

Purpose: The purpose of this policy is to inform staff of precautions to be taken in the event of a bomb threat.

The current national situation of increased bombings, bomb threats, and bomb scares must be given immediate consideration. In the past, the vast majority of bomb threats were hoaxes. However, the current trend nationally is that more of the threats are materializing.

Upon receipt of a bomb threat, it is impossible to know if it is real or a hoax. Therefore, precautions need to be taken for the safety of our residents and employees.

Procedure: If you receive a bomb threat over the phone, follow these procedures:

1. Keep the caller on the line as long as possible.
2. Ask the caller to repeat the message.
3. Ask the caller his/her name.
4. Ask the caller where the bomb is located.
5. Record every word spoken by the person making the call.
6. Record time call was received and terminated.
7. Inform the caller that the building is occupied and the detonation of a bomb could result in death or serious injury to many innocent people.
8. Complete the bomb threat form, attached, to record the caller's characteristics.

If possible, during the call, try to notify the charge nurse immediately. The charge nurse shall:

1. Call the Police Department at 9-1-1.
2. Call the Administrator if not present.
3. Organize staff to evacuate residents upon police or administrative order.

Once the Police have arrived:

- Keys shall be available so that searchers can inspect all rooms. Employee lockers will be searched. If padlocked, padlock will be cut off.
- The Administrator or designee shall remain with the Search Commander during the entire search to provide assistance and counsel during the search.
- If a suspected bomb is located within the building, the responsibility for investigation will be that of the law enforcement officials having jurisdiction over such matters.

Bomb Threat Telephone Procedure Form

Use the following template in the situation of a potential bomb threat •

Homeland Security: Bomb Threat Checklist (PDF)

Annex E: Chemical Spills

Purpose: To inform staff of action to be taken in the event of an outdoor chemical spill.

Policy: The following action will be taken in the event of an outdoor chemical spill.

1. Shut down outside intake ventilation.
2. Close all doors to the outside and close and lock all windows.
3. Maintenance staff should set all ventilation systems to 100% recirculation so that no outside air is drawn into the building. When this is not possible, ventilation systems should be turned off. This is accomplished by pulling the fire alarm.
4. Turn off all heating systems.
5. Turn off all air conditioners and switch inlets to the "closed" position. Seal any gaps around window type air conditioners with tape and plastic sheeting, wax paper or aluminum wrap.
6. Turn off all exhaust fans in kitchens and bathrooms.
7. Close as many internal doors as possible in the building.
8. Use tape and plastic food wrapping, wax paper or aluminum wrap to cover and seal bathroom exhaust fan grills, range vents, dryer vents, and other openings to the outside.
9. If the gas or vapor is soluble or partially soluble in water, hold a wet cloth over your nose and mouth if gases start to bother you. For a higher degree of protection, go into the bathroom, close the door and turn on the shower in a strong spray to wash the air.
10. If an explosion is possible outdoors, close drapes, curtains or shades over windows. Stay away form external windows to prevent injury from flying glass.
11. Tune into the Emergency Broadcasting System on the radio or television for further information and guidance.

Law enforcement agencies will make a determination regarding possible evacuation of residents

Annex F: Communications Plan

The following resource from the American Health Care Association and the National Center for Assisted Living is a guidance document on how to write a communications and media plan.

Emergency Preparedness Requires a Communications Plan

Annex G: Electrical Power Outage Policy and Procedure

Purpose: It is the policy of this facility to provide auxiliary power to designated areas within the facility to operate life-support equipment should our normal power supply fail.

The facility has an emergency generator that should be automatically activated in the event of a power outage. The generator operates on natural gas (diesel, etc.), and as long as the gas lines are not damaged or disrupted, the generator is capable of providing the facility with a minimal supply of electricity.

Procedure: In the event of a power outage, the following steps should be followed:

1. Immediately identify any residents that require oxygen concentrators or other life support equipment. Move the resident to areas supplied with emergency power (outlets that are red).
2. Gather all flashlights and other needed supplies. Check on all residents to ensure their safety. Calm any residents experiencing distress.
3. Make sure back up phones are available (cell phone)

Facility Generator DOES NOT...

- Provide Heat or Water
- Provide Power to Laundry or Kitchen
- Operate Fire Alarm System (this is on its own battery back-up system and should also be connected to a generator, if an Alabama nursing facility)
- Operate the phone system

Areas Equipped with Emergency Lighting:

- Front Lobby
- Hallways
- Break room
- Laundry Room
- Boiler Room
- Stairways
- Medication Prep Room

Annex H: Elevator Policy and Procedure

PURPOSE: To provide facility staff a course of action to follow in the event the elevator should become stuck between floors.

PROCEDURE:

1. Obtain the key to open the elevator maintenance room.
2. Locate and shut off power to the elevator. This will return elevator to the ground floor.
3. Take key with a red tag, located to the left of the power shut off.
4. Put key in hole at the top of the elevator door and turn. This opens the first door.
5. Push the latch on the second door and push open at the same time, the person on the elevator can also help push door open.
6. Turn on power to the elevator.
7. If the power is not restored, push the reset button, which is in the panel on the left.
8. If this does not work contact the Maintenance Supervisor, if not available contact the Elevator company at _____

Annex I: Emergency Notification of Administrator

The Business Office Manager during normal business hours, or the Charge Nurse at any other time shall notify the Administrator. In the following situations, the Administrator is to be notified immediately, if possible, on a 24-hour basis:

- Death involving unusual circumstances or family dispute;
- Emergency requiring immediate services or repair authorization;
- Fire of any size or nature;
- Missing resident;
- Formal Division of Health Inspection or Annual Survey;
- Urgent resident/family problems;
- Any situation involving violence by staff or resident.

Absence of Administrator

In the absence of the Administrator from the facility, the Director of Nursing shall be the designated "Person-in-Charge."

If the Administrator and Director of Nursing are absent from the facility, there shall be two persons in charge of the facility. The charge nurse on duty shall be in charge of staff and all resident care delivery. The Business Office Manager shall be in charge of all business matters.

If the Administrator cannot be reached, a board member shall be contacted. The President of the Board of Directors should be contacted first. If the President cannot be reached, contact the Vice-President.

If the Vice-President cannot be reached, the Secretary shall be notified. If none of the latter persons cannot be reached, attempts should continue to inform any one of the other board members.

Annex J: Fire Policy & Procedure

Purpose: The primary purpose of the Fire Policy and Procedure is to provide a course of action for all personnel to follow in the event of a fire.

Procedure:

R - Rescue anyone in immediate danger.

A - Alert other staff members of the fire and location over the intercom system. Pull the nearest fire **alarm**. The Person in Charge shall contact the fire department by calling 911.

C - Contain the fire. Close all doors and windows adjacent to the fire. Close all fire doors. Shut off all fans, ventilators and air conditioners, as these will feed the fire and spread smoke throughout the building.

E - Extinguish if the fire is small. The extinguisher should be aimed low at the base of the fire, and move slowly upward with a sweeping motion.

- Never aim high at the middle or top of the flames as this will cause the fire to spread.
- If you cannot extinguish the fire, **evacuate** the smoke compartment immediately.

Special Note: The most common cause of death in a fire is smoke, and not the flames. Keep low to the floor and avoid inhaling too much smoke.

Duties of Personnel: *Person In Charge:*

1. Call the fire department at 9-1-1. Give exact location of the fire and its extent.
2. Call the Administrator.
3. Assist with residents if evacuation is necessary.
4. Assign a staff member to meet the fire department in order to direct them to the fire. Assign a staff member to keep a roster of residents if evacuation is necessary. Assign a staff member to answer the telephone and relay messages and instructions.

Nursing, Dietary, and Housekeeping/Laundry Personnel:

1. Remove residents from immediate danger.
2. Close all doors and windows.
3. Turn off fans, ventilators, air conditioners, and other equipment.
4. Stay close to residents to provide reassurance and provide comfort measures.
5. Make sure fire exits are clear.

Maintenance Personnel:

1. Go directly to scene of fire, taking extra fire extinguishers.
2. Check to be sure that all ventilating or blower equipment is shut off.
3. Once fire is over, care for all fire extinguishers.

Annex J: Fire Policy & Procedure

Administrator:

1. Call the fire department if not already done.
2. Coordinate staff movement for highest efficiency.
3. Assist with resident movement in coordination with charge nurse.
4. Delegate responsibility for the movement of records as deemed necessary.

Check with department heads in the event of evacuation to determine that all staff and residents are out of the building.

Annex K: Heat and Humidity Policy and Procedure

Purpose: The purpose of this policy is to provide precautionary and preventative measures for our residents during the hot and humid summer months. Elderly people are extremely vulnerable to heat related disorders.

Definitions:

Heat Exhaustion: A disorder resulting from overexposure to heat or to the sun. Early symptoms are headache and a feeling of weakness and dizziness, usually accompanied by nausea and vomiting.

There may also be cramps in the muscles of the arms, legs, or abdomen. The person turns pale and perspires profusely, skin is cool and moist, pulse and breathing are rapid.

Body temperature remains at a normal level or slightly below or above. The person may seem confused and may find it difficult to coordinate body movements.

Heat Stroke: A profound disturbance of the body's heat-regulating mechanism, caused by prolonged exposure to excessive heat, particularly when there is little or no circulation of air.

The first symptoms may be headache, dizziness and weakness. Later symptoms are an extremely high fever and absence of perspiration. Heat stroke may cause convulsions and sudden loss of consciousness. In extreme cases it may be fatal.

Precautionary Procedures:

1. Keep the air circulating.
2. Draw all shades, blinds and curtains in rooms when exposed to direct sunlight.
3. Remove residents from areas that are exposed to direct sunlight.
4. Keep outdoor activities to a minimum.
5. Check to see that residents are appropriately dressed.
6. Provide ample fluids, and provide as many fluids as the resident will take.
7. Increase the number of baths given.

Alabama Nursing Home Association

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