

Emergency Preparedness Manual

2025

3rd Edition

HealthCap
RISK MANAGEMENT SERVICES

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HealthCap Risk Management Services

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Emergency Preparedness Manual

SECTION 1
GENERAL



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Policy:
This Emergency Preparedness Manual was developed to assist communities in meeting the responsibility of maintaining a comfortable environment for residents, employees and visitors. The emphasis of this manual is to provide ongoing training to ensure appropriate response to unexpected emergent events, provide for the orderly operation of the community, and coordinate the use of resources and personnel in an effective and timely manner.

Procedure:
The management team will institute the appropriate emergency plan located in this manual to address emergent situations as they arise. The responsibilities of the management team include initiating a calm, effective approach to addressing emergencies and avoiding panic among residents and employees.

Important reminders for managers to reinforce with employees include:

- Do not panic or startle residents unnecessarily
- Do not run through the building but walk with purpose
- Do not use elevators in the event of fire
- All employees return to their designated units immediately
- Do not use telephones or other wired communication devices in the event of fire
- Reassure residents with a calm approach; do not rush residents

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Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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EMERGENCY/DISASTER CONTACT INFORMATION

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for residents, employees and visitors. Emergency and Disaster Contact Information will be in the Emergency Preparedness Manuals at each nursing station and in a central location with other policies and procedures. The management team will provide appropriate training for staff on where contact information is located to expedite making related reports and request for assistance.

Procedure:

1. The general orientation process includes training on the location of contact information.

2. Documentation for training will be included in the individual employee personnel file.

3. The location of the Contact Information list will be included on the annual in-service calendar as mandatory training for all employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. Updating the Emergency and Disaster information on the Contact Information List will be the responsibility of the Administrator or designee.

7. The Contact Information List will be reviewed annually and with any change in management personnel for accuracy by the Administrator or designee.

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** Emergency Preparedness Manual*

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EMERGENCY/DISASTER CONTACT INFORMATION

(Remember to include business, cellular, home, pager, and off hours/emergency numbers)

Name	Department	Home Phone	Cell Phone
	Administrator		
	Assistant Administrator		
	Administrative Secretary		
	Director of Nursing		
	Medical Director		
	Physiatrist		
	Controller		
	Asst. Director of Nursing		
	Corporate Compliance		
	Infection Control Nurse		
	Staff Dev./In-service		
	MDS Nurse leader		
	Assisted Living Director		
	Maintenance Director		
	Safety Committee		
	Admissions		
	Social Service Lead		
	Human Resources Lead		
	Laundry/Housekeeping Lead		
	Activities Director		
	Dietary Manager/Dietician		
	Rehabilitation Director		
	Activity Director		
	Nurse Managers		
	Office Manager		
	Financial Specialists		
	Medical Records		
	Scheduling Coordinator		
	Medical Records		

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Physicians

(Include Cell Phone Number, Home Phone Number and Office Phone Number)

Name	Title/Position	Cell Phone	Home #	Office #
	Medical Director			
	Staff physicians			
	Podiatrist			
	Psychiatrist			
	Dentist			
	Ophthalmologist			
	Optometrist			

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Fire/Police/Emergency	Telephone Number
Fire Department	
Local Police Department	
State Police Department	
Sheriff Department	
Ambulance Company (companies) & Name	
Local Civil Defense	
Local American Red Cross	
Poison Control	
Hospice	
Local Hospitals	
Hospital #1	
Hospital #2	
X-Ray Services	
Laboratory	
Pharmacy (Pharmacies)	
State Abuse Hotline	
State Reporting Hotline	
Licensing Officer	
Evacuation Locations:	

Suppliers/Support

Type	Name	Telephone Number
Corporate Contact		
Liability Insurance Support Hotline		
Attorney/Corporate Counsel		
Electric Service		
Gas Service		
Water Supplier		
Transportation		
Information Technology/Computers		
Telephone Service		
Hospitals		
Alarm Company/Door and Fire		
Boiler Company		

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Elevator Company		
Locksmith		
Plumbing		
Air Handlers		
Telephone		
Sewer/Drain Service		
Cable Company/Satellite		
Food Service		
Dairy Service		
Oxygen Supplier		
Waste Removal		
Vending Machines		

Media Source	Name	Telephone Number
Television	**CBS**	
	ABC	
	NBC	
	FOX	
Radio		
Weather Bulletins		
Newspapers		

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DESCRIPTION OF EMERGENCY CODES

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees and visitors. Emergency Codes will be established to identify different types of disasters for employee notification, i.e., Fire, Elopement, Tornado, etc. The management team will provide appropriate training for employees, emphasizing the importance of continuing to provide care for our residents with as little disruption as possible during emergency events.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure Description of Emergency Codes used to identify the different types of disasters.

1. Documentation for training will be included in the individual employee personnel file.

2. The Description of Emergency Codes policy will be included in the annual in-service calendar as mandatory training for employees.

3. Documentation of training will be maintained in the employee training records.

4. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

5. A list of all Emergency Codes will be posted in the Emergency Preparedness Manual that is located _____ and locations determined by the community.

7. The Emergency Codes are (*Use the space below to identify Emergency Codes specific to your facility).*
    a.
    b.
    c.
    d.
    e.

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** Emergency Preparedness Manual*

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Emergency Preparedness: Community Audit Checklist

The following supplies shall be maintained and accessible to all members of the community 24 hours a day. It is the responsibility of the Administrator and designated Safety Officer to perform regular audits to assist in ensuring compliance is maintained.

_____ Non-electric radio or weather monitor station on each floor

_____ Batteries for non-electric radio or weather monitor station available to staff 24 hours a day (batteries to be replaced quarterly and dated)

_____ Flashlights for each nurse's station and each manager (at a minimum)

_____ Flashlight batteries (batteries to be replaced quarterly & dated)

_____ Additional supply of each battery type maintained at each nurse's station and replenished by the Safety Officer

_____ Fully charged cell phone (at each nurse's station if multi-level facility)

_____ Hand bells or whistles for residents to notify staff in case of emergency in the event of call light failure

_____ Current resident roster identifying resident specific evacuation abilities, priority location for evacuation (hospital or other non-medical location, depending upon agreements and contracts)

_____ Visitor sign-in log (in event evacuation is necessary)

_____ Resident sign-out log (in event evacuation is necessary)

_____ Employee sign-in log (in event evacuation is necessary)

_____ Emergency Preparedness manuals in each manager's office and at each nurse's station

_____ Disposable plates and silverware for one month (large Styrofoam "take out" boxes especially useful in multi-level facilities that require food be transported in stairwells)

_____ Adequate supply of bottled water (per state requirements)

_____ Current contract for emergency food and water delivery

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_____ Emergency menu and products for three days of food service

_____ Emergency food supplies kept separate from daily supplies and rotated every six months

_____ One week of food supply for each resident

_____ Emergency back up box containing critical medications

_____ Emergency electrical outlets for life-sustaining medical equipment easily identifiable per regulation, checked monthly for appropriate operation and documented

_____ Current MSDS manual at each nurse's station

_____ Non-electric generator for emergency outlets, nurse station, night lights, exit & corridor lights, boiler room, fire alarm system, stairwells, heat and smoke detectors, dietary department; full load test performed per regulation

_____ Fire alarm connected directly to the local fire department

_____ Up-to-date, accurate evacuation plans posted at nurse's stations

_____ Evacuation drills and in-service provided as appropriate and required by regulation, minimum of 85% employee participation, documentation of training materials and sign-in sheets maintained

Date of Audit: _____ Time of Audit: _____

Signature of Auditor: _____

Any corrective actions taken: _____

_____

Administrator Signature: _____

Date Submitted to QA: _____

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EMERGENCY PREPAREDNESS: COMMUNITY AUDIT CHECKLIST

Policy and Procedure

Policy:
It is the policy of this community to provide appropriate emergency supplies, equipment and resources at all times, to meet the needs of our residents, employees and visitors in the event of an emergency. It is the responsibility of the Administrator to ensure that regularly scheduled audits of emergency supplies are performed by the designated Safety Officer. A summary report in the form of the Community Audit Checklist will be provided to the Quality Assurance Committee quarterly.

Procedure:

1. The designated Safety Officer will conduct a comprehensive audit of emergency supplies, equipment and resources monthly.
2. Areas identified as not meeting community expectations will be corrected immediately and the Administrator will be notified of the corrective action.
3. A summary report of each audit will be provided to the Quality Assurance Committee on a quarterly basis.
4. Areas requiring corrective interventions will be reviewed to determine the root cause of the deviance.
5. The Community Audit Checklist is the designated documentation tool for the results of each audit.
6. The Community Audit Checklist will be completed by this policy, signed and dated by the designated Safety Officer and maintained with the Quality Assurance documents.

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Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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EMERGENCY SUPPLY BOX

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees and visitors. The management team will provide appropriate training for employees, emphasizing the importance of having necessary emergency equipment available.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Emergency Supply Box.

2. Documentation for training will be included in the individual employee personnel file.

3. The Emergency Supply Box policy will be included in the annual in-service calendar as mandatory training for all employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. Provide a waterproof container (such as a plastic tote) at each nursing station containing the following supplies:

    - Replacement batteries for emergency equipment used at specific nursing stations, which may include:
        - Portable telephones
        - Door alarms
        - Flashlights
        - Emergency radio
        - Any other battery powered devices used for resident care

    - Three-pronged extension cords – the number to be established based on the number of beds served by the nursing unit and the capacity of the generator.

    - Duct tape to secure extension cords to reduce the risk of trip and falls.

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- Hand bells or whistles for individual resident use in the event the call light system is inoperable.
- Flashlights for each staff member.
- Emergency contact information for management team including Administrator, Director of Nursing, Director of Environmental Maintenance, etc.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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TRAFFIC CONTROL AND PARKING

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees, and visitors. Anxious relatives and friends may cause traffic congestion at the scene of an emergency that could hinder or delay assistance from emergency agencies, equipment and/or community personnel. The management team will provide appropriate training to all employees, emphasizing the importance of continuing to provide care for our residents with as little disruption as possible during emergency events.

Procedure:

1. The new employee orientation program will include a review of the Traffic Control and Parking policy and procedure.

2. Documentation of training will be maintained in individual employee training records.

3. The Traffic Control and Parking policy and procedure will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend a scheduled mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. Roadblocks may be set up by the local law enforcement agencies once a disaster is reported to them.

7. It is the responsibility of the individual employee who has been summoned to respond to the community during an emergency to determine which route to use in order to reach the community in an expeditious manner.

8. Carpooling from the road block area to the designated employee parking area has been a successful practice in other emergency situations.

9. A designated parking area should be identified and highlighted in the Emergency Disaster Manual prior to an emergency event occurring.

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10. Depending upon the nature and location of the emergency, the location for employee parking is_____.

11. Depending upon the nature and location of the emergency, the location for visitor and family parking is_____.

12. After arrival at the community, report to the Administrator or designated manager for further instruction.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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SUMMONS/RECALL OF OFF-DUTY PERSONNEL

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees and visitors. Off-duty employees may be recalled for support at times of immediate and restorative stages of a disaster. The management team will provide appropriate training for employees emphasizing the importance of continuing to provide care to our residents with as little disruption as possible during emergency events.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding the Summons/Recall of Off-Duty Personnel.

2. Documentation for training will be included in the individual employee personnel file.

3. The Summons/Recall of Off-Duty Personnel policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. A list of facility employees will be maintained and updated at least annually, with their telephone numbers and distances to the facility. Department heads and other key staff will be clearly identified.

7. The first person to be called back will be the Administrator. If the Administrator is not available, an alternate will be called back according to the Line of Authority.

8. Employees will be called back as directed by the Administrator, or designee, regarding the need for their job description and traveling distance and/or without travel restrictions caused by the disaster.

9. Employees will be reminded to bring their facility identification with them for identification purposes with the local authorities.

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10. After arrival at the community, recalled employees will report to the person in charge of assignment.

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Medical Director Signature: _____ Date: _____

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Emergency Preparedness Manual

SECTION 2
FIRE



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FIRE/EXPLOSION: SAFETY PLAN

Policy and Procedure

Policy:
It is the policy of this community that regular safety inspections be performed, and mandatory employee emergency preparedness training be provided to assist in maintaining a comfortable environment for residents, employees, and visitors.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Fire/Explosion: Safety Plan.

2. Documentation of orientation training will be maintained in individual personnel files.

3. The Fire/Explosion: Safety Plan policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of attendance at mandatory training will be maintained in individual personnel files.

5. Failure to meet the mandatory training requirements will result in the employee being removed from the staffing schedule until successful completion of all mandatory training has been achieved.

In the event a fire/explosion should occur, the following procedure is to be initiated:

1. If the fire alarm has not been automatically activated, pull the nearest fire alarm station, and contact the local fire department.

2. Close all fire doors if they are not automatically closed.

3. Move residents from affected areas to a safe zone within the facility. It may not be necessary to evacuate residents from the building depending on the structure, amount of smoke, toxicity of smoke, and fire barriers.

4. Determine if anyone has been injured, stabilize the injured and call 911 for emergency assistance in assessing residents for smoke inhalation and transportation.

5. Notify the Executive Director/Administrator and Director of Nursing Services.

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6. Make a general assessment of damage and determine if fire is present. Do not open doors where there is an active fire or immediate danger.

7. If more information becomes available prior to the arrival of emergency response personnel, contact 911 and inform them of pertinent information.

8. Refer to facility floor plan for evacuation if an evacuation procedure is determined to be necessary.

9. If possible, obtain visitors sign in logs, resident rosters and staffing sheets to determine the number of people potentially in the facility at the time of the event.

10. Perform a visual head count of residents, employees, and known visitors to determine their status and document their presence.

11. Ensure all necessary, life sustaining equipment is connected to emergency outlets.

12. Maintain resident comfort as allowable by performing regular, continuous rounds.

13. Assign employees to monitor residents with behaviors and acute medical conditions until evacuation is completed or facility is deemed safe to return residents to their rooms.

14. If injuries are evident, contact local emergency rooms to inform people of emergency transport.

15. Laundry personnel will secure their area by shutting down all equipment and reporting to their designated emergency position.

16. Dietary personnel will secure their area by shutting down all equipment and reporting to their designated emergency position.

17. Maintenance personnel will secure their area by shutting down all equipment and reporting to their designated emergency position.

18. The receptionist shall lock the elevators on the main floor to prevent inadvertent use.

19. Residents, employees and visitors shall remain in designated safe zones until the facility is deemed safe by the fire department and/or construction engineers.

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ALERTING AND EXTINGUISHING SYSTEMS

Policy and Procedure

Policy:
It is the policy of this community that employees be familiar with and competent in the operation of each alerting and extinguishing system within the community. Each employee will successfully demonstrate the ability to engage fire alarms, fire extinguishers, call alert systems, etc. as appropriate.

Procedure:

1. The new employee orientation process includes education on the facility emergency alert systems and fire extinguishing systems. New employees will be required to return demonstrate their individual ability to perform the appropriate steps in identifying and/or activating an alert system or extinguishing device.

2. Documentation of successful demonstrations will be maintained in individual employee training records.

3. Mandatory in-services to reinforce alerting and extinguishing systems operation will be provided on an annual basis and will require a return demonstration of each skill by each employee.

4. Documentation on training and successful completion of the return demonstration will be maintained in the employee training records.

5. Employees who fail to attend scheduled mandatory training on alerting and extinguishing systems operation will be removed from the staffing schedule until successful completion of the training and return demonstration is achieved.

6. Mandatory fire/evacuation drills will be conducted quarterly or as defined in state and federal regulations. Employees who are not in attendance for mandatory drills will be provided with individual training opportunities to reinforce the community's policy and procedure for emergency response.

7. Fire, tornado (seasonal), hurricane (seasonal), and/or other natural disaster drills will be conducted quarterly (geographically appropriate) on each shift to ensure that employees have appropriate practice hours to successfully respond to an actual emergency.

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8. Documentation of individual training will be maintained in the individual employee training records.

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Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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HealthCap
RISK MANAGEMENT SERVICES

FIRE ALERTING SYSTEMS – TYPES OF SYSTEMS AND OPERATION

Policy and Procedure

Policy:
It is the policy of this community that employees be familiar with and competent in the operation of each fire alerting and extinguishing system within the center. Employees will successfully demonstrate the ability to engage fire alarms, fire extinguishers, call alert systems, etc. as appropriate.

Procedure:

Sprinkler Systems:
Selected areas within the community are protected by sprinkler systems which are heat activated and release water over and around an area of intense heat. Once this system is activated, an alarm will sound, and all fire doors will close automatically.

Pull Systems:
To use any pull station, simply pull down on the handle as instructed. This automatically trips the toggle switch, which in turn activates the system. Once this system is activated, an alarm will sound, and all fire doors will close automatically.

Smoke Detectors - Electrical:
Smoke detectors are located throughout the facility. These systems are activated when sensors detect a build-up of smoke in the area. Once the smoke detector system is activated, an alarm will sound, and all fire doors will close automatically.

Resident Room Smoke Detectors – Battery Powered:
Smoke detectors located in resident rooms will sound an alarm when a build-up of smoke is detected. These alarms are ***NOT*** connected to the electrical system; therefore, the fire alerting pull system must be utilized to activate an alarm and automatically close all fire doors.

Note: Fire doors automatically close when any of the above electrical systems are activated. Fire doors are designed to contain fire. Do not open them once they are closed until and unless directed to do so by Fire Department authorities.

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RISK MANAGEMENT SERVICES

RESETTING THE FIRE ALARM

Policy and Procedure

Policy:
The Administrator of this community shall ensure that each department manager and shift supervisor has been provided with the necessary training to enable them to reset the fire alarm system. The fire alarm system shall not be reset until the community has met the "all clear" criteria, a pull station has been identified as engaged, and/or there are no maintenance personnel in the building.

Procedure:

1. Each department manager and shift supervisor shall attend mandatory training on the process of resetting the fire alarm system on an annual basis.

2. Documentation of training shall be maintained in the individual employee file.

3. No employee will be designated as a supervisor until such time as the training on resetting the fire alarm system has been successfully achieved and documented.

4. The department manager or shift supervisor will check the enunciator panel located _____; a red indicator light will identify the area where the fire alarm was triggered.

5. The department manager or shift supervisor will proceed to the area indicated on the enunciator panel as being engaged.

6. The department manager or shift supervisor will determine which pull station was used to trigger the system by performing a visual inspection of all pull stations in the area.

Example of Resetting Process:

7. *Use a screwdriver to turn the screw (counterclockwise) at the top of the pull station box.

8. *Open the pull station to expose the toggle switch.

9. *Reset the pull station by returning the toggle switch to the "normal" position.

10. *Reset the handle to the pull station by returning it to the upright position.

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11. *Close the door to the pull station.

12. *Return to the enunciator panel located _____.

13. *Use the key to open the door to the enunciator panel.

14. *Press the “reset” button.

15. *Close and lock the door on the enunciator panel.

16. *Call the maintenance supervisor at _____ to inform he/she of the event.

17. *Return the key and screwdriver to the identified storage location.

NOTE: If unable to reset the system after following these instructions, notify the maintenance director.

Steps 4 through 14 are facility specific and used here as an example of the step-by-step process only. Please adjust the information in each step to reflect specific facility alerting systems.

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Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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FIRE DRILL

Policy and Procedure

Policy:
It is the policy of this community that employees be familiar with the Fire Drill procedure and be able to successfully demonstrate the ability to engage fire alarms, fire extinguishers, call alert systems, etc. as appropriate. The management team will provide appropriate training for employees, emphasizing the importance of continuing to provide care for our residents with as little disruption as possible during emergency event.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure on Fire Drills.

2. Documentation for training will be included in the individual employee personnel file.

3. The Fire Drill policy and procedure will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. Fire drills will be conducted at least quarterly on each shift to ensure employees are aware of their duties and responsibilities.

7. Records will be maintained for each drill by the Maintenance Director that includes:
    a. Date of the drill
    b. Time of the drill
    c. Location of the fire
    d. Name of the person in charge of the drill
    e. Analysis of the performance of the staff
    f. Any identified additional training that is needed or other pertinent comments
    g. A sign-in list of all staff participants

Fill in the community specific procedure for a fire emergency and drill. Reinforce any acronyms if the community uses them, such as:

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R –Race
A – Alarm Alert
C – Close and Clear
E – Extinguish and Evacuate

If the community exit door alarms and locks are deactivated when the fire alarm is activated, ensure the policy includes assigning a staff member to observe each door to prevent an elopement from occurring.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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Fire Drill Report

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees, and visitors in the event of an emergency. The management team will provide appropriate training for staff emphasizing the importance of continuing to provide care for our residents in the event of a fire

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding mandatory fire drills.

2. Documentation of training will be included in the individual employee personnel file.

3. The fire drill policy will be included on the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. Fire drills will be conducted per state and federal regulations A summary of fire drill outcomes will be provided to the Quality Assurance Committee quarterly.

7. The manager in charge of performing a scheduled fire drill will monitor the response of staff, residents and visitors throughout the drill process.

8. Documentation of the drill outcomes will be completed by the manager on the Recap and Analysis of Fire Drills tool including:

    a. Staff who were present during the fire drill and responded to the alert
    b. Positive outcomes identified during the drill and post-drill recap
    c. Negative outcomes which require discussion and a plan of action to correct
    d. Recommendations for improvement in the overall fire drill process specifically addressing the negative outcomes identified

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9. The Director of Maintenance will provide a summary of the outcomes from each fire drill to the Quality Assurance Committee on a quarterly basis.

10. The Quality Assurance Committee will discuss corrective actions, make recommendations to improve outcomes, and initiate a timeframe for implementation of the corrective action plan as needed.

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Medical Director Signature: _____ Date: _____

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RECAP & ANALYSIS OF FIRE DRILLS

Date: _____ Time: _____

Observers

Positive Outcomes

Negative Outcomes

Recommendations/Plan

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FIRE SAFETY: WEEKLY

Policy and Procedure

Policy:
It is the policy of this community to perform regular safety inspections to assist in maintaining a comfortable environment for our residents, employees, and visitors.

Procedure:

1. Fire inspection audits will be performed weekly by a member of the Environmental Maintenance department and documentation will be maintained on the Fire Safety Weekly Log.

2. The Director of the Environmental Maintenance department will implement a monitoring process to ensure weekly checks are performed per this policy.

3. Fire/smoke doors will be checked weekly to ensure proper closure properties are maintained.

4. Enunciator panel will be checked weekly to ensure proper operation and audio/visual signaling systems are working.

5. The procedure for re-setting of the Fire Alarm System is posted for employees to initiate.

6. Exit signs will be checked to ensure they are lit and unobstructed from view.

7. Lint filters on clothes dryers in the laundry area and grease filters/traps in the dietary department will be checked weekly to ensure they are free of debris/grease/etc.

8. Smoke detector batteries will be checked on a rotation basis to ensure proper operation. Each battery will be dated when placed in the smoke detector and with each inspection.

9. The Fire Safety Weekly inspection log will be completed, signed, dated, and filed in the Environmental Maintenance department.

10. A summary of weekly audit findings will be provided to the Quality Assurance and Safety Committees monthly.

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Medical Director Signature: _____ Date: _____

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FIRE SAFETY: WEEKLY LOG

Date	Fire/Smoke Door Check	Enunciator Check	Filters (Kitchen/ Laundry) Check	Battery Smoke Detectors Check	Exit Sign Checks	Initials	Comments, Repairs or Replacement

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** Emergency Preparedness Manual*

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FIRE SAFETY – MONTHLY

Policy and Procedure

Policy:
It is the policy of this community to perform regular safety inspections within the center to assist in maintaining a comfortable environment for our residents, employees, and visitors.

Procedure:

1. Fire inspection audits will be performed each month by a member of the Environmental Maintenance department and documentation will be maintained on the Fire Safety: Monthly Log.

2. The Director of the Environmental Maintenance department will implement a monitoring process to ensure monthly checks are performed in accordance with this policy.

3. The Fire Safety Monthly Log will be initiated, documented and maintained by the Director of Environmental Maintenance or designee.

4. Fire drills will be conducted monthly to ensure that each of the three (3) shifts has performed a drill on a quarterly basis. The date and time of each drill will be documented on the Fire Safety Monthly Log.

5. Each fire drill will be observed by a member of the Environmental Maintenance department or a designee to ensure that the process is timely and appropriate.

6. The observer will monitor that the process includes the following:

    a. The station pulled will be identified by a staff member as soon as possible
    b. Fire extinguishers will be brought to the location and be available for use
    c. Employees will respond appropriately to the fire alert and provide a safe environment for the residents
    d. Exit doors will be monitored by a designated employee if door alarms are deactivated by the fire alarm system

7. A summary of findings from the Fire Safety Monthly Log will be provided to the Quality Assurance and Safety Committees on a quarterly basis and will include corrective actions as necessary.

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Medical Director Signature: _____ Date: _____

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FIRE SAFETY – MONTHLY LOG

Drill Date	Station Pulled	Shift/ Time	Extinguishers Present	Date	Extinguisher Check	Initials	Comments/Repairs

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** Emergency Preparedness Manual*

Emergency Preparedness Manual

SECTION 3
UTILITY EMERGENCIES



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LOSS OF CALL LIGHT SYSTEM

Policy and Procedure

Policy:
This emergency policy is developed to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees and visitors. The management team will provide appropriate training to employees emphasizing the importance of maintaining a process where residents are able to notify staff when assistance is needed and/or in an emergency.

Procedure:

1. The general orientation process includes training on the Loss of Call Light System policy and the procedure for addressing failure in the call light system.

2. Documentation of orientation training will be maintained in individual employee files.

3. The Loss of Call Light System policy will be included on the annual in-service calendar as mandatory training for employees.

4. Documentation of attendance at mandatory training will be maintained in individual employee files.

5. Employees who fail to attend mandatory training sessions will be removed from the staffing schedule until mandatory training requirements have been met.

6. Training will include identifying how to maintain a safe environment in the event of call light system failure.

7. If the call light system is identified as being inoperable, the Executive Director/Administrator, Director of Nursing Services and the Director of Maintenance shall be notified immediately.

8. Employees shall provide residents with a means of alerting caregivers when assistance is needed (i.e., hand bells, whistles, etc.), demonstrate how to use the device and inform them that they are to be used when assistance is needed until further notice.

9. Emergency supplies including hand bells/whistles, etc. are available 24 hours a day, 7 days per week and are located _____.

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10. Employees shall be assigned to perform ongoing rounds and document findings every fifteen (15) minutes or more frequently if needed.

11. Residents may be grouped together in activity areas to assist in identifying and meeting their needs timelier.

12. The Administrator or designee shall determine the report-ability of the call light system failure and report to the appropriate licensing agency as outlined in the state regulations.

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Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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NATURAL GAS LEAK

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees, and visitors. The management team will provide appropriate training for employees emphasizing the importance of continuing to provide care to our residents with as little disruption as possible during emergency events.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Natural Gas Leak.

2. Documentation for training will be included in the individual employee personnel file.

3. The Natural Gas Leak policy and procedure will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. If a natural gas leak is identified, the shift supervisor, with the assistance of available staff members will attempt to determine the source of the leak.

7. Smoking or open flames are not permitted on the facility property until the source of the leak is identified.

8. All electrical equipment located around the gas leak is to be shut off or disconnected.

9. All windows around the gas leak shall be opened immediately and monitored to prevent residents from attempting to close the windows or to exit through open windows.

10. The community manager or shift supervisor shall call 911 immediately and alert the fire department that there may be a natural gas leak.

11. Residents in the general area of the identified leak shall be relocated immediately.

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12. The Dietary and Laundry departments shall extinguish all pilot lights and turn off or disconnect all electrical equipment.

13. The Administrator and Maintenance Director shall be notified and be present in the center if necessary.

14. Additional precautions and instructions will be initiated by the Administrator or designee as deemed necessary up to and including evacuation of the building.

15. The Administrator or designee will notify the appropriate State regulatory agencies as outlined in state specific regulations.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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INTERRUPTION OF NATURAL GAS SERVICE

Policy and Procedure

Policy:
This emergency policy has been developed to assist the community in maintaining a comfortable environment for our residents, employees and visitors. The management team will provide appropriate training for employees, emphasizing the importance of continuing to provide care to our residents with as little disruption as possible during an interruption of natural gas service.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Interruption of Natural Gas Service.

2. Documentation of the orientation training on the Interruption of Natural Gas Service will be maintained in the individual employee files.

3. The Interruption of Natural Gas Service policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of attendance at mandatory in-service training on Interruption of Natural Gas Service will be maintained in the individual employee file.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until compliance is achieved.

6. The shift supervisor or manager shall notify the Administrator and supplier of natural gas upon identifying that the gas service has been interrupted.

7. Health care communities are placed on a priority basis during emergency events and as such should be identified as a health care facility when notifying the gas provider.

8. In inclement weather, such as winter months when temperatures are below 60 degrees outdoors, implement the Cold Weather Emergency protocol.

9. Meals will be prepared using the dietary steam table and the emergency menu plan of canned foods.

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10. The laundry department will assess the backup supply of linen and use emergency disposable incontinent products and bed liners.

11. Nursing will perform linen changes only when soiled.

12. Additional precautions and instructions may be initiated by the Administrator or designee as needed up to and including evacuation of the building.

13. The Administrator or designee will notify the appropriate State regulatory agencies as outlined in state specific regulations.

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Medical Director Signature: _____ Date: _____

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TELEPHONE SERVICE FAILURE

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees, and visitors. The management team will provide appropriate training to employees emphasizing the importance of continuing to provide care for our residents with as little disruption as possible during a Telephone Service Failure.

Procedure:

1. The general orientation process for new employees will include a review of the policy and procedure regarding Telephone Service Failure.

2. Documentation for training will be included in the individual employee personnel file.

3. The Telephone Service Failure policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

In the event of a Telephone Service Failure the following procedure will be initiated:

6. **For 911 Emergencies:** locate a cell phone or go to a telephone off site, dial 911 and give location, address, type of emergency, etc.

7. Notify the Administrator and Director of Nursing of service issues and initiate plan as directed.

8. Notify the telephone service company and identify the community is a priority health care facility.

9. Notify other services that would rely on the telephone system to alert them that the telephone service is not operational.

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10. Additional precautions and instructions may be initiated by the Administrator or designee as needed.

11. The Administrator or designee will notify the appropriate State regulatory agencies as outlined in state specific regulations if necessary.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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WATER LINE BREAK/FLOODING

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees and visitors. The management team will provide appropriate training to employees, emphasizing the importance of ensuring that residents are maintained in a comfortable environment.

Procedure:

1. The general orientation process includes training on the Water Line Break/Flooding policy.

2. Documentation for training will be included in the individual employee personnel file.

3. The Water Line Break/Flooding policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. Training will include identifying the risks posed to the residents in the event a water line should break, and flooding occur.

7. All residents who may be in the affected area will be relocated.

8. Residents will be assessed for injuries, especially if hot water is involved. If injuries are identified that require immediate medical attention, the charge nurse or manager will call 911 for assistance.

9. If possible, shut the water valve that feeds the affected area.

10. Notify the Director of Maintenance if there are no other maintenance personnel on the premises.

11. Notify the Administrator and contact the local emergency response team if directed to do so by the Administrator in their absence.

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12. Prepare employees for the possibility of no water access for an undetermined amount of time.

13. Access emergency water supplies and stock units with the water necessary to meet each resident's hydration and hygiene needs.

14. Supply each unit with waterless hand sanitizer, pre-moistened towelettes, etc. for hand cleaning.

15. The Administrator shall report the water line break to the appropriate state regulatory agency as outlined in state specific regulations.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

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RISK MANAGEMENT SERVICES

INTERRUPTION IN WATER SUPPLY

Policy and Procedure

Policy:
This emergency policy is developed to assist the community in maintaining a comfortable environment for our residents, employees and visitors. The management team will provide appropriate training to all employees emphasizing the importance of continuing to provide care to our residents with as little disruption as possible during an Interruption in water supply.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Interruption in Water Supply.

2. Documentation of orientation training will be maintained in individual personnel files.

3. The Interruption in Water Supply policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of attendance at mandatory training will be maintained in individual personnel files.

5. Failure to meet the mandatory training requirements will result in the employee being removed from the staffing schedule until successful completion of all mandatory training has been achieved.

6. When an interruption in the water supply is identified, the shift supervisor or community manager will notify the local water department and Administrator immediately.

7. Immediately contact the service provider contracted to supply emergency water service in the event of an interruption in water supply (contact information for Emergency Water Supplies is in the front of the Emergency Preparedness Manual index of telephone numbers).

8. If the service provider is unable to provide a minimum of 200 gallons per day of drinking water, contact the local Health Department (contact information in front of the Emergency Preparedness Manual index of telephone numbers).

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** Emergency Preparedness Manual*

9. Assess whether the available water is usable for dishwashing, clothes washing or showering; if not:
    a. Utilize backup linen supply and disposable incontinent products
    b. Utilize disposable dishware and flatware to eliminate the need to sanitize dishes and utensils
    c. Use prepackaged beverages for meal service and serve in container with straws
    d. Use disposable, pre-moistened wipes to provide hygiene to residents

10. Additional precautions and instructions may be initiated by the Administrator or designee as needed up to and including evacuation of the building.

11. The Administrator or designee will notify the appropriate State regulatory agencies as outlined in state specific regulations.

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EMERGENCY WATER PURIFICATION

Policy and Procedure

Policy: This policy is intended to assist the community in meeting its responsibility of maintaining a comfortable environment for residents, employees and visitors and to emphasize the importance of training in preparing for unanticipated natural disturbances.

Procedure:
If there is a disturbance in the water supply that interferes with the community's ability to provide purified drinking water for residents, employees and visitors, the following procedure will be initiated under the direction of the Administrator and Director of Environmental Services:

1. Water may be purified using 5% household bleach such as Clorox, etc. using the following calculations:

    - If available water is visually clear (no sediment, cloudiness, turbidity, etc.) use the following calculations:

Gallons of Clear Water	Amount of Bleach
¼	2 drops
½	4 drops
1	8 drops
2	1 teaspoon
5	2 teaspoons
100	1 ounce
1000	1 cup

- If available water contains sediment, cloudiness, mud (turbid) etc., use the following calculations:

Gallons of Turbid Water	Amount of Bleach
¼	3 drops
½	5 drops
1	1 teaspoon
2	2 teaspoons
5	1 tablespoon
100	1 ½ ounces
1000	1 pint

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All water treated using the above calculations should be relatively clear, add the appropriate amount of household bleach, cover, shake well and allow to stand 30 minutes before use. If gas or electricity is available, water that is relatively clear may be purified by ***boiling the water briskly for 10 minutes*** and allowing the water to stand while cooling.

**Boiled and chlorinated water must be stored in clean covered containers. Water should be stored in the refrigerator if available.*

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EMERGENCY POWER OUTAGE

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees, and visitors. The management team will provide appropriate training for employees, emphasizing the importance of continuing to provide care to our residents with as little disruption as possible in the event of an Unscheduled/Emergency Power Outage.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Unscheduled/Emergency Power Outage.

2. Documentation of orientation training will be maintained in individual personnel files.
3. The Unscheduled/Emergency Power Outage policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of attendance at mandatory training will be maintained in individual personnel files.
5. Failure to meet the mandatory training requirements will result in the employee being removed from the staffing schedule until successful completion of all mandatory training has been achieved.

In the event an unscheduled electrical power interruption should occur, the following procedure will be initiated:

1. Assess each resident and determine their immediate medical needs to ensure resident needs are met and care is provided as needed.

2. Ensure all necessary life sustaining electrical equipment is connected to emergency power sources.

3. Notify the Administrator and the Director of Nursing Services.

4. The designated charge nurse will follow the direction of the Administrator in his or her absence regarding notifying the appropriate emergency response team.

5. If immediate response is needed, contact the local police department by dialing 911, inform them of the problem and request their immediate assistance.

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6. Provide each resident care area with portable lanterns to illuminate resident rooms, halls and bathrooms. Each resident must be supplied with a means of calling for assistance (i.e., hand bells, whistles, etc.); plug in telephone (cordless telephones will not work without electricity); and/or cell phone for emergency contact.

7. Assign employees to perform continuous rounds to monitor resident status and document findings and time of rounds.

8. The Administrator or designee will maintain continuous monitoring and intervention up to and including evacuation of the building if necessary.

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EMERGENCY POWER OUTAGE – NO GENERATOR

Policy and Procedure

Policy:
Communities with no access to emergency power generators are still required to maintain resident comfort in the event of a power outage. Providing heat, lights, food, fluids and ADL care without electricity can be challenging and emergency pre-evacuation procedures should be initiated.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Unscheduled/Emergency Power Outage – No Generator.
2. Documentation of orientation training will be maintained in individual personnel files.

3. The Unscheduled/Emergency Power Outage – No Generator policy will be included on the annual in-service calendar as mandatory training for employees.
4. Documentation of attendance at mandatory training will be maintained in individual personnel files.

5. Failure to meet the mandatory training requirements will result in the employee being removed from the staffing schedule until successful completion of all mandatory training has been achieved.
6. ***If power is out for greater than two continuous hours and the outside temperature is below 60 degrees F, pre-evacuation procedures should be initiated to include:***

7. Initiate the procedure outlined in Unscheduled/Emergency Power Outage Policy and Procedure.
    a. Ensuring each resident has a current armband and/or picture ID
    b. Emergency contact information is available for each resident
    c. Battery powered lanterns and flashlights are operable and have replacement batteries available
    d. Emergency medication box is available
    e. Additional employees have been contacted to assist in evacuating residents

8. If battery powered emergency lighting fails or indoor temperature drops below 65 degrees F, evacuation procedures must be initiated.

9. Refer to facility specific evacuation procedures in the Emergency Preparedness Manual including mandatory state-specific reporting requirements.

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Emergency Preparedness Manual

SECTION 4
WEATHER RELATEDY EMERGENCIES



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COLD WEATHER EMERGENCY

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees, and visitors. The management team will provide appropriate training to employees emphasizing the impact extreme cold may have on the frail elderly and the importance of preventing weather related illness/death.

Procedure:

1. The general orientation process includes training on the Cold Weather Emergency policy.

2. Documentation of training on Cold Weather Emergency will be maintained in each employee personnel record.

3. The Cold Weather Emergency policy will be included in the annual in-service calendar as a mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend a scheduled mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. Training will include identifying the signs and symptoms of hypothermia and exposure.

7. During severe cold weather, window coverings will be kept closed to contain heat within the building.

8. Residents will be provided with additional blankets and bedspreads.

9. Room temperatures will be monitored on a scheduled basis by the Maintenance department designee and documented.

10. Residents will be moved from rooms where room air is found to be below acceptable standards and placed in warmer areas (refer to state and Federal regulations).

11. Electric heaters will be authorized for use ***only*** in designated areas under ***direct supervision*** while in use (i.e., common dining areas, day rooms, etc.).

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12. Residents will be dressed in layers of clothing and socks that are easily added and removed for comfort.

13. Warm or hot snacks and beverages will be offered to residents, employees, and visitors on a regular basis.

14. Additional precautions may be initiated by the Administrator or designee as deemed necessary to ensure ongoing warmth and comfort up to and including evacuation of the building.

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HEAT WAVE ADVISORY

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees and visitors. The management team will provide appropriate training for employees emphasizing the impact extreme heat has on the frail elderly and the importance of preventing heat related illness/death.

Procedure:

1. The general orientation process includes training on the Heat Wave Advisory policy.

1. Documentation for training will be included in the individual employee personnel file.

2. The Heat Wave Advisory policy will be included in the annual in-service calendar as mandatory training for all employees.

3. Documentation of training will be maintained in the employee training records.

4. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

5. Training will include identifying the signs and symptoms of heat exhaustion.

6. During a heat wave advisory, all window coverings will be closed during daylight hours.

7. Fans will be placed strategically in the corridors and resident rooms to assist in circulating air.

8. All available air conditioning units will be used and relocated as necessary to provide optimal cooling effects for the largest number of residents.

9. Residents will be encouraged and assisted in dressing in light weight, short-sleeved or sleeveless clothing.

10. Hydration rounds will be provided every hour, and each resident will be encouraged to consume a form of fluid orally, enterally or parenterally unless contraindicated by the resident's condition.

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11. Showers and/or sponge baths will be given to residents exhibiting signs and symptoms of heat exhaustion.

12. Residents will be encouraged to remain out of direct sunlight, preferably indoors.

13. Residents will be encouraged to engage in frequent rest breaks.

14. Employees will be provided with cool, refreshing beverages and snacks and will be encouraged to take frequent rest periods when relief is available.

15. Additional precautions may be initiated by the Administrator or designee as deemed necessary to ensure ongoing safety up to and including evacuation of the building.

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HEAVY SNOW/BLIZZARD/ICE CONDITIONS

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees, and visitors. The management team will provide appropriate training for employees emphasizing the importance of continuing to provide care to our residents with as little disruption as possible during weather related events.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Heavy Snow/Blizzard/Ice Conditions.

2. Documentation for training will be included in the individual employee personnel file.

3. The Heavy Snow/Blizzard/Ice Conditions policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. A battery powered weather band radio will be available to monitor for condition changes and announcements from the National Weather Service.

7. Employees will be notified of the National Weather Service broadcast and be periodically updated on this information as it is available.

8. Arrangements will be made for emergency service with snow removal, ice removal and/or for salting for ice with the contracted vendor.

9. The shift supervisor or department manager will monitor staffing levels and ratios to ensure that adequate staffing is available for each shift.

10. The Administrator will authorize the use of transportation services as necessary to ensure adequate staff are in the community to provide care.

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11. Lodging and meals will be offered to employees and volunteers as needed to ensure that adequate staff are in the community to provide care.

12. Department managers and supervisors are required to remain in the community for the duration of the weather-related event to ensure continuity of care for residents, employees, and visitors.

13. The Dietary Department will be responsible for maintaining an adequate food supply to satisfy the needs of the facility during the crisis.

14. Additional precautions, instruction and intervention will be instituted by the Administrator, Director of Nursing or their designee as necessary.

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TORNADO WARNING

Policy and Procedure

*A **Tornado Warning** means that a tornado has been sighted in the vicinity and safety action should be taken immediately*

Policy:
This community is in a geographical area where the risk of seasonal tornado activity is a possibility. This policy is intended to assist the community in meeting its responsibility of maintaining a comfortable environment for residents, employees, and visitors while emphasizing the importance of training in preparing for impending anticipated weather disturbances.

Procedure:

1. The general orientation process will include having each employee instructed and given a copy of the community policy and procedure regarding Tornado Warning.

2. Documentation for training will be included in the individual employee personnel file.

3. Training on this policy and procedure is mandatory and will be conducted at least annually prior to and during the anticipated peak tornado period.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. When a tornado warning has been issued by the National Weather Service, "Severe Weather Alert" will be announced on the overhead paging system three (3) times by the shift supervisor or charge nurse.

7. The shift supervisor or charge nurse will bring emergency equipment to the designated emergency location on each nursing unit including flashlights, first aid kits, blankets, pillows, cell phone, etc.

8. The shift supervisor or charge nurse will assign all available employees to bring or escort non-bed bound residents into the designated corridors and ensure they are seated comfortably in chairs, wheelchairs, etc.

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9. Bed bound residents will be secured in their rooms and assisted with positioning pillows to protect their head area.

10. All available employees will perform rounds on the unit and ensure all windows, blinds, window and cubicle curtains, and room doors remain closed.

11. The shift supervisor or designee will continuously monitor the weather reports for updates on weather conditions and maintain contact with local emergency response teams.

12. Residents will be maintained comfortably in the corridors where they can be attended to and easily located in the event an evacuation becomes necessary.

13. Staff members will remain on their assigned units until the weather alert has been discontinued by the National Weather Service.

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TORNADO WATCH

Policy and Procedure

A tornado watch *means that conditions are right for a tornado to develop, however no active tornado has been sighted*

Policy:
This community is in a geographical area where the risk of seasonal tornado activity is a possibility. This policy is intended to assist the community in meeting its responsibility of maintaining a comfortable environment for residents, employees, and visitors while emphasizing the importance of training in preparation for impending anticipated weather disturbances.

Procedure:

1. The general orientation process will require each employee to be instructed on and given a copy of the Tornado Watch policy.

2. Documentation for training will be included in the individual employee personnel file.

3. Training of the Tornado Watch policy is mandatory and will be conducted at least annually prior to and/or during the anticipated peak tornado period.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. The Director of Environmental Maintenance or shift supervisor will assign employees to assess the area around the exterior of the building and secure any objects which may become airborne in high winds.

7. The shift supervisor or charge nurse will ensure emergency equipment is functional and available, i.e., flashlights, first aid kits, blankets, pillows, cell phones, etc.

8. The shift supervisor or charge nurse will assign all available employees to bring chairs into the corridor to provide seating for residents and staff in the event an upgrade to “Tornado Warning” is issued by the National Weather Service.

9. The shift supervisor or designee will monitor the weather reports for updates on weather conditions.

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10. All available employees will perform rounds on the unit and close all windows, blinds, window and cubicle curtains.

11. Residents will be maintained comfortably in their rooms where they can be quickly located and moved to corridors if necessary.

12. Employees will remain on their assigned units until the weather alert has been discontinued by the National Weather Service.

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HURRICANE SAFETY

Policy and Procedure

Policy:
This community is in a geographical area conducive to hurricane threats, making it a priority that a comfortable environment for our residents, employees and visitors is maintained.

Providing a comfortable environment is every employee's responsibility and includes taking appropriate, timely actions necessary to promote safety, up to and including a calm, systematic evacuation of the community. It is each employee's responsibility to attend all mandatory in-service training regarding emergency preparedness and evacuation procedures. Attendance at mandatory training will be maintained in individual personnel files and employees who fail to meet mandatory training will be removed from the staffing schedule until training requirements are met.

Procedure:
In the event a hurricane is possible, the following steps will be initiated by the designated charge nurse or facility manager.

1. Tune a non-electric radio, television or weather monitor to a local station or frequency to keep current on the changing weather conditions:

   Radio Stations: **AM: _____** **FM: _____**

   Television Stations: **Local: _____** **Cable: _____**

2. Notify the Executive Director/Administrator or designee. Emergency contact numbers are in the Emergency Preparedness Manual located at each nurse's station.

If a hurricane is imminent, continue with the following steps of the hurricane preparedness plan.

3. Remove all residents from areas where the risk of breaking glass or flying debris could cause injury.

4. Close all windows and doors in resident care areas.

5. Prepare residents for possible evacuation (i.e., place in wheelchairs, etc. if appropriate).

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6. Disconnect or turn off non-essential electrical equipment.

7. Assign employees to assist with transporting acutely ill and/or confused, fearful residents.

8. Ensure that all necessary life sustaining, electrical equipment is connected to emergency outlets.

9. *Residents who require life sustaining equipment are to be prioritized* as the first for transport to safety and/or evacuation.

10. Supply evacuation area with adequate drinking water and disposable cups.

11. Provide flashlights to direct care of staff in the event they are needed during power outages.

12. Secure emergency medication and first aid supplies and place on evacuation unit.

13. *At a minimum, secure a current resident roster;* all other medical records should be obtained and secured only if emergency evacuation personnel determine there is adequate time to do so safely.

14. Follow directions of emergency evacuation personnel, i.e., fire department, first response teams, police departments, etc.

15. Secure community to prevent exiting or entering until safety has been determined and maintained for residents, employees and visitors.

If a hurricane is not declared as imminent await further instructions from the management team and local emergency response personnel.

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EARTHQUAKE PREPAREDNESS

Policy and Procedure

Policy:
This community is in a geographical area conducive to earthquakes. This policy is intended to assist the community in meeting its responsibility of providing a comfortable environment for residents, employees and visitors in the event of an earthquake while emphasizing the importance of training in preparation for unanticipated natural disturbances.

Procedure:

1. The new employee orientation process will include Emergency Preparedness training including response expectations in the event of an Earthquake.

2. Documentation of orientation training will be maintained in individual personnel files.

3. The Earthquake Preparedness training is mandatory for employees on an annual basis.

4. Documentation of training will be maintained in individual personnel files.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

Preparedness before an Earthquake: Assess, Plan, Train, and Secure

6. The Director of Environmental Maintenance or Safety Officer shall assess the community as it pertains to safety in the event of an earthquake. The assessment process shall include:
   - Monitoring items hanging over the head of beds, removing such items and educating residents and families on the risks of such items.
   - Securing water heaters to the floor or studs using strapping or other devices.
   - Securing heavy items such as televisions on high stands or moving heavy items to lower secure locations.
   - Securing large, heavy pieces of furniture such as bookcases and armoires to walls or wall studs.
   - Installing latches on cupboard doors to prevent opening during an event, increasing risk of injury from falling items.

7. The Director of Environmental Maintenance or the designated Safety Officer shall periodically audit to ensure that conditions are maintained, and that emergency equipment and safety kits are functional and available, i.e. flashlights, first aid kits, blankets, pillows, cell phones, extra batteries, emergency radios, etc.

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8. The Director of Environmental Maintenance or the designated Safety Officer shall periodically conduct earthquake drills to assure staff is aware of safety procedure expectations in the event of an earthquake. Documentation of these drills should be maintained with other emergency drill documentation.

9. When annually reviewing the Earthquake protocol refer to the State specific website for additional and updated information such as the Office of Homeland Security and the Emergency Management Agency.

10. Revise the protocol as needed to comply with State Agency recommendations.

11. Provide mandatory educational opportunities for employees on community expectations regarding maintaining a comfortable environment in the event of an earthquake.

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EARTHQUAKE ACTUAL EVENT

Policy and Procedure

Policy:
This policy is intended to assist the community in meeting its responsibility of maintaining a comfortable environment for residents, employees and visitors while emphasizing the importance of training in preparation for unanticipated natural disturbances.

Procedure:

1. The general orientation process for new employees will include emergency preparedness training specific to Earthquake Safety and preparing for an Actual Event.

2. Documentation of training will be maintained in individual employee files.

3. Mandatory training will be provided for employees on an annual basis and will include emergency preparedness training specific to Earthquake Safety and preparing for an Actual Event.

4. Documentation of training will be maintained in individual employee files.

5. Employees identified as failing to meet mandatory emergency preparedness training will be removed from the staffing schedule until training requirements have been met.

Mandatory training on preparing for an actual earthquake event will include:

- DROP to the ground
- COVER by getting under a sturdy table or other piece of furniture
- HOLD ON until the quake stops to assist in maintaining safety for residents, visitors, and employees

6. If there is no heavy object to provide cover, sit on the floor against an interior wall away from windows.

7. Move to the closest place of safety.

8. Stay away from windows, heavy mirrors, and heavy furniture that may fall or tip.

9. If an earthquake occurs at night, instruct staff to assist residents in staying in bed and cover their heads with a pillow.

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10. Seeking protection in doorways is not recommended as:

    - Many doorways are not built into the structural integrity of a building and may not offer protection
    - Doorway openings are generally not designed for more than one (1) person

11. Do not run for exits. Many injuries are caused by falling, so if you get down or brace yourself, you can avoid falling.

12. Do not be alarmed as sprinklers may go off and fire alarms may engage.

13. Do not try to escape a building while the ground is shaking. There is a greater risk of injury from falls or from flying debris. The risk of tripping, falling or getting cut by damaged floors, walls and items in the path of escape is also increased by movement during shaking. At least half of all injuries during an earthquake are from non-structural objects.

14. If outdoors when an earthquake occurs, stay away from trees, buildings and overhead power lines.

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Medical Director Signature: _____ Date: _____

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RISK MANAGEMENT SERVICES

POST EARTHQUAKE EVENT

Policy and Procedure

Policy:
This policy is intended to assist the community in meeting its responsibility of maintaining a comfortable environment for residents, employees and visitors while emphasizing the importance of training in preparation for unanticipated natural disturbances.

Procedure:
1. The new employee orientation process will include emergency preparedness training on Post Earthquake Event.

2. Documentation of all disaster training will be maintained in individual personnel files.

3. Emergency Preparedness training including Post Earthquake Event will be mandatory for employees.

4. Employees who fail to meet the requirements for mandatory training programs will be removed from the staffing schedule until such training requirements have been met.

5. Staff members, visitors, and residents are to remain in their assigned units or in a designated place until all clear has been called by the person in charge.

6. Each resident shall be assessed for injury.

7. Designated individuals shall inspect the building for damage. Evacuation shall only occur if major structural damage is identified, if a fire occurs or if directed by first responders.

8. Do not ignite matches, lighters, or candles as there is a risk that gas lines may be interrupted causing gas leaks.

9. A designated individual shall inspect gas, water, and electric lines. If the integrity of these lines is in question, turn off the main valves. If a gas leak is suspected (rotten egg smell) open windows, evacuate and report it to the local gas company or fire department.

10. A designated individual should monitor the emergency radio for updates on community conditions.

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11. Check all telephones to ensure they have not been dislodged and that they are in working order.

12. Telephones should remain open for emergency responder use and other calls should only be made for life threatening emergencies.

13. Residents, employees and visitors should be prepared for aftershocks that may occur from hours to days after earthquakes. If an aftershock occurs, DROP, COVER, AND HOLD ON! Post-aftershock assessment should include steps 1 through 8.

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Emergency Preparedness Manual

SECTION 5
MAN MADE THREATS



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BIOLOGICAL EVENT: SUSPECTED TERRORISM
Suspicious Letter, package or another item

Policy and Procedure

Policy
It is the policy of this community that all necessary care and precautions will be taken to maintain a comfortable environment for our residents, employees, and visitors. The Administrator or designee is responsible for overseeing and addressing identified concerns immediately. All situations addressed will be reported to the Quality Assurance Committee on a quarterly basis.

Purpose

1. The general orientation process for new employees will include a review of this policy and procedure regarding Biological Event: Suspected Terrorism.

2. Documentation of training will be included in the individual employee personnel file.

3. The Biological Event: Suspected Terrorism policy will be included in the annual in-service calendar as a mandatory for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who do not attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

In the event a biological act or threat occurs in the community (suspicious letter, package, or other device), the following actions will be initiated:

6. Place the letter or package on a flat surface; do not smell, touch, taste, or look closely at the item.

7. Quietly alert others in the area about the suspicious package or letter.

8. Evacuate the room where the package is located and close the door.

9. Prevent others from entering the general area and close and secure the door.

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10. Wash hands thoroughly with soap and water.

11. Notify the Administrator/Executive Director and the Director of Nursing Services.

12. Notify the Director of Maintenance and if possible, close/shut off the ventilation system.

13. Notify the local and/or state police clearly explaining the situation and the safeguards instituted.

14. Secure community doors and prohibit visitors from entering until the community has been deemed free of hazards.

15. Remain in the area and prevent others from moving freely throughout the building.

16. Create a list of people who were in the general area of the suspicious item and a list of who may have handled the item; give lists to authorities.

17. Follow the direction of the authorities for decontamination and treatment of exposed individuals.

18. Prepare community staff and residents for possible evacuation.

19. If evacuation is deemed necessary, initiate the community specific evacuation plan as outlined in the emergency preparedness manual.

20. No one returns to the community until clearance is obtained from the authorities and the threat is no longer in the community.

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Medical Director Signature: _____ Date: _____

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RISK MANAGEMENT SERVICES

BOMB THREAT

Policy and Procedure

Policy:
It is the policy of this community to maintain a comfortable environment for our residents, employees and visitors. This emergency policy is developed to assist the community in meeting its responsibility to emphasize the importance of training employees in appropriate response to a bomb threat.

Procedure:
While bomb threats or warnings may be received at any time by mail or message, the most common method is by telephone.

1. As part of the new employee orientation program, each employee will be instructed on the Bomb Threat Checklist and the importance of obtaining this information in the event of a bomb threat.

2. Documentation for training will be included in the individual employee personnel file.

3. The Bomb Threat policy will be included on the annual in-service calendar as mandatory for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. If a bomb threat is received the management team shall proceed to secure the community, in a calm manner.

7. The manager shall use the Threat of Violence Checklist which is in the Emergency Preparedness Manual to obtain and document as much information as possible.

8. The manager should notify the Administrator and the person in charge will notify the local law enforcement agency immediately.

9. The Administrator may elect to turn off all radio and paging systems using runners to carry messages.

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10. The Administrator in cooperation with local authorities will evaluate the potential danger and evacuation need.

11. A bomb search will be initiated by the police/bomb experts.

12. Personnel should report any suspicious or foreign object to the Administrator. DO NOT TOUCH THE OBJECT

13. If evacuation is necessary, it shall be conducted according to the community's evacuation plan.

14. Should detonation occur, the situation should be handled as a disaster emergency.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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HealthCap
RISK MANAGEMENT SERVICES

BOMB THREAT CHECKLIST

Policy and Procedure

Policy:
It is the policy of this community to maintain a comfortable environment for our residents, employees and visitors. This emergency policy is intended to assist the community in meeting its responsibility and emphasize the importance of employee training to respond appropriately in the event of a bomb threat.

Procedure:
It is the responsibility of the manager within the community to notify the Administrator immediately and complete the Bomb Threat Checklist if a bomb threat occurs. It is critical that the information provided is clear, accurate and timely. The tool should be completed immediately to ensure that facts are remembered accurately and articulated appropriately.

Section II

If a bomb threat is received it is important that the community manager or person receiving the call attempt to get the caller to reveal the following details:

Exact location of the alleged bomb: _____

_____

Time of anticipated detonation: _____

_____

Description of what the bomb looks like: _____

_____

Identify what explosives were used to create the bomb: _____

_____

Obtain as much information as possible from the caller. (Legitimate callers will usually avoid injury or death.) Request more data by expressing a desire to save lives.

Additional information obtained: _____

_____

Name of person receiving the call: _____

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Date and Time of Call: _____

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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Blood Spill Clean Up
Policy & Procedure

Policy:
It is the policy of this facility to respond promptly to biohazard conditions that may increase the risk of the spread of infection.

Procedure: The following procedures are intended to assist in cleaning up small spills of blood, blood products and other body fluids. (For larger spills that go beyond your ability to clean with the supplies on hand, contact OSHA Haz Mat by dialing 911).

1. Required personal protective equipment (PPE) – prior to beginning the cleanup, put on a pair of rubber, latex, PVC, or similar type gloves. In addition to gown and or plastic apron if applicable, and face mask either goggles or face shield (if splash risk)
2. For small blood spills no other PPE should be required.
3. For larger spills where there is a possibility of contaminating your face or other parts of your body, call HazMat to perform a clean-up.
4. Obtain a spill kit containing:
    a. 10% bleach solution (or Lysol, Virex or other EPA reg. Tuberculocidal)
    b. Gloves
    c. Clear plastic bags
    d. Biohazard labels (available from OSHA HazMat)
    e. Leak-proof sharps containers
    f. Brush and dustpan or tongs or forceps for picking up sharps
    g. Disinfectant wipes
5. Spill decontamination procedures:
    a. Clover the spill area with a paper towel and then pour freshly mixed 10% bleach and water solution on the towel.
    b. Allow solution to soak into the contaminated material.
    c. Work from the outside edges of the spill inward when applying the bleach solution.
    d. Any glass, needles or other sharp objects that may puncture the skin will not be picked up by hand.
    e. Only mechanical means such as a brush and dustpan, tongs, forceps are to be used to pick up sharps.
    f. Wipe up bleached material with paper towels or absorbent pads. It may be necessary to use a scrub brush to remove material if it impacted a hard, porous surface such as concrete.
    g. If porous surfaces such as a carpet have been contaminated, an outside vendor may be needed to clean the area.

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   h. Mark off spill area to prevent contact, as well as accidental slips and falls.
6. Disposal:
   a. Place bleached material, gloves and other disposable materials into a labeled biohazard bag and place into either another labeled biohazard bag or container.
   b. Ensure lids are firmly sealed on all waste containers when spill clean-up is complete, keep biohazard waste container in a secured area until received by the approved medical waste professional.
7. Decontaminate re-usable equipment:
   a. Decontaminate with the bleach solution all potentially contaminated re-usable tools or protective equipment used in the cleanup.
   b. This includes dustpans, brooms, forceps, buckets, cleaning cloth, mops, etc.
   c. Anything that cannot be effectively cleaned (bleach solution must be able to contact all surfaces) must be placed in a biohazard waste container in a secured area until received by the approved medical waste professional.
   d. After the contaminated area has been cleaned, use fresh water to remove bleach residue from all surfaces.
8. If handwashing facilities are not available at the job site use disinfectant wipes and then wash hands as soon as possible.
9. If you believe you were exposed (skin puncture or splash to eyes or mucous membranes) to biohazard material that had not been decontaminated with the bleach solution:
   a. Vigorously wash affected skin with plenty of soap and water while removing contaminated clothing and shoes.
   b. Wash your eyes for at least 10 minutes with copious amounts of water lifting the upper and lower eyelids occasionally.
   c. Seek follow-up medical attention by contacting your supervisor for referral to the Occupational Health Clinic.

DEFINITIONS:

Small Spill — A volume that is easily managed with a minimal amount of decontamination Equipment and materials

Large Spill — A volume that would require more than one-person, large amounts of Decontamination equipment material, and/or contamination of objects that would prove difficult to decontaminate (i.e. rugs, mattresses, furniture, electronic gear).

Major Spill — Large amounts of blood and/or tissue (usually because of a homicide or suicide).

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** Emergency Preparedness Manual*

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RISK MANAGEMENT SERVICES

WORKPLACE WEAPONS

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees and visitors. The management team will provide appropriate training for employees emphasizing the importance of continuing to provide care to our residents with as little disruption as possible during emergency events. This is a posted, weapon free community.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Workplace Weapons.

2. Documentation for training will be included in the individual employee personnel file.

3. The Workplace Weapons policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. This community is designated as weapon free, and postings are in public areas throughout the community.

7. Any employee, resident, or guardian of a resident who has obtained a restraining order or personal protection order should immediately provide a copy of the order to the Administrator.

8. The Administrator will notify those in need of the information to protect the residents, visitors, families, and facility.

9. Any person observing, or hearing of, weapons in the workplace shall immediately inform their supervisor. If possible, leave one person in the area while a runner reports the weapon.

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10. The supervisor shall immediately notify the local police department if immediate danger is perceived, and then immediately notify the Administrator, DON, or designee.

11. The designated person responsible in cooperation with the police will evaluate the situation and determine if an evacuation is needed.

12. Use the facility investigation form to record occurrences.

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THREAT OF VIOLENCE CHECKLIST

Policy and Procedure

Policy:
It is the policy of this community to maintain a comfortable environment for our residents, employees and visitors. This emergency policy is intended to assist the community in meeting its responsibility and emphasize the importance of providing training for employees in the event of a threat of violence.

Procedure:
It is the responsibility of the manager within the community to notify the Administrator immediately if a threat of violence is received and to complete the Threat of Violence Checklist. It is critical that the information provided is clear, accurate and timely. The tool should be completed immediately to ensure that facts are remembered accurately and articulated appropriately.

Section I **Date:** _____ **Time:** _____

What did the caller say? Document the exact wording used:

_____

_____

Male: _____ Female: _____ Adult: _____ Child: _____ Estimated Age: _____

Speech:

Slow: ____ Excited: ____ Disguised: ____ Rapid: ____ Loud: ____

Broken: ____ Normal: ____ Sincere: ____ Angry: ____

Did the person have an accent? If so, describe (i.e., Southern, European, etc): _____

_____

_____

Was there any background noise heard (i.e., traffic, machinery, etc.)? _____

_____

_____

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Did the caller indicate why the threat was being made? If so, explain: _____

_____

_____

If this is a bomb threat refer to Bomb Threat Checklist

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

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CHEMICAL SPILL

Policy and Procedure

Policy:
It is the policy of this community that all necessary care and precautions will be taken to maintain a comfortable environment for our residents, employees, and visitors. The Administrator or designee is responsible for overseeing the community and addressing identified concerns immediately. All events involving safety-related issues and corrective actions shall be reported to the Quality Assurance Committee on a quarterly basis.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Chemical Spill.

2. Documentation of training will be included in the individual employee personnel file.

3. The policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

In the event a chemical spill occurs at or near the community, initiate the following actions:

1. Immediately notify a supervisor, manager, or Administrator of the spill.

2. Secure the affected area and consult the MSDS (Material Safety Data Sheet) for appropriate action and/or health risks.

3. If the spill/release is determined to be immediately hazardous to the health of residents, employees, and visitors contact the local emergency response team.

4. Close doors and turn off air conditioners/heating units, if possible, to minimize the spread of fumes throughout the community.

5. Clean spill in accordance with the MSDS guidelines and/or manufacturer's instructions.

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6. Notify the Administrator of the steps initiated the response team recommendations and the status of the spill/release.

7. If evacuation becomes necessary, please refer to the Evacuation Policy in the Emergency Preparedness Manual.

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Medical Director Signature: _____ Date: _____

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HAZARDOUS ACCIDENTS OR INCIDENTS

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees and visitors. The management team will provide appropriate training for all employees, emphasizing the importance of continuing to provide care for our residents with as little disruption as possible in the event of a hazardous accident or incident.

An overturned tanker, broken water main or fuel line, a chemical or oil spill, biochemical attack and even a plane crash are potential hazards which could affect the community. There can be no standardized plan for a sudden hazard or threat. The incident can be so varied that the information and severity of the situation may be difficult to assess immediately.

Warnings of a hazardous accident or incident are usually received from the police or fire department and often over the news media. For some disasters, it may be found that public information messages will be the only actual "warning" the community receives.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Hazardous Accident or Incident.

2. Documentation for training will be included in the individual employee personnel file.

3. The Hazardous Accident or Incident policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. The community will be evacuated if necessary, following the facility specific evacuation procedure and only as directed by the Administrator and Emergency Response personnel.

7. The Administrator or designee will notify the appropriate State regulatory agencies as outlined in state specific regulations.

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Emergency Preparedness Manual

SECTION 6
EVACUATION



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EMERGENCY EVACUATION: UNIT/FLOOR

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees and visitors. The management team will provide appropriate training for employees, emphasizing the importance of continuing to maintain a comfortable environment for our residents in the event an emergency evacuation is deemed necessary.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Emergency Evacuation.

2. Documentation for training will be included in the individual employee personnel file.

3. The Emergency Evacuation policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. Evacuation maps/floor plans will be posted at or nearby:
   - all emergency exit doors
   - elevator access doors with a notation that the elevators are not to be used in the event of fire
   - at stairway doors, and
   - each nurse's station

7. Evacuation maps/floor plans will include:
   a. location of the person when viewing the map "you are here"
   b. emergency exit locations
   c. fire extinguisher locations
   d. fire alarm call station location
   e. directional signs to nearest emergency exit from each location
   f. MSDS locations
   g. tornado shelter locations

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8. In the event of an emergency, the Community Service, i.e., police or fire departments or the Administrator/designee will make the determination if an evacuation of residents is necessary.

9. Determine the need to evacuate a specific unit/floor and the evacuation destination.

10. The person in charge or his/her designee will announce on the overhead paging system "all evacuation personnel report to the designated area" which is determined at the time of the emergency.

11. Residents, visitors and employees will be relocated to the safe area, as designated.

12. Personnel, except one nurse and one CNA from each unit will report to the Nursing Station on the unit/floor requiring evacuation unless otherwise instructed.

13. Nursing personnel will be partnered with ancillary personnel to work as teams during the evacuation effort.

14. Evacuation of residents will be systematic and begin with ambulatory and mobile residents first followed by bed/chair bound residents.

15. Evacuation will take place through passable stairwells; NEVER USE ELEVATORS!

16. Residents requiring lifting and/or carrying (bed-bound or non-ambulatory) will be evacuated using bed linen or slings.

17. Employees will remain with their assigned residents until further instructions are given.

18. Evacuation Map/Floor Plans will be updated by the Administrator or designee whenever locations or floor plans are changed.

19. Evacuation Map/Floor Plans will be reviewed annually for accuracy by the Administrator or designee.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

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RISK MANAGEMENT SERVICES

EMERGENCY EVACUATION: UNIT/FLOOR

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees and visitors. The management team will provide appropriate training for employees, emphasizing the importance of continuing to maintain a comfortable environment for our residents in the event an emergency evacuation is deemed necessary.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Emergency Evacuation.

2. Documentation for training will be included in the individual employee personnel file.

3. The Emergency Evacuation policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. Evacuation maps/floor plans will be posted at or nearby:
   - all emergency exit doors
   - elevator access doors with a notation that the elevators are not to be used in the event of fire
   - at stairway doors, and
   - each nurse's station

7. Evacuation maps/floor plans will include:
   a. location of the person when viewing the map "you are here"
   b. emergency exit locations
   c. fire extinguisher locations
   d. fire alarm call station location
   e. directional signs to nearest emergency exit from each location
   f. MSDS locations
   g. tornado shelter locations

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8. In the event of an emergency, the Community Service, i.e., police or fire departments or the Administrator/designee will make the determination if an evacuation of residents is necessary.

9. Determine the need to evacuate a specific unit/floor and the evacuation destination.

10. The person in charge or his/her designee will announce on the overhead paging system "all evacuation personnel report to the designated area" which is determined at the time of the emergency.

11. Residents, visitors and employees will be relocated to the safe area, as designated.

12. Personnel, except one nurse and one CNA from each unit will report to the Nursing Station on the unit/floor requiring evacuation unless otherwise instructed.

13. Nursing personnel will be partnered with ancillary personnel to work as teams during the evacuation effort.

14. Evacuation of residents will be systematic and begin with ambulatory and mobile residents first followed by bed/chair bound residents.

15. Evacuation will take place through passable stairwells; NEVER USE ELEVATORS!

16. Residents requiring lifting and/or carrying (bed-bound or non-ambulatory) will be evacuated using bed linen or slings.

17. Employees will remain with their assigned residents until further instructions are given.

18. Evacuation Map/Floor Plans will be updated by the Administrator or designee whenever locations or floor plans are changed.

19. Evacuation Map/Floor Plans will be reviewed annually for accuracy by the Administrator or designee.

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POST-EVACUATION OF RESIDENTS

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees, and visitors. The management team will provide appropriate training to employees on maintaining a calm environment for the residents upon return to the community post-evacuation.

Procedure:

1. The general orientation process includes training on the Post-Evacuation of Residents policy.

2. Documentation for training will be included in the individual employee personnel file.

3. The Post-Evacuation of Residents policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. Training will include identifying the negative impact of evacuation on residents' overall well-being and interventions to be utilized in the process of returning the residents to the community.

7. Residents will be returned to their rooms and each resident will be accounted for and documented on the resident roster.

8. If a resident cannot return to his or her room for any reason, arrangements will be made through the resident's family, Administrator, and physician to transfer the resident to an alternate room or health care facility.

9. A full report of the emergency events which required emergency evacuation will be sent to the State regulatory agency as required by individual state regulations.

10. A summary report of the evacuation process and post-evacuation return of residents will be compiled by the Administrator and presented to the Quarterly Quality Assurance Committee at their next scheduled meeting. The report should include corrective

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actions that were taken to address any issues that hindered the evacuation/post-evacuation process.

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PLAN FOR RETURN OF EVACUEES
Point of Emphasis Checklist

Category	Task	Monitor
Returning Evacuees	• Head-to-toe skin assessments and pain assessments with vital signs completed on date of departure and residents treated/medicated as indicated. • Residents are being toileted prior to departure; a disposable protective pad is available for each resident. • An airsick bag or comparable product is available to each resident during transportation.	Regional Staff Administrator Director of Nursing
Medical Records	• An identifying pre-arranged sticker is placed on the medical record of each evacuee by the receiving facility and the records are stored securely at the receiving nurse's station (paper charts) • A new chart is created for each evacuee. Documentation generated during the stay (all assessments, evaluations, reports, test results, etc.) is maintained in the new chart (paper charts) • On day of departure a copy of this chart is placed in the original medical record and returned with the evacuee. The original "new chart" is then closed and maintained by the medical records department.	Regional Staff Director of Nursing Charge Nurse Medical Records Unit Secretary
Personal Property and Equipment	• On arrival at the receiving community, all personal property/equipment is inventoried by the evacuating community and the receiving community, tagged for identification and an Inventory Sheet is completed and signed by both parties. • On the day of return all equipment is inventoried for return and validated with the inventory sheet. The sheet is then signed by both parties and a copy placed in the medical chart of the evacuee. The original is kept by the receiving community.	Regional Staff Administrator Director of Nursing
Personal Supplies	• An airway, ambu-bag and 02 supplies, disposable incontinent briefs, disposable sanitary wipes, disposable incontinent pads, disposable gloves, hand sanitizing gel, treatment supplies, pillows and blankets are available on each transportation vehicle.	Regional Staff
Medications	• Medications are inventoried upon receipt by the receiving community. All medications are checked against physician orders to ensure availability and accuracy. • A new count sheet is initiated for each controlled substance by the receiving community. The medications are counted by a licensed nurse from the evacuating community and validated by a licensed	Regional Staff Director of Nursing

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	nurse from the receiving community and signatures documented appropriately. • On the day of return medications for administration during the trip are preset, labeled and bagged. • On day of return Controlled Drugs are counted by licensed nurses from the receiving and evacuating communities, appropriate signatures are documented on the count sheet and a copy of the sheet is kept by the receiving community in medical records. **Controlled drugs will be signed out ONLY to a licensed nurse for transportation.**	
Hydration and Nutrition	• Return transportation times should be coordinated with regular mealtimes when possible, to ensure that evacuees receive adequate hydration and nutrition and that any diet restrictions can be adhered to. • One to two brown bag meals should be prepared and packaged for each evacuee for the return trip. An adequate supply of pureed foods and thickened beverages should be available on each transportation vehicle as indicated by diet restrictions. • A minimum of three eight-ounce bottles of water should be available for each evacuee on each transportation vehicle.	Regional Staff Director of Nursing Registered Dietitian

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EMERGENCY EVACUATION: UNIT/FLOOR

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees and visitors. The management team will provide appropriate training for employees, emphasizing the importance of continuing to maintain a comfortable environment for our residents in the event an emergency evacuation is deemed necessary.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Emergency Evacuation.

2. Documentation for training will be included in the individual employee personnel file.

3. The Emergency Evacuation policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. Evacuation maps/floor plans will be posted at or nearby:
   - all emergency exit doors
   - elevator access doors with a notation that the elevators are not to be used in the event of fire
   - at stairway doors, and
   - each nurse's station

7. Evacuation maps/floor plans will include:
   a. location of the person when viewing the map "you are here"
   b. emergency exit locations
   c. fire extinguisher locations
   d. fire alarm call station location
   e. directional signs to nearest emergency exit from each location
   f. MSDS locations
   g. tornado shelter locations

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8. In the event of an emergency, the Community Service, i.e., police or fire departments or the Administrator/designee will make the determination if an evacuation of residents is necessary.

9. Determine the need to evacuate a specific unit/floor and the evacuation destination.

10. The person in charge or his/her designee will announce on the overhead paging system "all evacuation personnel report to the designated area" which is determined at the time of the emergency.

11. Residents, visitors and employees will be relocated to the safe area, as designated.

12. Personnel, except one nurse and one CNA from each unit will report to the Nursing Station on the unit/floor requiring evacuation unless otherwise instructed.

13. Nursing personnel will be partnered with ancillary personnel to work as teams during the evacuation effort.

14. Evacuation of residents will be systematic and begin with ambulatory and mobile residents first followed by bed/chair bound residents.

15. Evacuation will take place through passable stairwells; NEVER USE ELEVATORS!

16. Residents requiring lifting and/or carrying (bed-bound or non-ambulatory) will be evacuated using bed linen or slings.

17. Employees will remain with their assigned residents until further instructions are given.

18. Evacuation Map/Floor Plans will be updated by the Administrator or designee whenever locations or floor plans are changed.

19. Evacuation Map/Floor Plans will be reviewed annually for accuracy by the Administrator or designee.

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PLAN FOR ACCEPTING EVACUEES

Policy and Procedure

Policy:
This emergency policy is intended to assist the community in meeting its responsibility to maintain a comfortable environment for our residents, employees, and visitors. The management team will provide appropriate training for employees, emphasizing the importance of continuing to provide resident care and support in the event emergency evacuees are brought into the community.

Procedure:

1. The general orientation process for new employees will include a review of this policy and procedure regarding Plan for Accepting Evacuees.

2. Documentation of training will be included in the individual employee personnel file.

3. The Plan for Accepting Evacuees policy will be included in the annual in-service calendar as mandatory training for employees.

4. Documentation of training will be maintained in the employee training records.

5. Employees who fail to attend mandatory training will be removed from the staffing schedule until successful completion of the training is achieved.

6. The administrator shall initiate the "Points of Emphasis Checklist," policy and procedure prior to accepting evacuees.

7. The Administrator and/or Director of Nursing are required to be on the transportation vehicles.

8. The receiving facility shall set up several stations to accommodate residents arriving.

9. Food and hydration stations will be set up and provided with dietary checklists to ensure appropriate resident specific dietary restrictions are followed.

10. Physicians or nurse practitioners shall assess each resident for medical conditions.

11. Vital signs and blood glucose monitoring will be performed at the triage area.

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12. Skin assessments will be performed during the process of providing toileting and personal care to the returning residents.

13. Medication Administration Records will be available, and residents will be provided with medication as ordered by their attending physician.

14. Rest areas will be set up that allow residents to lie down for rest periods as necessary during the admission process.

15. Controlled drugs will be accounted for by the receiving licensed nurse and the Director of Nursing Services or designee.

16. Residents' personal property will be inventoried and left with the resident or placed in a secure location until room assignment has been completed.

17. An additional supply of wheelchairs, Geri-chairs are brought to the receiving area to accommodate arriving residents.

18. Supplies such as oxygen, gloves, treatment supplies, pillows, blankets, and any additional items are to be at the receiving area for use in providing care to the residents as they are admitted.

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PLAN FOR ACCEPTING EVACUEES

Points of Emphasis Checklist

Category	Task	Monitor
Staff	• Administrator and/or Director of Nursing are required to be on the transportation vehicles	Administrator Director of Nursing Regional Staff
Triage	• The receiving community sets up several stations to accommodate arrivals • Food and hydration stations – check diet clipboard. • Assessment of medical conditions – nurse practitioner or physician available for assessment process. • Vital sign and blood glucose monitor station • Changing and skin assessment station • Medication station to check if residents have received or are due for medication • Rest area for residents to lie down if necessary	Regional Staff Director of Nursing
Medical Records	• Medical records are offloaded with the residents at receiving community • Diet clipboard is used to ensure that snacks, meals, etc. at food and hydration station are correct • Controlled drug count is performed when transportation vehicle arrives	Regional Staff Director of Nursing Charge Nurse Registered Dietitian
Personal Property	• Personal property is inventoried by receiving community and signed as received • Personal property is stored either with the resident or in a secure location	Regional Staff Administrator Director of Nursing
Supplies	• Additional food and hydration are ordered and available by receiving community • Medications – pharmacy is called to be alert, and medications are ordered if needed after inventory is completed • Wheelchairs – Geri-chairs, all available are brought to receiving facility to accommodate arriving residents	Regional Staff

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	• O2, gloves, treatment supplies, pillows, blankets, and any additional supplies are acquired by receiving facility prior to evacuees' arrival	

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Emergency Preparedness Manual

SECTION 7
ELOPEMENT



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ADMISSION ELOPEMENT RISK ASSESSMENT
Policy and Procedure

Policy:
It is the responsibility of the interdisciplinary team to provide an environment that meets each resident's individual needs. The following guidelines will be followed for residents upon admission.

Procedure:

1. Upon admission, residents will be assessed for elopement risk using the ***Wander Elopement Risk Assessment form***. The assessment should include information provided by the resident, family or resident representative including:
    a. diagnoses,
    b. medications that may affect cognition or safety awareness,
    c. behaviors,
    d. wandering activity,
    e. mobility with or without assistive devices, and
    f. acceptance of admission to the facility.
    g. History of elopement
2. The ***Wander Elopement Risk Assessment Form*** will be completed as soon as practicable after admission. The algorithm will be used to support risk assessment decisions.
3. Residents identified at risk will be added to the elopement risk system, at the receptionist area and other locations identified by the facility.
4. A resident photo will be obtained and added to the resident record. The photo will be placed in an easily retrievable/printable location. At a minimum, photographs will be maintained in the resident's medical record and on the Medication Administration Record.
5. Photographs will be updated as required to reflect changes in resident appearance as needed post admission.
6. Residents identified as high risk for elopement will have preventive interventions initiated on the resident care plan. Interventions will reflect resident related behaviors and needs as well as specific facility layout and environmental circumstances that should be considered.
7. Direct care staff will be informed of the resident's risk and the appropriate interventions to address the risk of elopement.
8. Residents actively exhibiting exit seeking behaviors will be placed on 15-minute checks or other measures based on interdisciplinary review until

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appropriate placement on a secure wing or more appropriate facility is located.

9. Residents who are at risk of elopement but not actively exhibiting exit seeking behaviors may be appropriate for the ***Wander Management Program.***

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ELOPEMENT RESPONSE GUIDELINES

Policy:

It is the responsibility of all staff to provide a comfortable environment for each of our residents. The following guidelines will be followed if a resident is identified as missing. For the purposes of this policy, elopement is defined as leaving the facility premises without following the facility's policies and procedures for leave of absence.

Procedure:

1. Upon admission, each resident shall receive a name band with their name and facility name identified on it. It is the responsibility of each nursing assistant to ensure that each of their assigned residents is wearing an identification bracelet and that it is legible. Replacement bands are available from the charge nurse.
2. During medication pass, nurses shall check that a name band is present, particularly for residents at risk for wandering or who are cognitively impaired.
3. After receiving permission to photograph two photographs of newly admitted residents will be taken. The photographs will be used for identification purposes only, one will be maintained in the resident's medical record, the other in the Medication Administration Record. Photographs will be updated as required to reflect changes in resident appearance.
4. Resident and/or responsible party will receive instruction on the facility's leave of absence policy.

Responding to a suspected elopement:

1. It is the responsibility of all staff within the center to respond to activated door alarms and to return residents to their unit if leaving the facility premises without following the facility's leave of absence policy.
2. Any resident who is at imminent risk for elopement should be approached according to accepted guidelines as follows:
    a. Approach the resident in a calm and reassuring manner.
    b. Approach the resident one on one. Discourage large numbers of staff around the resident.
    c. Avoid arguing with the resident. DO NOT say, "You can't," or "You have to."
    d. Avoid touching the resident, if possible, use redirection as the first choice.
    e. Restraints are not to be used as the primary solution; rather, diversionary activities should be encouraged to prevent recurrences.
3. When a suspected elopement has occurred:
    a. Note the time the resident is first identified as unaccounted for and the time that the resident was last seen.

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b. Staff members assigned to the unit where the resident resides will verify that the resident has
c. not followed the facility's leave of absence policy.
d. Staff members will do a thorough, simultaneous search inside and outside of the center to locate the resident. If the resident is not located, proceed with the following:
    i. Notify the nursing supervisor and staff via overhead page (using facility selected code, i.e., Dr. Wander to room _).
    ii. The charge nurse shall immediately check sign out books to determine if the resident has left with family/friends per the facility's leave of absence policy.
    iii. The charge nurse shall assign one employee to physically check each alarmed exit to determine if all alarms are in working order (this may identify the exit the resident used to elope).
    iv. The charge nurse shall initiate a search of the facility and grounds by assigning staff to specific areas of the facility.
    v. If department heads are on duty, they shall be responsible for the search in their respective areas. If department heads are not on duty, the charge nurse shall oversee the search of all areas of the facility and grounds where it is believed the resident might be found.
    vi. Once the resident is located, the charge nurse shall page facility all clear code overhead three times (i.e., "Dr. Wander all clear").
    vii. A thorough, physical assessment shall be performed by the charge nurse to identify if the resident is injured.
    viii. If a thorough search of the facility and grounds does not locate the resident, the charge nurse shall ***immediately notify the Administrator and Director of Nursing Services.***

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ELOPEMENT
Policy and Procedure

Policy:
It is the policy of this facility to provide a comfortable environment for our residents while preventing elopements from occurring. For the purposes of this policy, elopement is defined as leaving the facility premises without following the facility's policies and procedures for leave of absence.

Procedure:
When an elopement is suspected the following steps will be initiated:

1. Notify the nursing supervisor and staff via overhead page (using facility selected code, i.e., Dr. Wander to room _).
2. The charge nurse shall immediately check sign out books to determine if the resident has been taken out of the building by the responsible party.
3. The charge nurse shall assign one employee to physically check each alarmed exit to determine if all alarms are in working order (this may identify the exit the resident used to elope).
4. The charge nurse shall initiate a search of the facility and grounds by assigning staff to specific areas of the facility.
5. If department heads are on duty, they shall be responsible for the search in their respective areas. If department heads are not on duty, the charge nurse shall oversee the search of all areas of the facility and grounds where it is believed the resident might be found.
6. When/if the resident is located, the charge nurse shall page facility all clear code overhead three times (i.e., "Dr. Wander all clear").
7. If the resident is not located after a thorough search of the facility and grounds, the charge nurse shall

immediately notify the Administrator and Director of Nursing Services.

When a resident cannot be located after a thorough search of the facility and grounds, the following steps shall be taken:

1. A written description of the resident and a recent photograph of the resident shall be obtained by the charge nurse.
2. Notify law enforcement officials.
3. Notify the resident's legal representative and/or family.
4. Notify the resident's attending physician.

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5. Maintain a documented timeline in the medical record as the situation progresses. Such documentation shall include the date and time resident was last seen, steps taken to locate the resident and the parties notified of situation.

   NO BLOCK CHARTING!
6. If a resident cannot be located for greater than two (2) hours or other conditions exist that place the resident in harm's way (inclement weather, etc.), the state licensing and regulatory agency shall be notified using the designated 800 hot line telephone number***. (Please refer to regulations specific to your state).***

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Emergency Preparedness Manual

SECTION 8
Active shooter



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ACTIVE SHOOTER EVENT

Policy and Procedure

Policy:

It is the policy of this community to attempt to mitigate risk of death and injury for residents, visitors and staff members related to an Active Shooter Event. This center has adopted an Active Shooter Event Preparedness Program to meet the goal of mitigating risk for death and injury.

Definition: An Active Shooter is defined as: An individual actively engaged in killing or attempting to kill people in a confined and populated area, typically using firearms.

Procedure:

In accordance with the Active Shooter Event Preparedness Program this center will:

1. Prepare for and reduce risk of an active shooter event through implementation of a Threat Assessment Team with duties described in the Active Shooter Event Preparedness Program.
2. Train and educate staff members and residents on actual or suspected Active Shooter Response.
3. Train and educate team members and residents to cooperate with First Responders and law enforcement.
4. The new employee orientation process will include education on the Active Shooter Event Policy.
5. Develop and implement a Response After Active Shooter Event including components of infection control and psychological first aid.

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Active Shooter Event Preparedness Program

The staff members of this community will be trained and educated using a comprehensive Active Shooter Event Preparedness Program. This program is based on FEMA's 2014 booklet "Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans" and the Department of Homeland Security's Active Shooter booklet. The home's Active Shooter Event Preparedness Program consists of four phases.
An Active Shooter is defined as: An individual actively engaged in killing or attempting to kill people in a confined and populated area, typically using firearms.
Survival and preservation of life is the goal of Active Shooter training. Team members are provided with training and information but are not expected to risk their own lives to save other lives.

- Phase I: Efforts to prepare for and reduce the risk of an active shooter event.
- Phase II: Train and educate staff members on plans to respond to an active shooter; including attempts to protect the residents and other people in the home from harm during an Active Shooter Event
- Phase III: Interacting with First Responders and
- Phase IV: Implement a response and recovery plan after an active shooter event.

Phase I: Preparing for and Reducing Risk of an Active Shooter Event

Preventing violent acts cannot be guaranteed by the community but attempts to protect the residents and mitigate risks related to an Active Shooter are in place. The Interdisciplinary Team (IDT) will be provided with the FEMA and Homeland Security booklets and will be educated on the standards established in those documents. Members of the IDT will form the Threat Assessment Team (TAT) and the IDT will also recruit TAT involvement from other team members. The TAT will establish the home's position and policies regarding the home's weapon environment (i.e. weapons permitted or weapons free).

Threat Assessment Team

1. The community's Threat Assessment Team (TAT) is under the direction of the QAPI Committee and have developed and implemented Emergency Action Plan (EAP) policies and procedures to address emergency actions including Active Shooter Event Response that are reviewed at least annually during TAT's threat assessment evaluation.
2. The TAT will meet regularly and provide recommendations to the QAPI Committee regarding risk assessments, policies, communication and training and testing. The QAPI Committee will be responsible for operationalizing the recommendations.
3. TAT will complete threat assessment and planning evaluations at least annually, or as directed by the QAPI Committee, with a report of findings to the QAPI Committee.
4. The EAP includes the following:
    a. An emergency notification system to alert the facility and police/fire of the

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emergency; communication system includes an overhead page in plain language to alert all people in the facility of the event and call 9-1-1 as soon as possible while maintaining personal safety.

b. System to alert other parties of an emergency including:
    i. Individuals at remote locations within premises
    ii. Local area hospitals
c. An evacuation policy and procedure; evacuation routes are prominently posted throughout the facility
d. Emergency escape procedures and route assignments (i.e., floor plans, safe areas) are included in the emergency preparedness manual and annual training; first aid kits are in identified safe areas
e. Contact information for, and responsibilities of individuals to be contacted under EAP are available in the emergency preparedness manual.
f. Local area hospitals and transportation services contacts and understanding of EAP (i.e., name, telephone number, and distance from your location) are located in the emergency preparedness manual.

5. The TAT will direct Human Resources to complete the following and will review the process during the annual threat assessment:
    a. Complete employee screening and background checks
    b. Create a system for reporting signs of potentially violent behavior
    c. Have counseling service references and referrals available to employees
6. Drills, training and testing are in place and will occur upon hire and at least annually. The EAP will be reviewed at least annually during TAT's threat assessment evaluation. Components of training will include:
    a. Providing information verbally and in print form to notify employees, residents, families and vendors that Active Shooter drills may occur without prior notice.
    b. Residents may participate in the drills, as a component of disaster preparedness, but will not be formally trained in the response protocols.
    c. Recognizing the sound of gunshots
    d. Reacting quickly when gunshots are heard and/or when a shooting is witnessed
    e. Evacuating the area - Hiding out - Acting against the shooter as a last resort
    f. Call 9-1-1
    g. Reacting when law enforcement arrives
    h. Adopting the survival mind set during times of crisis
    i. Stabilization and response
7. Recovery procedures have been developed and are reviewed at least annually to restore the facility's operation as soon as possible. These include:
    a. Following law enforcement directives to preserve the identified crime scene
    b. Coordinating care to victims
    c. Implementing staffing agency contracts to address personnel shortages
    d. Implementing the pharmacy emergency action plan to obtain medications if medication administration records, medications, medication carts and/or

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medication rooms are designated as part of a crime scene

e. Implement the Crime Scene Clean Up Contract and Infection Control procedures for bodily fluids and clean up.

Identification of Individuals on a trajectory to commit a violent act

No profile exists for an Active Shooter; few offenders had previous arrests for violent crimes. The facility will attempt to mitigate the risk of an Active Shooter event by identifying and communicating signs of a potentially volatile person and responding to imminent risk. The active shooter may be a staff member, vendor, visitor, family member, or stranger to the community.

8. Pre-attack behaviors may include:
    a. Personal grievances against the facility, staff members, residents or others affiliated with the community and operations (might talk about getting even or how much person or facility will regret actions);
    b. Recent acquisitions of multiple weapons (may talk or brag about weapons)
    c. Recent interest in explosives, fire and destruction
    d. Intense interest or fascination with previous attacks and mass attacks
    e. Experiences that are real, or perceived to be real, including personal issues such as - death, divorce, break up, or loss of job
    f. Other behaviors, comments or actions that have hostile or threatening implications
    g. Increased use of alcohol and/or illicit drugs
    h. Noticeable decreased attention to appearance and hygiene
    i. Depression/withdrawal/suicidal statements; “putting things in order”
    j. Paranoia and/or statements such as “everybody’s against me”
9. Report concerning behaviors to the Administrator or designee immediately.
10. The Administrator or designee will assemble the Threat Assessment Team to determine the response to a potential threat. Response may include:
    a. Meeting with the person in a public area when the person does not appear to be armed to discuss their behavior and affect.
    b. Alerting law enforcement.
    c. Offering Employee Assistance Programs.
    d. Termination/separation of person; banning person from community.
    e. Placing the community in a lockdown mode.
    f. Educating staff members on the level of threat concerns.
    g. Other responses are based on the level of threat and resources.
11. If a person presenting signs of a trajectory to commit a violent act displays escalating behaviors call 9-1-1 and text “Potential Shooter” to the group text; include the persons location and name if known and begin moving residents away from the location if possible. Be prepared to run, hide or fight.

Phase II: Training and Education on Active Shooter Event Response

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Active Shooter or Suspected Active Shooter Response

The community will attempt to reduce harm related to an active shooter event. An active shooter(s) is a person(s) actively engaged in killing or attempting to kill people generally using firearms. During an Active Shooter event, Law Enforcement may be onsite – follow their directions at all times.

During an Active Shooter event Run, Hide, Fight

1 Call 9-1-1 as soon as it is safe - if staff members see someone with a firearm, or suspect a person has a firearm, or hear gunshots on the premises call 9-1-1 to provide information about the shooter as soon as possible while maintaining personal safety.
2 Use overhead paging system to alert staff and visitors of active shooter if possible; use plain language “Active Shooter; run, hide, fight; Active Shooter; run, hide, fight”. Call 9-1-1 as soon as it is safe.
3 If the Active Shooter is in vicinity and there is an accessible path, attempt to run/evacuate and assist others to run/evacuate:
    a. Have an escape route and plan in mind
    b. Call 9-1-1 when in a secure location
    c. Help others escape, if possible
    d. Evacuate regardless of whether others agree to follow
    e. Leave belongings behind
    f. Try to prevent individuals from entering an area where the active shooter may be
    g. Keep your hands visible
    h. Follow the instructions of police officers/first responders if present
    i. Do not attempt to move wounded people
4 Hide out if evacuation is not possible, find a place to hide where the active shooter is less likely to find you. Your hiding place should:
    a. Be out of the active shooter’s view
    b. Provide protection if shots are fired in your direction (i.e., behind closed door and barricade)
    c. Not trap you or restrict your options for movement (i.e., room with a window)
    d. Be locked and/or barricaded to reduce the likelihood of an active shooter entering your hiding place.
5 If the active shooter is nearby:
    a. Lock and/or barricade the door
    b. Silence your cell phone and/or pager
    c. Turn off any source of noise (i.e., radios, televisions)
    d. Hide behind large items (i.e., cabinets, desks)
6 Remain quiet if evacuation and hiding out are not possible:
    a. Remain calm
    b. Dial 9-1-1 to alert police/first responders of the active shooter’s location
    c. If it is unsafe to speak, leave the line open and allow the dispatcher to listen
7 Homeland Security directs as a last resort: Act against the active shooter only when your

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life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:

a. Acting as aggressively as possible against him/her
b. Throwing items and improvising weapons
c. Yelling and screaming
d. Committing to the actions

Phase III: Interacting with First Responders

Law enforcement will arrive with the intent of stopping an active shooter as soon as possible. They generally proceed to the area where the last shots were reported, and they do not stop to assist the wounded. It is critical to not interfere with their work.

Law enforcement will secure the scene. During this time first responders work with facility staff and victims to treat and transport the injured. Law enforcement/designees interview witnesses and initiate the investigation.

They may arrive in a group wearing protective gear and carrying weapons; they may use pepper spray or tear gas as they shout commands and push people down. When law enforcement arrives:

1 Follow their directions, avoid quick movements, raise empty hands in the air until told otherwise; do not ask questions; try to remain calm and avoid yelling, crying and screaming.
2 Remain in the area designated by law enforcement until instructed to do otherwise; witness statements and interviews by law enforcement may occur.
3 Law enforcement may request assistance; provide the assistance.

Phase IV: Response and Recovery Plan after an Active Shooter Event

Response after Active Shooter Event

Once the scene is secured and law enforcement and first responders are managing the process, the community should communicate the following:

1 Required employee facility return point: designated employees may be requested or directed to return to the facility.
2 Coordinate care and services for victims with the first responders.
3 Crash carts/boxes with hemorrhage control equipment will be available.
4 Designated team leaders will account for residents, on-duty employees and vendors or visitors signed into the building at the time of the event.
5 The physicians and families will be notified by designated team members including notification of casualties; law enforcement will be involved in this process and may provide direction.
6 Implement family unification plan for employees and residents. Determine which community spokesperson will provide “real time” updates to families when the immediate threat has ended to reduce frustration and de-escalate emotions. This includes the following:

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a. Identified spokesperson will provide "real time" updates and information on location and status of those present during the event.
b. Immediate family members and guardians/responsible parties for residents will be allowed in the facility as soon as law enforcement permits.
c. Staff members will be provided with a quiet area away from the public and press to be unified with their immediate families and/or as directed by law enforcement.

7 As needed orders will be obtained for residents remaining on site; pharmacy emergency action plan will be initiated to obtain medications that may be in designated community locations.
8 Preserve the Crime Scene; do not begin cleaning up or moving items unless directed by law enforcement.
9 Call off-duty employees as needed; use contracts in place with staffing agencies to assist in caring for the residents and relieve on-duty team members involved in the event.

Recovery Plan after an Active Shooter Event

After the community has been cleared by law enforcement and is no longer a crime scene the leadership team will implement the Recovery Plan.

1. A crime scene clean-up service contract will be implemented place; the service will be used to clean the crime scene(s).
2. Under the direction of the leadership team, critical personnel and/or operational gaps will be evaluated to identify and address as needed.
3. The leadership team will coordinate a physical plant inspection to determine structural and physical environmental needs.
4. Determination of time frame and strategic plan to resume full operations will be determined post-crime scene clean up.
5. Contracts for services related to Psychological First Aid (PFA) to help those involved in the Active Shooter Event will be enacted. Core actions of the community to coordinate PFA using internal and/or external resources are:
    a. Contact and engagement
    b. Safety and comfort stabilization
    c. Information gathering; current needs and concerns
    d. Practical assistance
    e. Connection with social support
    f. Information on coping
    g. Linkage with collaborative services
6. When coordinating PFA, the leadership team will be aware of special circumstances that make residents more susceptible to developing emotional distress after a disaster, including but not limited to:
    a. Memory and cognitive loss or various forms of dementia
    b. Serious mental illness (i.e., schizophrenia, bipolar disorder)
    c. Multiple evacuations and displacements, sometimes resulting in "transfer

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trauma”

d. Low literacy level or non-English speaking; other communication deficit
e. Significant loss of possessions (e.g., memorabilia and photos) due to the disaster
f. Those who have been previously exposed firsthand to grotesque scenes or an extreme life threat
g. Residents who have specialized needs such as ventilator and dialysis care to address their fear associated with the threat of interrupted services because of the disaster

7. The TAT, under direction of the QAPI Committee, will coordinate an evaluation of Emergency Action Plan including an analysis of the effectiveness of the existing plan and a plan for improving the Emergency Action Plan if needed. This evaluation may be coordinated with the assistance of law enforcement.

Sources:

- Active Shooter Event Quick Reference Guide — FBI
- Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans FEMA. 2014.
- Psychological First Aid: Field Operations Guide for Nursing Homes. Emergency Preparedness 2024
- Active Shooter - Pocket Card Information

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Emergency Preparedness Manual

SECTION 9
PANDEMIC - PUBLIC HEALTH EMERGENCY



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Pandemic Emergency Planning Checklist

Whether a facility has experienced an outbreak or not, all facilities should reassess their emergencies to effectively prevent or control outbreaks. This requires ensuring that plans and structures are in place to respond, including the ability to contribute to the overall community response by maintaining operations throughout the incident.

AREA REVIEWED	DATE	COMMENTS
Review of your facility's: • Emergency operations plan, • Continuity of operations plan, and/or • Business continuity plan To identify any course of action that requires implementation or revision. If your facility experienced an outbreak earlier, ensure plans have been updated based on lessons learned.		
Ensure employees and volunteers (if applicable) are trained in your facility's emergency operations plan.		
Your emergency operations plan should include succession planning with a clear chain of command should leadership be exposed or become ill. It is recommended that healthcare facilities in areas with high levels of community transmission identify and train at least three levels of succession to provide relief should those with primary or secondary responsibility for each position be unable to work.		
Maintain awareness with daily/regular updates on the pandemic from local and state authorities, the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the World Health Organization, professional organizations, and other reputable sources. Sign up for federal and state health alert messages if you are not already subscribed.		
Assess your facility's current infection prevention practices and address areas of concern relative to the pandemic. Ensure a plan for correcting areas of risk have been developed and implemented.		
Partner with your local healthcare coalition (HCC) and/or public health agency to communicate your plan.		
Define cohorting, escalation, and testing strategies; and identify potential resource needs and coordination strategies.		

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Know what factors trigger your local and state conventional, contingency, and crisis standards of care plans, particularly as they relate to personal protective equipment use (PPE) and patient care strategies during a surge.		

AREA REVIEWED	DATE	COMMENTS
Establish a framework for ensuring quality in the context of available resources, including a review of staffing and care processes.		
Identify backup systems for critical utility and information technology systems used by the facility, including electronic health records and web-based recordkeeping systems.		
Conduct workshop discussions/tabletop exercises to review the plans and processes for managing residents with active infection and revise as required.		
Review your facility assessment and update as needed.		
Consider other hazards in your community (e.g., hurricanes, wildfires) and assess how their occurrence concurrently with the pandemic might affect your plans.		

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Pandemic Infection Prevention

- Screening all who enter the facility for signs and symptoms of infection (e.g., temperature checks, questions or observations about signs or symptoms).
- Denial of entry to the center for anyone presenting with signs or symptoms of infection.
- Hand hygiene (use of alcohol-based hand rub is preferred).
- Face covering or mask required (covering mouth and nose).
- Social distancing at least six feet between persons.
- Instructional signage throughout the facility and proper visitor education on signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting high frequency touched surfaces on a scheduled basis and PRN.
- Cleaning and disinfecting designated visitation areas after each visit.
- Appropriate staff use of Personal Protective Equipment (PPE).
- Effective cohort of residents.
- Resident and staff testing as required.
- Report fever/symptoms of infection within 14 days of visit.

https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/

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*Alcohol hand sanitizers are ineffective for Norovirus; soap and water are recommended

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Core Principles of Infection Prevention

Clean and disinfect high-touch areas on a scheduled basis	Social distancing at least six feet	Practice hand hygiene	Appropriate use of PPE
Clean and disinfect common areas	Conduct resident and staff testing	Screen everyone for symptoms of infection	Deny entry to anyone with signs of infection



Place informational signage throughout the facility for education. These could include signs and symptoms of infection, infection control precautions, proper face mask use, hand hygiene, and any other information important to your facility.

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Documentation During Pandemic

Documentation is an ongoing means of communication among healthcare professionals. The medical record serves as the legal document in the event of a negative outcome/claim. Thorough documentation is critical to the facility's success to support proper assessment and care and services were provided to the resident.

Just the Facts:
Factual - make sure all entries represent the facts.
Actual - record all entries as they happen, with the date and time of the entry.
Complete - make sure all entries are complete.
Timely - Document all events as close as possible to the time they occurred.
Sensible - take care that all entries make sense, and the reader understands what was written.

Medical Record Documentation:
- All notifications to the physician; include the physician's name and the date/time of the notification.
- All notifications to the legal decision maker, include the person's name and the date/time of the notification.
- Utilize the nursing process when documenting:
  - Assessment of the resident
  - Diagnosis - nursing diagnosis such as SOB, pain, etc.
  - Plan - what is the plan based on the assessment such as notifying the physician etc.
  - Implementation - implement the plan such as administering a medication, transfer to the hospital, etc.
  - Evaluation - evaluate the resident after the plan is implemented.

Facility Documentation
- Development and updates to policies.
- Dates if/when Implementation of interventions to prevent the spread of infection:
  - Non-essential visitors were restricted.
  - Education to staff and residents on policy changes.
  - Communal activities were put on hold and individual activities were initiated.
  - Screening of staff and essential HCP.
  - Mandatory, universal use of face masks.
  - Communications to residents, family members and staff.
  - Challenges faced by the facility such as shortages of PPE and efforts taken by the facility to solve those challenges.

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Record Retention Infection Control Logs - Pandemic

Policy and Procedure

Purpose:
The purpose of this policy is to provide uniform procedures for the facility's records management system. The records management system exists to ensure records are maintained as appropriate, so that information is available when and where it is needed. This policy applies to all employee infection control documentation, including screening and temperature logs and viral test results, regardless of the medium used to create such documentation.

Authority:
- Occupational Safety and Health Association (OSHA); (29 CFR 1910.502).
- Americans with Disabilities Act (ADA); (42 CFR 129.12101).
- Centers for Disease Prevention and Control (CDC).
- Centers for Medicare and Medicaid Services (CMS); Appendix PP, State Operations Manual, 42 CFR §483.12(a)(1).

Definitions:
- *"Employee"* includes all staff, the medical director, consultants, contractors, agency staff and volunteers. Staff would also include caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and students from affiliated academic institutions, including therapy, social, and activity programs.
- *"Visitor"* includes immediate family members and other relatives and friends of a facility resident. A visitor also includes any entity or individual that provides health, social, legal, or other services to the resident.
- "*Employee and Visitor infection control documentation*" includes documentation that was created and maintained in response to a Public Health Emergency. Employee and visitor documentation includes documentation maintained by the facility which identifies individual employees and visitors in association with infection control screening and/or testing. The employee and visitor infection control documentation might include documents such as temperature logs; test results; Leave of Absence documentation; symptom tracking logs; and similar documentation.

Policy:
It is the facility's policy to ensure that employee and visitor infection control documentation is maintained and managed as required by applicable State and Federal Law.

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Procedure:

1. The facility's designated records maintenance representative is identified in the facility's general recordkeeping policy.
2. The facility's designated records maintenance representative shall organize, arrange, and maintain employee and visitor infection control documentation using a filing or records-keeping system that is appropriate to the nature, purpose, and use of the records; can be easily understood by all users, and will facilitate the location of and access to those records, when and where it is needed.
3. The facility should maintain employee infection control documentation separate from the employee personnel records to promote the continued confidentiality of the health-related information.
4. The facility, through its designated records maintenance representative, shall maintain and make available employee and visitor infection control documentation, including log(s) and testing results in a manner consistent with its records retention and maintenance program requirements.
5. The facility shall ensure the retention of all employee and visitor infection control documentation for a minimum of 30 years following the date of last employment or 30 years following the date of the last visit.

NOTE: Should your organization consistently maintain logs for employees, agency staff and contractors separate and distinct from visitor logs, consider reviewing current state law(s) and/or seeking legal advice to determine if a shorter retention period for visitor logs might be appropriate and/or beneficial.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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Medical Record - Surveyor Access - Pandemic

Policy and Procedure

Policy:
In the event CMS limits surveyor on-site visits during a pandemic the facility will assist in the survey process by allowing remote medical record access upon request.

Procedure:

- Verification of surveyor credentials will be done prior to initiating remote access to medical records.
- Upon written request and acknowledgement that the surveyor will utilize HIPAA compliant technology to access and review the medical records, a username and password will be given to the surveyor who has requested remote access.
- Remote "surveyor" access will be granted for 72 hours, and limited to normal business hours (9:00 AM-5:00 PM).
- At 72 hours, the remote access username and password will end.
- No additional access will be permitted without additional verification and documentation supporting the need.
- Documentation of credential verification and HIPAA compliance will be maintained in the survey documentation folder with "do not destroy" label.

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Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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Elements of Crisis Communication - Pandemic

1. Identify the crisis (or crises) – During a pandemic there may be several crises that your facility will face concurrently, such as a severe staff shortage and shortage or absence of essential PPE. Identifying and prioritizing needs can help you plan the next steps.

2. Identify the communicators – Because crisis communication of health information must be complete, transparent, and compliant with HIPAA privacy and security requirements, planning is best handled by a team. The team will vary depending on the setting; for example, in a nursing home a team may include medical (i.e., medical director, director of nursing), administrative (i.e., nursing home administrator) and legal and communications representatives. However, to ensure consistency across communications, one individual should coordinate the communication for the team whenever possible.

3. Identify stakeholders – Your stakeholders may include staff, residents and their loved ones, state and local government entities, such as the health department or survey agency and local healthcare providers and coalitions. They can also change depending on the crisis, so taking a moment to define who they are will allow you to develop a strategy and tailor your message. Sometimes, you may be forced to prioritize the needs of some stakeholders over others.

   For example, there may be a shortage of PPE in a nursing home in a state that has mandated every nursing home admit individuals with active infection. By taking these residents there is a risk of exposing an unprepared facility. The team will need to effectively express its facility's limitations to acute care partners as soon as possible and work with them and health officials to identify an alternative.

   In this instance, the immediate stakeholders are your organization's acute hospital referral partners. Other stakeholders you could consider prioritizing include the health department, state survey agency, emergency management agency and the long-term care Ombudsman partners in your area.

   Your assessment should be transparent and coincide with your data. Communicating these facts effectively will show why it would be mutually beneficial to avoid exposing your vulnerable population to this disease.

4. Create a hierarchy for sharing information on the crisis – the crisis team should be known to the entire organization. Inquiries should be delivered to the crisis team and answered by their designated person. This will decrease the chance of inconsistent communications to stakeholders. All answers should also be aligned with policies and procedures.

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5. Assign people to create fact sheets – During a crisis your organization will be inundated with questions. Many of them will be predictable and others may be unpredicted but common. Your organization should publish and continually update a page of frequently asked questions with clear answers pertaining to the crisis. You may have separate documents depending on the intended audience, clinicians, staff or residents/families. These documents can be developed by experts identified by your crisis team.

6. Create a repository of best practices – When dealing with a rapidly evolving crisis such as a pandemic, it is a good idea to develop a repository of best practices. These best practices should be made readily available to leaders in your organization, and the date (or revision date) should be bolded at the top. It should also be continually evolving and updated to conform to CDC and governmental regulations. Assign someone on your crisis team to be alert for the latest guidance from the government. This guidance should be consistent with your organization's policies and procedures. In some cases, your best practices may precede and even influence your facilities' policies and procedures.

7. Identify potential risks – The communications team should think about potential risks to the organization that your communication plan can expose and how they will respond to missteps. For instance, to be transparent, you accidentally disclose protected health information under the HIPAA Privacy Rule. What must your team do? How do you mitigate reputational injury related to having to report your infection data to the state for publication?

8. Create guidelines specific to broadcast, print and social media – This can be an important tool to promote transparency and highlight what your organization is doing to combat a pandemic. Things like listing your visitation policies and explaining why they are in place, sharing ways that your staff is keeping residents engaged and active during isolation and encouraging family members and friends to donate needed items and call/video conference with their loved ones in the nursing home can lead to positive stories in the media.
   You may also want to publish certain stories internally. Many of your own healthcare providers will be watching what you do during this crisis. As an example, many will be nervous, and some may be ready to quit. Consider interviewing staff in your facility who have recovered from the infection and returned to work. This will abate some of the fears your team has. Be ready to listen to them and respond accordingly. Weekly staff huddles can help with this.

9. Align communications to meet federal civil rights requirements – Federal civil rights laws such as Section 504 of the Rehabilitation Act of 1973 and Section 1557 of the Affordable Care Act, require covered entities to ensure effective communication and provide appropriate auxiliary aids and services to persons with disabilities unless doing so would fundamentally alter the nature of the program, or constitute undue financial and administrative burdens. This may include the provision

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of qualified interpreters, information in alternate formats, accessible electronic and information technology, access to designated support persons for individuals with disabilities to assist in their communication and care.

Federal civil rights laws, including Title VI of the Civil Rights Act of 1964 and Section 1557 of the Patient Protection and Affordable Care Act, also require recipients of federal financial assistance to take reasonable steps to provide meaningful access to individuals with limited English proficiency eligible to be served or likely to be encountered in its programs and activities which may involve providing language assistance services. Reasonable steps may include providing written or oral language assistance services, such as written translations of documents or oral language assistance from a qualified interpreter, either in person or using remote communication technology.

Finally, as a condition of receiving federal disaster assistance, section 308 of the Stafford Act also prohibits discrimination based on race, color, religion, nationality, sex, age, disability, English proficiency or economic status.

https://files.asprtracie.hhs.gov/documents/covid-19-considerations-strategies-and-resources-for-crisis-standards-of-care-in-paltc-facilities.pdf

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Internal Communication – Pandemic

Clear lines of internal communication are critical to maintaining situational awareness and shaping incident response actions. Regular standing meetings, which may be held in person or virtually, should include the incident command and essential members of the team (i.e., nursing home administrator, director of nursing, etc.). Topics to cover in the context of a pandemic precipitated response may include:

1. Current summary of residents and staff including:
   a. Number of confirmed infections (residents, staff).
   b. Number of suspected infections (residents, staff).
   c. Number being treated in-house (residents).
   d. Number of new admissions, transfers and returns (overall and related to pandemic. infection.
   e. Number on transmission-based precautions (residents).
   f. Number of staff excluded from work and estimated time until return (staff).
2. Current PPE inventories and burn rates for critical supplies, including gowns, gloves, surgical masks, N95 masks, reusable shields, disposable shields, booties, etc.
3. Anticipated or actual resource scarcity and potential response strategies, including conservation, substitution, adaptation, reuse and reallocation. At a minimum, this discussion should cover the following critical categories:
   a. PPE
   b. Medications/pharmaceutical supplies
   c. Testing supplies if applicable
   d. Ventilators (If used)
4. Updates and recommendations from the medical director and/or infection preventionist, including any scheduled infectious disease training planned for facility staff.
5. Updates required by federal and state regulations.
6. Updates and recommendations from other key command function leads, including those responsible for:
   a. Facility operations
   b. External communications and public relations
   c. Resident services and
   d. Finance and administration

https://files.asprtracie.hhs.gov/documents/covid-19-considerations-strategies-and-resources-for-crisis-standards-of-care-in-paltc-facilities.pdf

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Communication is Key

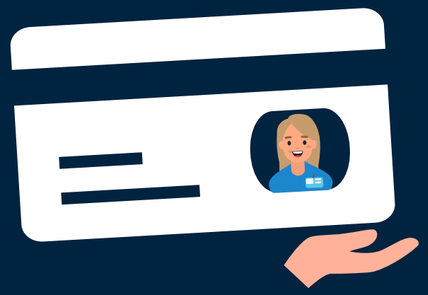
Staff-to-Residents

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Consider these ideas to strengthen communication between residents and staff.



Name Tags

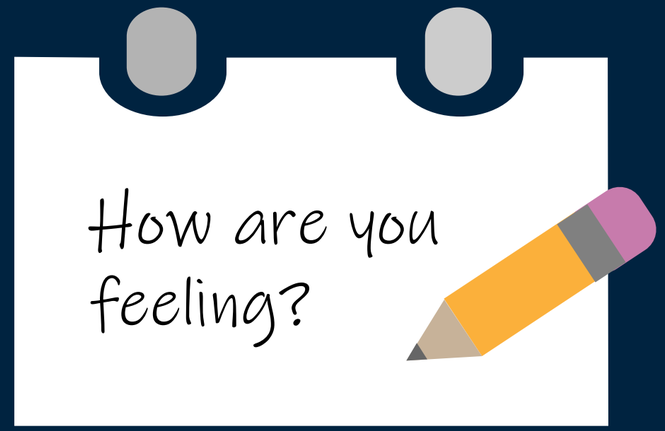




Create **name tags** with a prominent photo of each staff member including name and title. This will assist residents in identifying caregivers who are wearing PPE that obscures their face.

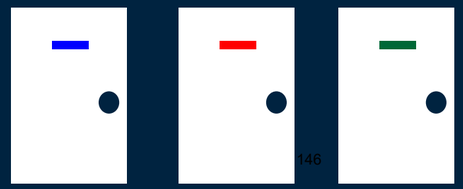
Communication Boards

Wearing PPE may make it difficult for hearing impaired residents to understand. Consider basic **communication boards** in each resident's room to ask the resident questions in writing.



Color Coded Doors

Develop a **color-coding system for doors** regarding isolation status to remind staff to use appropriate PPE per resident need.



2025

Communication is Key

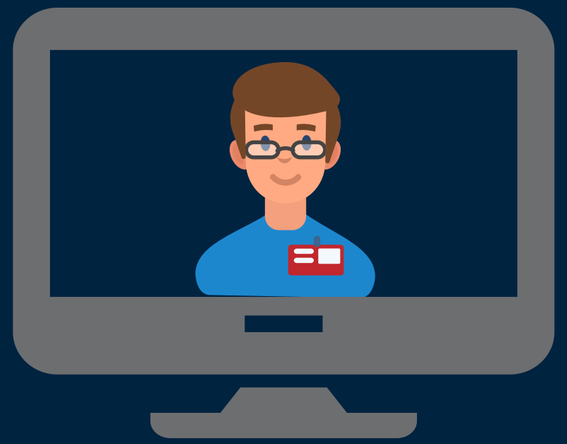
Facility-to-Outside Parties

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Consider these ideas to strengthen communication with families and outside ancillary providers.







Window Visits

Video, outdoor, social distanced or window visits between residents and families. Consider marking room numbers on windows to assist visitors in locating their loved ones' room.



Telehealth Visits

Telehealth visits for medical consultant providers such as podiatrists or dentists. Ensure proper cleaning/disinfecting of equipment used by these consultants.

Communication is Key

Customer Service

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Consider these ideas to strengthen your customer service efforts.



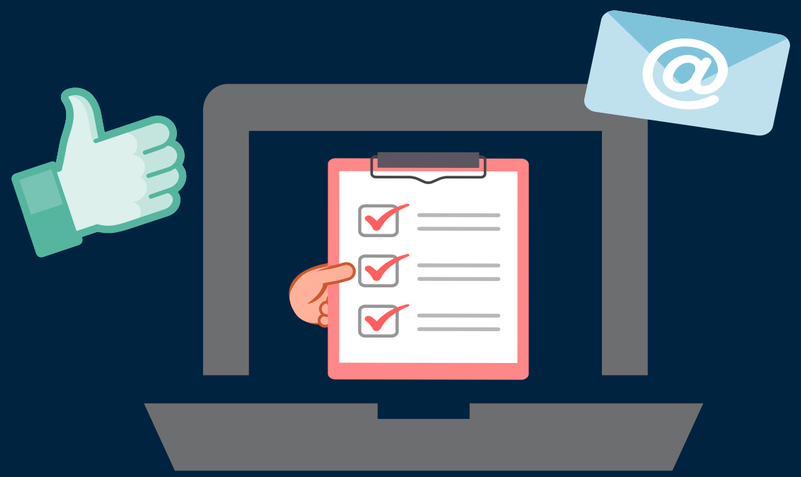
Memorial Services

Plan for a memorial/remembrance service following social distancing guidelines when acute management of the the crisis has resolved sufficiently to allow for reflection and shared condolences.



Facility Website Updates

Protocols should be in place to notify residents and families regarding facility infection rates per all local, state, and federal regulations. Possible ways to achieve this include updating the facility website daily to inform families or utilize a robocall system, group texts, email blasts, etc.



2025

Principles for Interacting with People Exposed - Pandemic

Language is important. Language sets the stage to build rapport with people exposed to infection and opens the door to honest dialogue. It is critical to establish open communication with people exposed to infection, so they feel comfortable expressing what they need to safely quarantine and seek help if they develop symptoms of infection.

When supportive statements and genuine concern are combined with active listening and open-ended questions, powerful information can be shared to interrupt the spread of infection. Asking open-ended questions prompts a dialogue and elicits more detailed information. Oftentimes, the information is helpful in learning more about the person and their circumstances. Remember, each person is unique, and this is not intended as a script. The interviewer should carefully listen to responses and add or subtract questions as appropriate.

Principles for Interacting with People Exposed:

- Ensure and protect confidentiality.
- Demonstrate ethical and professional conduct.
- Create a judgment-free zone.
- Be open-minded (everyone has a unique story).
- Be attentive and respectful.
- Be aware of your own bias (cultural humility).
- Establish open dialogue and pause often to listen.
- Ask open-ended questions.
- Use reflective listening techniques.
- Use culturally and linguistically appropriate language.
- Employ critical thinking and problem solving.
- Adapt to address concerns and information that arise naturally during conversation.
- Identify areas of need and link to appropriate resources.
- Don’t overstep or overpromise.
- Set the stage for ongoing communication and support during quarantine.

https://publichealth.tulane.edu/blog/communication-in-healthcare/

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Medical Care and Treatment - Pandemic

The medical care and treatment rendered to residents in an emergency or crisis should be designed to assure appropriate and effective responses to a variety of situations and conditions. The overall purpose is to provide person-centered care, while ensuring the safety of facility staff.

General Care Guidelines

- Facilities should have a plan for triaging care if needed, with a focus on:
  - Provision of essential supportive services including nutrition support, personal hygiene, and safety.
  - Administration of only essential medications and treatments.
  - Comfort care, including fluids and pain management.
- Medical care and treatment provided in PALTC facilities should be based on current clinical guidelines from appropriate public health authorities, other organizations and professional societies and the judgment of practitioners in the facility.
- When a resident becomes ill, decisions about where and what kind of care (i.e., palliative or lifesaving) is provided should be determined by his or her condition and care goals as well as current PALTC facility and/or hospital capacity to provide the desired level of care. Communication with family or resident representatives is essential.
- Where possible, facilities should minimize in-person and follow-up care visits with external consultants who may be visiting other facilities (i.e., podiatry, wound care, dental). Instead, facilities should expand access to and usage of tele-medicine and online evaluations for primary, specialty and emergency care.
  - Expanded use of these and other technologies that support alternative care models (i.e., wearables that allow remote patient monitoring of blood pressure, blood sugar or oxygen saturation) can help residents maintain access to the care they need while minimizing exposure risks for residents, staff, and service providers.
  - The decision to have in-person visits should be made by assessing risks and benefits on a case-by-case basis in accordance with the residents' goals of care (i.e., critical surgical, vascular and/or cardiac procedures). Communication between facility practitioners and outside consultants will be needed to minimize risk.
- Staff, nursing assistants and therapists may need to assume roles of care that are not within their typical responsibility, but that do not violate their legal scope of practice or mandates for training.

Potential Strategies

- For residents who do not have advanced directives, have informed discussions with those residents and/or their representatives to obtain advanced directives.

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- Focus on proven medical interventions and therapies that provide benefit; forgo those interventions that lack clear evidence of benefit or have high resource utilization in all residents.
  - Optimize medication management by de-prescribing any unnecessary medications (i.e., multivitamins), simplifying medication regimens or their administration (i.e., consolidating administration times or changing timing for doses).
  - Reduce nursing care requirements by adjusting the frequency of prescribed medical orders (i.e., routine yearly TSH orders for residents with stable hypothyroidism) or extending the interval between administration (i.e., extended-release preparation of antihypertensive in lieu of multiple doses of short acting medication)
    - Monitor for changes if dosage intervals change.
- Collaborate with pharmacies and vendors to forecast needs and ensure adequate supply of critical medication and medical supplies such as:
  - Morphine (liquid) with backup of oxycodone and hydrocodone and fentanyl patches
  - Antianxiety agents
  - Corticosteroids
  - Antibiotics
  - IV fluids
  - Urinary catheters which may be used for comfort during crisis care.
  - Oxygen and oxygen supplies (large cylinders and concentrators, regulators delivery devices).
- Emphasize nutrition, hydration, skin and mouthcare.
  - Promote nutrition modifying and liberalizing diets if necessary and offering liquid caloric supplements.
  - Combine multiple tasks in one interaction (bundle care); monitoring of pulse oximetry, offering hydration and turning of the resident can all be done in one visit with proper infection control measures.
  - Provide recommended management and supportive care to residents with suspected and confirmed infection in accordance with their goals of care
    - Support respiratory symptoms with supplemental oxygen (high flow oxygen may be needed) and bronchodilators (metered dose inhalers with or without spacers, oral, or in nebulized forms).
    - Staff should make all efforts to minimize disease transmission during high-risk procedures that can cause aerosolization.
    - Use of steroids and antibiotics may be warranted in some patients. Symptomatic treatment of dyspnea with opioids may also help generalized pain.

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- Uncommon gastrointestinal symptoms may need symptomatic management.
- Support metabolic encephalopathy and poor oral intake with frequent oral hydration.
- Hypodermoclysis or intravenous fluid support may be required especially in residents with underlying dementia and failure to thrive.
- Consider thromboembolic prophylaxis with subcutaneous low molecular weight heparin.

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Legal and Ethical Considerations – Pandemic

There are many legal and ethical considerations when managing resident care during a pandemic.

Legal

- National and state emergency declarations of a pandemic may provide additional flexibility, including the waiver and/or suspension of certain federal and state laws and regulations.
  - The federal government may issue blanket waivers and flexibilities to certain Medicare, Medicaid and Children's Health Insurance Program (CHIP) requirements under its authority pursuant to section 1135 of the Social Security Act, including waivers and flexibilities that directly pertain to post-acute, long-term care facilities.
  - The federal government may also act allowing and encouraging greater use of telehealth during a public health emergency under the Health Insurance Portability and Accountability Act (HIPAA) and under Medicaid.
- Post-acute/long-term care facilities should ensure that any changes to their operations and standards of care comply with the federal, state, and local laws and regulations in their jurisdictions.
  - Civil rights laws and regulations are not suspended or waived in the disaster context and continue to apply during a public health emergency.
    - Prioritization of care, including denials of care, must be made after non-discriminatory consideration of each situation based on the best available, objective medical evidence, free from stereotypes and biases based on a person's race, gender, disability, or age, including generalizations and judgments about their quality of life or relative value to society. Reasonable modifications to clinical instruments for evaluating short-term mortality risk for prioritization purposes may be necessary for accurate use of patients with underlying disabilities.
    - Reasonable modifications to policies restricting visitations may be necessary to permit access to support personnel who assist people with disabilities unless such modifications would constitute a fundamental alteration to CSC or would pose a direct threat to others.
    - Recipients and subrecipients of certain Federal block grants may not discriminate based on religion and in some cases, post-acute, long-term care facilities may need to make reasonable modifications to visitation policies to allow access to clergy and religious exercise on equal terms with secular based exceptions and accommodations.
- Post-acute, long-term care facilities should also coordinate operational adjustments with relevant state, regional and local authorities, including relevant medical direction.

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Ethical

- Standards of care at all levels should adhere to core ethical principles, including fairness, duty to care, duty to steward resources, transparency in decision-making, consistency, proportionality, and accountability.
    - Implementing these CSC guidelines will require active involvement of the facility medical director to ensure ethical principles are properly honored.
- Ethical decision making during a pandemic primarily concerns issues of equity and equality. Using resources wisely while still treating all people fairly can prove to be ethically challenging. Healthcare providers should focus on providing person-centered care first, with a recognition of duty to the wider community second.
    - When resource scarcity reaches crisis levels, clinicians are ethically justified to prioritize available resources and treatments based on the likelihood of immediate or near-term survival with treatments under consideration.

Ethical Principles - Advanced Care Planning (ACP)

- Most people residing in sub-acute, long-term care and assisted living facilities are older adults with multiple co-morbidities including diabetes mellitus, cardiac conditions like congestive heart failure, cardiomyopathy, chronic hypertension, renal failure, COPD, and cognitive impairment such as dementia.
- Advanced Care Planning (ACP) discussions that take a patient-centered approach are critical to determining patient preference for medical care in a public health emergency.
- PALTC facilities with up-to-date advanced care plans in place for their residents will be better positioned to adapt their standards of care in ways that balance resident preferences and available resources.
- While providers may revisit ACP discussions with residents, they must be careful not to exert pressure on residents with disabilities or older persons to decline life-sustaining treatment.

https://files.asprtracie.hhs.gov/documents/covid-19-considerations-strategies-and-resources-for-crisis-standards-of-care-in-paltc-facilities.pdf

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Acknowledgement and Liability Waiver
Infection/Pandemic

I understand that there is an ongoing, worldwide pandemic of a highly transmissible virus.

I _____am requesting admission to _____ nursing center, with the understanding that the center has active cases of infection. The center has described the steps being taken to mitigate the spread of infection within the facility per the CDC guidelines.

That despite the actions being taken by _____ nursing center, I understand that there is risk of contracting the virus from a resident, visitor, or staff member at
_____ nursing center.

That I understand that there currently is no known treatment for said virus, and that there is a possibility that if I were to contract the virus as a resident at _____ nursing facility, I could become sick and even die.

That with the full knowledge and understanding of the risk to me of contracting the virus from a resident, visitor, or staff member of _____nursing Center, I would like to be admitted to _____nursing center.

That in exchange for _____nursing center allowing my admission during the ongoing pandemic, I agree to waive on my behalf, and on behalf of my legal heirs and assigns, any and all claims, including any claim related to my death, that may arise if I were to contract the virus.

Resident / Legal Guardian: _____ Date: _____

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Minimizing Interactions - Pandemic

The CDC recommends that approaches be taken to reduce face-to-face contact with residents with active infection to slow disease transmission and reduce the number of people who get sick. The primary goal of facilities is to provide medical and nursing care while preventing the spread of infection.

The following recommendations are to minimize contact between staff and residents to reduce the risk of transmission infection. Resident procedures and monitoring will be evaluated individually with the physician to avoid any unnecessary contact.

Vital Signs
Routine vital signs will be decreased to those necessary, including evaluating monitoring frequency prior to medications. Acutely ill residents will be monitored as needed. Hospice/Palliative care residents vital signs will be limited to those essential to maintaining comfort.

Finger Stick Blood Sugars
Assess each resident's monitoring to determine if frequency can be decreased to what is necessary and safe for each resident. Review Beer's List.

Lab Monitoring
Evaluate and cease routine labs for medication monitoring unless necessary for resident safety. Labs should be ordered for acute situations only to assist in diagnosing and/or treatment.

Wound Care/Management
Evaluate decreasing the frequency of wound care procedures or discontinue if appropriate with physician orders.

Coumadin/Warfarin
Evaluate each resident to determine if the current drug regimen can be changed to a Direct Oral Anticoagulant which require less/no lab monitoring.

Nebulizer Treatments
- Evaluate individual resident needs and obtain physician orders to eliminate the treatment if possible. If long term PRN orders are in place, consider holding and calling MD prior to use. If chronic use, evaluate where using an inhaler with AeroChamber would be appropriate.
- Symptomatic residents should not have nebulizers initiated by standing orders. Since the procedure significantly increases the risk of transmission, the physician should be consulted as needed.
- Consider maintaining inhalers and/or nebulizer supplies at the bedside instead of the med cart.

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Unnecessary Medications

- Evaluate and reduce non-essential medications, such as supplements or multivitamins to reduce medication administration time and limit exposure to residents.

Outbreak Considerations for Long-Term Care Communities (hhs.gov) September 2023

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Hand Hygiene Recommendations - Pandemic

Guidance for Healthcare Providers about Hand Hygiene and infection control

Background

- **Hand hygiene is an important part of the U.S. response** to a pandemic. Practicing hand hygiene, which includes the use of alcohol-based hand rub (ABHR) or handwashing, is a simple yet effective way to prevent the spread of pathogens and infections in healthcare settings. CDC recommendations reflect this important role.
- **The exact contribution of hand hygiene** to the reduction of direct and indirect spread of viruses between people is currently unknown. However, handwashing mechanically removes pathogens, and laboratory data demonstrate that ABHR formulations in the range of alcohol concentrations recommended by CDC inactivate many viruses.
- **ABHR effectively reduces the number of pathogens present on healthcare providers' hands after brief interactions with patients or the care environment.**

Hygiene Methods

- **CDC recommends using ABHR with 60-95% alcohol** in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and effective without a sink.
- **Your hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom**. Learn more about hand hygiene in healthcare settings https://www.cdc.gov/clean-hands/hcp/clinical-safety/?CDC_AAref_Val=https://www.cdc.gov/handhygiene/providers/index.html

Impact to Operations

- **CDC does not have a recommended alternative** to hand rub products with greater than 60% ethanol or 70% isopropanol as active ingredients. Benzalkonium chloride, along with both ethanol and isopropanol, is deemed eligible by FDA for use in the formulation of healthcare personnel hand rubs. However, available evidence indicates benzalkonium chloride has less reliable activity against certain bacteria and viruses than either of the alcohols.
- **The USP hand sanitizer toolkit formulas** have final concentrations of 80% ethanol or 75% isopropyl alcohol concentrations. A final concentration of 80% ethanol or 75% isopropyl alcohol are recommended in the USP hand sanitizer toolkit. https://www.usp.org/covid-19/hand-sanitizer-information

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Environmental Infection Control - Pandemic
Policy and Procedure

Policy:

The facility has environmental infection control procedures in place to prevent transmission of communicable diseases.

General Principles:

- Residents with known or suspected infection should be placed in a single-person room with a dedicated bathroom if possible. The door to the room should remain closed.
- Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients who will be undergoing aerosol-generating procedures. (AIIRs are single-patient rooms with negative pressure relative to the surrounding area with a minimum of 6 air exchanges per hour.)
  - Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter directly before recirculation.
  - Room doors should be kept closed except when entering or leaving the room, and entry and exit should be restricted to essential caregivers.
  - Monitor and document the proper negative-pressure function of these rooms.
- Only essential personnel should enter the room of patients with active infection.
- Daily cleaning and disinfection of high-touch surfaces should be assigned to nursing personnel who will be in the room providing care. If assigned to environmental services personnel, they should wear all PPE when in room, remove PPE upon leaving and perform hand hygiene.
- Dedicated medical equipment should be used when caring for patients with
- known or suspected infection.
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's
- instructions and facility policy.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital- grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) in

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Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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Infection Control Strategies – Isolation - Pandemic

Goal:
Minimize the risk of non-infected residents interacting with infected or colonized residents as part of intensified interventions for an outbreak, novel or resistant pathogen or highly transmissible disease and limit exposure to staff by:

- Residents infected or colonized with the same infectious agent are confined to one area.
- Staff are assigned a specific set of cohorted residents and bundle care when possible.
- Management overseeing an active surveillance program with Standard and Transmission-Based Precautions to control disease spread.

General Information
During an epidemic or pandemic, the demand for AIIRs may exceed their availability. When this occurs, healthcare facilities may choose to use portable fan systems with high-efficiency particulate air (HEPA) filtration to establish surge AIIR capacity.

Expedient Patient Isolation Rooms | Healthcare Workers | CDC

Isolation Unit

- Standard Precautions plus, when applicable, respirator, gown, gloves and eye protection for each staff member.
- Physically separate location when possible.
- Dedicated nursing assistants and nurses.
- Restrict ancillary staff whenever possible if unable to dedicate them to the isolation unit.
- Post signage at the entrance, including PPE instructions.
- Keep the door closed or create a barrier at the entrance and include disposal containers for PPE and hand sanitizing stations.
- Train unit personnel in infection prevention, including PPE use.
- Monitor PPE and implement optimization strategies if needed.
- Dedicate resident care equipment that does not leave the unit.

Considerations for "Other Designated Areas" in your center
General Population – Uninfected Residents
Observation Areas

- Admissions
- Readmissions

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- Roommates of infected residents
  - Single room preferred.
  - May place with another exposed roommate if single room not available.
- Dialysis Residents
  - Dialysis puts the resident at greater risk of acquiring disease.
  - Multiple transfers increase risk to other residents of acquiring disease from residents receiving dialysis.

Best Practices for Isolation Units

- Isolation unit on a separate floor or unit, with a separate staff entrance.
- Colored tape marks off hot, warm and cold zones.
- Staff change into hospital-provided scrubs and shoes that they leave here before entering the "Hot Zone". We launder the scrubs here".
- "It's important to set up a process for communication, supply and meal delivery with the "Hot Zone" as staff in this area can't leave until the end of their shift and other staff can't enter".
- "Once you think you have thought of everything, provide unit tours for the local health department and staff that did not participate in developing the unit, they may see things you forgot to include."

Lessons Learned for Isolation Units

- "You can get bed locked quickly if you don't already have an unused wing. We had 11 rooms in our isolation unit but filled it in just a few days with people who went out to medical appointments, so we had to then isolate in place".
- "The plastic separating the halls needed disinfecting hourly because everyone was touching it".
- "It takes less to change a room to negative pressure than you might think".

Cohorting Admissions and Readmissions

- All residents with confirmed infection not meeting Transmission-Based Precautions discontinuation criteria should be admitted to the isolation unit.
- Residents who meet Transmission-Based Precautions discontinuation criteria can be admitted to regular units.
- Residents with status unknown – place in single room or observation area and monitor for 14 days (about 2 weeks).
  - Unknown status includes residents tested during hospitalization or at the time of admission who may still be at risk for developing disease.
  - All recommended PPE should be worn during care.

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Discontinuing Cohorting

Continue Transmission-Based Precautions and cohorting until criteria for discontinuation are met.

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Health Care Settings - PubMed (nih.gov)

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Isolation Area/Unit - Pandemic

Defined as a dedicated space in the facility to care for residents with active, transmissible infections. This could be a dedicated floor, unit, or wing in the facility or group of rooms at the end of a unit.

Recommendations for Isolation Area/Unit

Facility layout for staff access:
- Designate separate entrance and exit doors (optimal).
- Staff break area separated from resident care area with bathroom for staff use only.
- Provide an area for staff to put on and remove personal protective equipment (PPE) when entering/exiting the unit.
- Ensure resident care area or rooms have access to bathrooms/showers.
- Designate area on unit where staff can perform documentation responsibilities while monitoring residents.
- Clean supply area/linen supply in protected area with easy access.
- Medication storage/preparation area with refrigerator.
- Soiled utility area for waste and used equipment for reprocessing.

Personal Protection Equipment:
- N95 or higher-level respirator (or facemask if respirator not available).
- Eye Protection (i.e., goggles or disposable face shield that covers the front and sides of the face).
- Gloves
- Gowns

Depending on the availability of PPE, items such as gowns and respirators may need to be prioritized. See Strategies for Optimizing PPE Supply for additional guidance.

Resident rooms
- Limit the number of residents in each room where possible.
- Private rooms with separate bathrooms **or at least 6 feet between beds** with cubicle curtain in closed position.
- Consider positioning beds in head-to-toe configuration if possible.
- Remove unnecessary furniture/equipment.
- Avoid porous surfaces (upholstered furniture, carpet) if possible.

Medical supplies for unit
- Alcohol-based hand sanitizer
- Soap and paper towels
- Incontinent products
- Bedside commodes
- Urinals
- Personal hygiene supplies

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- Vital sign equipment including thermometers
- Wheelchairs, etc.

Food services

- Catering with disposable plates/utensils; carry out containers.
- Separate staff space to eat without wearing PPE.
  - Designated break room.
  - Maintain social distancing, monitor.

Environmental

- Trained staff provided with necessary PPE.
- EPA registered disinfectants from List N.
- Daily and terminal cleaning of room, floors and bathrooms.
- Immediate cleanup of spills.
- Regular disinfection of high-touch surfaces.

Diagnostic equipment

- Individual glucometers.
- Individual pulse oximetry equipment or disinfection plan per manufacturer's recommendations.
- Anticoagulation monitoring equipment with manufacturer's recommendations for disinfecting.

Recommended Staffing

- Infection prevention training for staff prior to being assigned to the unit.
- Infection prevention coordinator; oversight of unit including surveillance.
- RN charge nurse on site each shift (if possible).

https://www.cdc.gov/marburg/hcp/training/creating-an-isolation-area-in-your-facility.html

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Daily Care and Life Enrichment - Pandemic

It may be necessary to modify the provision of activities of daily living (ADL) and resident life enrichment activities during an emergency or crisis, particularly if social contact between staff and residents and among residents could create opportunities for ongoing disease transmission. However, infection control and prevention practices enacted to prevent the spread of infection may have an adverse effect on physical, mental, and emotional health. For example, communal dining and other group activities may be suspended, and times of showering/bathing may be altered due to staff changes, staffing challenges, and PPE shortages.

Potential Strategies

- Healthcare providers (e.g., nurses, nursing assistants, resident care providers) providing personal care for residents must be given priority for PPE and testing.
- Person-centered care plans and service plans can be modified to address the unique challenges and threats to psychosocial and psychological health and wellness related to infection control and prevention measures in place to prevent the spread of infection.
- Routines are very important for residents with dementia, facilities need to carefully consider potential risks and benefits of moving residents out of the memory care unit to a designated isolation unit.
- An abbreviated care plan can be included as a stand alone document to communicate with staff or can be incorporated into the care plan.
- In addition to the modification of individual plans, a facility engagement plan should address how life enrichment activities will overcome the unique challenges infection control and prevention practices including but not limited to:
    - social distancing,
    - room isolation,
    - absence of communal gatherings, and
    - the lack of intimate/familial touch that accompanies the physical presence of loved ones.
- Find new ways to help residents remain physically, mentally, and socially active and connected, such as:
    - Ask the resident to march in place or do sit-to-stand or range of motion exercises (with appropriate safety precautions) while helping him/her get his/her clothes out.
    - Help residents to access and follow range of motion exercise videos in their rooms during ADL care.
    - Ask residents to stand at their doors (every other room to start, then switch to group two to increase distance between residents) and lead them in stretching and balance exercises as appropriate.

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    - Play music in the hallways for residents to hear or play live or recorded music outside in a courtyard where residents can watch and listen from their rooms.
    - Find additional inspiration at the Pioneer Network's ABCs of Combating Isolation resources. https://www.pioneernetwork.net/resource-categories/engagement/
    - The National Certification Council for Activity Professionals has a wealth of information specific to supporting resident activities during isolation, including 101 Ideas for in room & 1-to-1 Activity Programs.
    - An individualized approach may be needed to ensure individuals with physical and intellectual disabilities have the same level of access to alternative activities. For example, adjustments may be needed to address limited mobility and difficulty accessing information, trouble understanding information, and/or difficulties with changes in routines.
- Reconfigure existing spaces to support socially distanced communal activities and dining, such as spacing dining chairs so residents may eat together while maintaining at least 6 feet of distance between one another. Facilities should ensure any in-person communal activities adhere to core principles for infection control and best practices that reduce the risk of spreading infection (e.g., appropriate hand hygiene and use of a face covering).
- Verbally and visually cue residents to participate in as much of their care as possible.
- Provide alternative means of communication--such as video chat, telephone, texting, or social media; and (where necessary) staff assistance for residents to contact their loved ones or for residents with dementia, a phone call or videoconference a few times a week may not be sufficient; consider using a simulated presence.
    - Be sure to communicate these alternatives clearly and proactively and the facility's reasons for shifting from in-person to virtual visitation to residents and their families.
- Create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available.

https://files.asprtracie.hhs.gov/documents/covid-19-considerations-strategies-and-resources-for-crisis-standards-of-care-in-paltc-facilities.pdf

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Management of Neurological and Mental Manifestations Associated with Pandemic

Residents with infection are at high risk for delirium, and sometimes delirium may be a presenting feature of infection even without respiratory symptoms. Anxiety and depressive symptoms are often common reactions for people with active infection, especially for those who are hospitalized.

Stressors particular to infection include:

- Fear of falling ill and dying.
- Fear of being socially excluded/placed in quarantine.
- Loss of livelihood.
- Loss of loved ones.
- Feelings of helplessness, boredom, and loneliness due to being isolated.

These stressors may trigger new symptoms or exacerbate underlying mental or neurological conditions. Residents with pre-existing mental health conditions and substance abuse disorders may also be adversely impacted. Residents with infection are at higher risk for sleep problems owing to acute stress responses, as well as additional reasons for those who are hospitalized such as environmental factors, invasive medical procedures (e.g., mechanical ventilation) and the frequent combination of multiple medications possibly disrupting sleep patterns.

Delirium:
It is highly recommended that in residents with active infection, measures to prevent delirium be implemented and using standardized protocols, evaluate for the development of delirium. If the resident is suspected of having delirium, immediately evaluate, address underlying causes of delirium, and seek treatment orders from the attending physician.

1. Manage any underlying causes of delirium by:
    a. Monitoring oxygenation and fluid status.
    b. Correcting metabolic or endocrine abnormalities.
    c. Addressing co-infections.
    d. Minimizing the use of medications that may cause or worsen delirium.
    e. Treating withdrawal from substances.
    f. Understanding and minimizing the effects of any harmful drug-drug interactions.
    g. Maintaining normal sleep cycles as much as possible.
2. In residents experiencing agitation (defined as marked restlessness or excessive motor activity, often accompanied by anxiety), use calming communication strategies, and attempt to reorient the resident.

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3. Acute pain due to physical illness or air hunger should be considered as triggers for agitation and need to be addressed immediately. If the resident continues to be agitated despite these interventions and is experiencing severe distress, it may be necessary to use psychotropic medications.
4. When using antipsychotic medications for agitation, consider side-effects that may worsen symptoms including:
    a. Sedation
    b. Respiratory or cardiac function
    c. Risk of fever or other immunological abnormalities
    d. Coagulation abnormalities
    e. Potential drug-drug interactions between these and other medications.

Use minimum effective doses of antipsychotic medications at the lowest frequency and for the shortest duration possible, with doses adjusted according to age, medical co- morbidities, and degree of distress.

Mental health and psychosocial support:
Provide basic mental health and psychosocial support for residents with suspected or confirmed infection by asking them about their needs and concerns and addressing them.

1. It is critical that prompt identification and assessment for anxiety and depressive symptoms in residents diagnosed with infection and that psychosocial support strategies be initiated to manage new anxiety and depressive symptoms.
2. For residents who are experiencing symptoms of anxiety, psychosocial support strategies such as psychological first aid, stress management, and brief psychological interventions based on the principles of cognitive behavioral therapy should be considered.
3. For residents who are experiencing symptoms of depression, brief psychological interventions based on the principles of cognitive behavioral therapy, problem-solving treatment and relaxation training can be considered.
4. If the resident's anxiety or depressive symptoms persist beyond recovery from infection and/or discharge from the hospital, then an underlying anxiety or depressive disorder may be suspected, and a mental health professional should be consulted.
5. It is important to ask about thoughts or acts of self-harm due to risk factors for self-harm and suicide such as sense of isolation, loss of a loved one, job, or financial loss and hopelessness. Remove possible means of self-harm, activate psychosocial support, follow up with the person, and consult a mental health professional, as necessary.

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6. Sleep hygiene and stress management (including relaxation techniques and mindfulness practices) are effective in reducing sleep problems and may be offered. Psychological interventions based on the principles of cognitive behavioral therapy may also be considered.
7. For residents who are hospitalized, additional causes of insomnia may include environmental factors (e.g., excessive light and noise at night), anxiety, delirium, agitation, pain, or air hunger. Identifying and promptly addressing underlying causes should be prioritized before using any pharmacological sleep aids.

https://apps.who.int/iris/bitstream/handle/10665/332196/WHO-2019-nCoV-clinical-2020.5-eng.pdf

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Transport and Transfer Pandemic

Emergency or crisis situations may require changes in where residents receive care and other services and how they get to service sites.

- This may include deferral of transport for sub-specialty evaluation for non-emergency conditions (i.e., ortho, eye evaluations) and changes to the threshold for transport for acute evaluation and treatment.
- During a pandemic, PALTC facilities may need to modify current EOP to incorporate alternative strategies and standards for different kinds of transport and transfer, including: Internal transportation, such as moving residents between rooms or floors because of crisis conditions and
    - External transportation under common scenarios that present potential unique considerations (i.e., emergency transfer/EMS or death).
- PALTC facilities should work closely with hospitals, funeral homes, emergency medical services and other stakeholders to develop new, or modify existing, policies and procedures around external transport and transfers.
    - Internal transportation, such as moving residents between rooms or floors as a result of crisis conditions.
    - External transportation under common scenarios that present potentially unique considerations (i.e., emergency transfer/EMS or death).
    - EMS agencies may be significantly delayed responding to requests for assistance, particularly non-emergency transfers.
    - Healthcare facilities may become overwhelmed with patients, making it necessary to consider alternative options for managing patients who would be otherwise transported to the hospital under normal circumstances.
    - The status of local hospitals should be updated continuously to the facility leadership to inform transport destination decisions. In rapidly evolving scenarios, local, state, and regional access to care sites is likely to be dynamic and frequently changing. ○ Disposition of deceased residents may be an issue due to funeral homes and crematoria being at full or more capacity. A contingency should be developed to accommodate removal of the deceased.
- In all situations, the goal remains to ensure and provide appropriate, effective responses to emergencies or crises that secure the safety of residents, staff and visitors.

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Potential Strategies

- Establish a process and system to track current capacity and open beds across health care facilities.
  - Under an ideal scenario, this would be developed and maintained on a state-wide basis by the department of health.
- Determine if there are facilities that will house residents with suspected or confirmed infection and establish protocols and processes for transporting/transferring residents there.
- Identify locations that could be used if needed to house and care for affected residents, including areas that may not typically be used for resident care.
  - Ensure that the location meets all federal and state regulations for alternative care sites and is appropriate for the care of the patient.
- Establish dedicated sites for resident pick-up and drop-off (i.e., following return from a dialysis or chemotherapy appointment)
- Notify local hospitals and other settings if the facility is closed to admissions and readmission while operating at a crisis standard of care.
- Work with local resources on community alternatives, consistent with the community integration mandate under the Supreme Court's decision in Olmstead v L.C. that services (including community-based services) must be provided to persons with disabilities as appropriate and desired by the individuals, with reasonable accommodations as available. ○ For example, partner with home health agencies to identify options that would support continuity of care while allowing safe discharge of residents to their homes.
  - Make referrals to other entities with expertise in community-based services and support such as the Centers for Independent Living, Area Agencies on Aging, the Long-Term Care Ombudsman.
- In collaboration with area hospitals, nursing homes and funeral homes, develop a plan for care of the resident after death including how the resident will be identified and postmortem care.
  - Determine who will notify the family and how that notification will occur.
    - Notification processes should offer families both critical information and grief support.
  - Discuss with the partners who will be in charge; how critical post-mortem supplies will be maintained; and security measures.

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- Identify a central location where deceased can be transferred if morgues are overwhelmed (i.e., refrigerated warehouses or trailers that can function as temporary morgues).
  - If using a military site, have agreement with military to provide personnel to provide security for storage areas.
  - Predetermine who will be monitoring the arrivals and departures of the deceased at the central location site (could be representatives of funeral homes).
  - Design a tracking log to enter all names of deceased and location at storage area and final disposition, date, time and who the body was released to.
  - Include notification of family of arrival and disposition.
- Develop protocols for aftercare of the body that ensure minimal exposure to transport personnel, such as:
  - Identifying the deceased by labeling the body and the covering (include family name and phone number for notification).
  - Placing the body in a body bag, casket cover, shroud or even sheets.

https://files.asprtracie.hhs.gov/documents/covid-19-considerations-strategies-and-resourcesfor-crisis-standards-of-care-in-paltc-facilities.pdf

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RISK MANAGEMENT SERVICES

Assisted Living Admissions – Infection Control - Pandemic

Policy and Procedure

Given the congregated nature and population served, the facility is at high risk of infections spreading and affecting residents. Many people living in the community are at higher risk of getting extremely sick from infections because they are older adults and many have chronic conditions such as heart disease, diabetes, or lung disease.

Policy

This community will continue to adhere to the CDC (Centers for Disease Control) infection control guidelines to prevent the spread of infection while maintaining the recommended level of social interaction.

General Considerations

- Admissions will be postponed if there is an infectious outbreak. The health department will be consulted to resume admissions when the outbreak is over.
- Residents hospitalized will be monitored for active infection upon readmission and appropriate interventions will be implemented.
- Residents admitted from the hospital/nursing home will be screened for symptoms of active infection.
- Telehealth visits will be offered to enable residents to communicate with their physicians while reducing face-to-face interactions.

Residents

- Residents are encouraged to wear a cloth face covering when out of their rooms or around others, regardless of symptoms, unless contraindicated due to medical conditions.
- A "buddy" system may be established for residents to check in on each other (non-face- to-face communication), volunteers could assist.
- Education will be provided, and observations will be ongoing for social (physical) distancing, hand hygiene and cough etiquette.
- Residents leaving the center for medical treatment, including doctor appointments and dialysis treatment, will be monitored for signs and symptoms of infection upon return.
- Residents will be assessed daily for fever or symptoms of infection and/or change in condition.

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- Residents exhibiting symptoms of infection may remain in the facility if they are able:
  - To perform ADL's independently
  - Self-isolate during illness
  - To have meals delivered

Environmental

- Common areas and shared spaces will be cleaned and disinfected prior to use, after use and/or at least daily.
- High touch surfaces and shared equipment are cleaned before and after use.
- An adequate supply of soap and alcohol-based sanitizer will be stocked in restrooms and common areas
- Adequate cleaning and disinfection supplies are available for housekeeping and general use

Activities/Events

- Alter schedules to reduce mixing
  - Stagger mealtimes
  - Stagger activities and arrival/departure times
- Evaluate and limit programs with external staff
- Limit attendees based on room size and encourage social distancing

Ongoing education

- Communicate regularly with staff, residents and families about any actions or changes to protect residents and staff.
- Post for staff and residents' reminders on social distancing, hand washing and cough etiquette.

The Unique Challenges Faced by Assisted Living Communities To Meet Federal Guidelines for COVID-19 - PMC

Coronavirus Disease 2019 (COVID-19) | COVID-19 | CDC

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Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Date of Review and/or Revision: _____ _____ _____ _____

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Holiday Celebration Recommendations - Pandemic

Safer Ways to Celebrate Holidays

Holiday traditions are important for families and children. There are several ways to enjoy holiday traditions and protect your health as many generations tend to gather to celebrate. Here are some safer ways to celebrate the holidays:

Generally:

- Protect those not yet eligible for vaccination such as young children by getting yourself and other eligible people around them vaccinated if vaccines are available.
- Wear well-fitting masks over your nose and mouth if you are in public indoor settings if you are not fully vaccinated.
    - Even those who are fully vaccinated should wear a mask in public indoor settings in communities with substantial to high transmission.
    - Outdoors is safer than indoors.
    - Avoid crowded, poorly ventilated spaces.
    - If you are sick or have symptoms, don't host or attend a gathering.

Special Considerations:

- You might choose to wear a mask regardless of the level of transmission if a member of your household has a weakened immune system or is at increased risk for severe disease.
- If you are gathering with a group of people from multiple households and potentially from different parts of the country, you could consider additional precautions (i.e., avoiding crowded indoor spaces before travel, vaccinate if available) in advance of gathering to further reduce risk.
- Do NOT put a mask on children younger than 2 years old.

By working together, we can enjoy safer holidays, travel, and protect our own health as well as the health of our family and friends.

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RISK MANAGEMENT SERVICES

Mail and Package Delivery - Pandemic

Policy and Procedure

Policy:
Postal Carriers are subject to the same screening process as all essential personnel in our communities. Packages delivered by any outside agency including USPS, Fed Ex, Amazon, UPS, family, etc., will be left at the entrance of the building and distributed by facility staff.

General Considerations:
Getting mail is one of the primary ways for our residents to stay connected to loved ones as well as to continue their important everyday routines. Many residents also receive important/time sensitive packages that may contain prescriptions and tax preparation information.

Procedure:

1. Postal carriers will be screened according to the current essential personnel screening policy if they are delivering mail beyond the checkpoint at the main entrance to the center.
2. If the postal carrier refuses to be screened or if there are issues with the current delivery practices, the United States Postal Service (USPS) will be offering centers and other customers three options for mail delivery (see attached).
   - You may opt to redirect to a temporary mail receptacle inside or outside the building where screening would not be necessary.
   - Place the mail on hold at the Post Office servicing this delivery. Mail and parcels can be held for up to 30 days and will be available for customer pickup.
   - Redirect all mail for the business to an alternate location.

3. If the postal carrier or staff member will be **distributing resident mail to individual mailboxes**:
   a. Residents will be removed from the area where mailboxes are stored while mail is being placed in individual mailboxes.
   b. The postal carrier will clean their hands with hand sanitizer or with soap and water according to handwashing protocols.
   c. The postal carrier will apply gloves and a mask and proceed to the area where resident mailboxes are located and distribute mail.
   d. The mail carrier shall not leave the mailbox area without appropriate PPE.

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e. When the postal carrier or staff member has finished distributing mail to mailboxes, gloves and masks will be removed and hands will be cleansed with hand sanitizer or with soap and water according to hand washing protocols.

4. If a staff member is assigned to distribute mail ***directly to the residents***:
   a. The staff members will clean their hands with hand sanitizer or soap and water according to the center's policy on handwashing protocols.
   b. The staff member will apply gloves and a mask and proceed to the resident's room/apartment and deliver the mail, avoiding prolonged exposure to residents.
   c. Once mail is delivered, gloves and face mask will be removed, and hands will be cleaned
   d. The above steps will be completed before delivery to each resident's room
      i Refer to facility policy for reuse of face masks

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

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** Emergency Preparedness Manual*
** Pandemic Toolkit*

Protecting Your Home During the Holidays - Pandemic

Infections can spread anywhere, even places where you feel safe, like your home. If even one person in your household gets infected, it can spread to others in your home. Learn what you can do to keep infections outside your home, and if it gets in your home, what you can do to keep it from spreading.

What is a Household?

- Anyone who currently lives in and shares common spaces in your housing unit (house or apartment).
- Households can include family members and or people who aren't related to you, like roommates.
- People who don't currently live with you (for example, college students who return home from school on breaks) are part of different households.

Keep Infections Outside Your Home

When you leave your house for work, to run errands, or for any other reason, you have a chance of being exposed to infection and bring to back to your home. The chances of being exposed increase when you:

- Have close contact with other people (closer than 6 feet).
- Spend more time with other people.
- Spend time in crowds (more than 10 people).
- Spend time in indoor spaces, particularly if poorly ventilated.

Keep infection outside your home! When around people who don't live in your home, wear a mask, wash your hands and stay at least 6 feet apart to protect yourself and prevent bringing infection into your home.

Wear a Mask

- Wash your hands before putting on your mask.
- Wear your mask over your nose and mouth and secure it under your chin.
- Fit your mask snugly against the sides of your face.
- Make sure you can breathe easily.
- When you take off your mask, handle it only by the ear loops or ties.
- Store your used mask safely to keep it clean between uses.
- Wash your cloth mask regularly, preferably in a washing machine.

Stay at Least 6 Feet Apart and Avoid Crowds

- Stay at least 6 feet (about 2 arm lengths) from other people. Remember that people can spread the virus even if they don't have symptoms.

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- Avoid crowds and indoor spaces as much as possible, particularly ones that aren't well ventilated. The more people you are in contact with, the more likely you are to be exposed to infection.

Wash Your Hands

- Wash your hands often with soap and water for at least 20 seconds.
- If soap and water aren't available, use a hand sanitizer that contains at least 60% alcohol.
- Cover all surfaces of your hands and rub them together until they feel dry.
- Avoid touching your eyes, nose, and mouth until after you wash your hands.

Prevent Infection Inside Your Home

If your household includes one or more people who are more likely to get very sick if infected, then ***all household members should act as if they are more likely to get very sick.***

If you can't take steps to keep infection outside your home, then stop it from spreading inside your home, especially if you have someone at home who is more likely to get very sick if infected. Take these steps to protect people in your household.

- Wear a mask in shared spaces around others. If you or others in your household are in close contact (within 6 feet) of other people who don't live in your household and if you have household members who are more likely to get very sick if infected (older adults, people with specific medical conditions or who have to take extra precautions), consider wearing masks in shared spaces around others in your home.
- Stay at least 6 feet apart in shared spaces, about 2 arm lengths. Remember that people can spread the virus even if they don't have symptoms.

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- Wash your hands often with soap and water for at least 20 seconds or use hand sanitizer if soap and water aren't available.
- Monitor your health daily, watch for fever, cough, shortness of breath or other symptoms of infection.
- Clean and disinfect high-touch surfaces in shared spaces.
- Avoid sharing personal household items.
- Do not share items such as dishes, drinking glasses, cups, eating utensils or towels with other people in your home.
- Wash these items thoroughly after using them.

If Someone Gets Sick

- Separate the person who is sick from other people in your home, if possible.
- People in the household should stay separated from the person who is sick. If they must be around the person who is sick, they should wear a mask.
- The person who is sick should:
  - Stay in a separate room and away from other people and pets.
  - Use a separate bathroom.
  - Wear a mask around others.
- Be sure the person who is sick:
  - Covers their mouth and nose with a tissue when coughing or sneezing.
  - Throws away used tissues in a lined trashcan and washes their hands often.
  - Does not prepare, serve or assist in preparing or serving food to others.

It is likely that flu viruses and other viruses will spread during fall and winter. Healthcare systems could be overwhelmed treating both patients with flu and other viruses. This means getting a flu vaccine is more important than ever.

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Post-Mortem-Care-Pandemic
Policy and Procedure

Policy

The dignity of a resident who has died including their cultural and religious traditions/beliefs and their family will be respected and protected while providing postmortem care to the extent possible during a pandemic.

Pandemic Considerations

- Only the lungs of patients with pandemic influenza, if handled improperly during an autopsy, can be infectious. Otherwise, cadavers do not transmit disease.
- Avoid rushing the process of removing resident remains; take appropriate time, care and respect.
- Authorities should manage each situation on a case-by-case basis, balancing the rights of the family, the need to investigate the cause of death, and the risk of exposure to infection.
- Staff should apply standard precautions, ensure appropriate hand hygiene (before and after providing care) and personal protective equipment (PPE) supplies (gown, gloves, facemask and eye protection) should be used per facility policy.
- The remains do not need to be disinfected prior to transport to the funeral home.
- The use of body bags is not necessary unless there is excessive body fluid leakage, etc.
- No special transport equipment or vehicle is required.

Procedure

1. If the resident has a roommate, relocate them to a comfortable location within the center until post-mortem care is completed, and the remains have been removed.
2. Gather supplies: PPE, plastic bags, bathing supplies, etc.
3. Wash hands.
4. Put on gown, gloves, mask and eye protection.
5. Close curtains and doors to maintain privacy.
6. Treat the body gently and with respect.
7. Remove any tubes and dressings.
8. Lay body flat with pillow under head, limbs straight and place the hands on the chest.
9. Close eyes
10. If the resident has dentures, place them in the resident's mouth and close the mouth if possible.
11. Wash body as needed; keep movement and handling of the body to a minimum.
12. Comb hair.
13. Place fresh dressing over wounds if drainage is present; cover perineal area and other areas where body fluids may leak.

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14. Wrap the body in bath sheet/blanket and arrange for transport to the funeral home as soon as possible.
15. Remove PPE and perform hand hygiene.

https://www.osha.gov/coronavirus/control-prevention/postmortem-care

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Staffing During an Emergency - Pandemic

Policy:

During normal operations, the facility complies with the laws and regulations for staffing. During an emergency, including a pandemic, the facility may experience staffing shortages (potentially severe) and, under specific emergency conditions, will implement staffing strategies with minimal resident risk.

Staffing Guidelines:

The facility has a plan for expediting the credentialing and training of non-facility staff from other locations to provide resident care when a staffing crisis is realized.

A contingency staffing plan has been developed that identifies the minimum staffing needs based on acuity and census and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations.

In the event of a pandemic or other emergency that may impact staffing, the administrator or designee shall conduct a daily assessment of staffing status and needs.

Legal counsel and state health department contacts will be consulted to determine the applicability of declaring a facility "staffing crisis" and appropriate emergency staffing alternatives, consistent with state law and state and federal regulations.

The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.

During a disaster, staff may not be able to report to work, may be ill, or may need to take care of family members. Staff are notified by the staffing liaison that there is an emergency and off- duty staff are called in as needed/available. A detailed staff emergency contact list is in the emergency preparedness plan.

Daily meetings are conducted to review staffing for the current and following shift. The designated staffing liaison will communicate with absentee staff daily for updates on their situations. Documentation of all attempts to obtain staffing resources will be maintained and the reporting status to appropriate oversight agencies and local health department.

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Surge Strategies:

1. Rely on existing staff
    a. Increase number of work hours per week
    b. Call in off duty or PRN staff
    c. Reassign licensed administrative staff to resident care duties "within scope of practice."
    d. Reassign existing personnel to provide essential services outside their current job description.
        i. May need to involve collaboration with labor unions if applicable.
    e. All approved Paid Time Off (PTO) days during an event may be cancelled.
    f. Employees who do not provide direct patient care and whose departmental functions can be placed on hold until the emergency is over will be designated to a labor pool.
2. Call on external sources for temporary staff

Nursing agency staffing

    a. Agreements are reviewed annually and are included in the emergency preparedness plans to assist the facility in preparing for possible staffing challenges.
    b. Retired healthcare professionals may be recruited to assist with non-patient care duties.
3. Request additional staffing resources through the Emergency Management System
    a. Waivers or flexibility for regulatory requirements for hiring staff may be available.
4. Identify essential functions that plan be performed by:
    a. Trained unlicensed/uncertified personnel
    b. Private contractors
    c. Volunteers
    d. Family Members
    e. Community – based organizations

** Supervision of volunteers and temporary healthcare personnel will be accomplished through initially pairing them with experienced staff to determine their competency and reliability and oversee their work. Restriction of visitors in a pandemic may prevent use of volunteers/family members until visiting restrictions are lifted.

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Staff preservation:

Providing essential care to residents cannot be done without able-bodied staff. The infectiousness of a pandemic-causing virus could result in a loss of 20-50% of staff during an outbreak. Anxiety and concern may result in increased absenteeism. In addition, local public health departments may choose close schools, which could further exacerbate absenteeism of employees with children.
The facility will be prepared to preserve staff with policies to protect them and strategies to provide essential care with fewer available staff.

- Education and information will be provided to staff to provide support and decrease anxiety /fear.
- Staff, families and residents will be educated on how emergency/pandemic planning addresses their needs and how essential services will continue to be provided.
- The facility will be transparent and honest about what the facility plans to do to ensure that all participants in your facility's daily function (staff, residents and families) have the information they need to protect themselves and maintain their roles.

Minimizing absenteeism and its consequences during an emergency:

Review attendance/leave policies:

- Suspend requirement for a doctor's note
- Encourage ill workers to stay home
- Isolate/send home symptomatic employees
- Reassign employees at higher risk for complications (i.e. Immunocompromised, pregnancy)
- Provide cross-training/universal caregivers
- Increase inter-facility communication
- Consider the hardship of unpaid time off that could discourage ill workers from staying home.
    - Allow to exhaust PTO and go into negative balances
    - Advance sick time
    - Provide special time off allotment
    - Allow employees to donate time off to others
    - Provide information on FMLA

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Cross Training/Universal Caregivers:

Staff are cross trained to perform essential functions to enable the facility to operate if key staff are not able to report to work. These critical functions include:

- Essential resident care
- Food service
- Housekeeping (especially environmental disinfection)
- Laundry
- Essential administrative functions including billing and payroll

* Training can be in advance or with brief checklists.

Pandemic_Workbook_2010.pdf

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Terminal Cleaning/Disinfection - Isolation Rooms - Pandemic

Policy

Terminal cleaning of an isolation room should be performed by environmental services (EVS) personnel/designated staff after the resident is discharged.

Key Points

1. In rooms where a resident had an active airborne infection, housekeeping staff should wait to clean the room until minimum air exchanges occur. It is recommended the room be vacant from 138-207 minutes before a resident or HCP without PPE should enter to allow enough time for enough air changes to remove potentially infectious particles.
2. EVS staff should enter the room wearing a gown, gloves, and mask with eye protection if splashes or sprays are anticipated, otherwise standard PPE including gown and glove is needed.
    a. Shoe covers are not required.
    b. Medical waste (trash) coming from residents is treated no differently than waste from non-infected rooms.
3. If resources permit, dedicate supplies and equipment for these areas.
4. During terminal cleaning, clean low-touch surfaces before high-touch surfaces.
5. Cleaning considerations include, but not limited to, the following:
    a. Clean from areas that are visibly clean and least likely to be contaminated to areas visibly dirty.
    b. Clean from top to bottom (bring dirt from high levels down to floor levels).
    c. Clean from back to front of room.

Procedure

1. Obtain cleaning cart and appropriate supplies and EPA approved disinfectants:
    a. Keep cart and supplies at the door.
    b. Bring in the supplies needed for the cleaning process.
    c. Change mop bucket water between rooms and when visibly dirty.
2. Don PPE as indicated based on discharged resident's infection status and level of precautions:
    a. Wash hands.
    b. Put on a gown, mask, eye protection and gloves as needed.
3. Remove soiled/used personal care items (e.g., cups, dishes) for reprocessing or disposal.
4. Remove linens for reprocessing.
5. Remove and launder window and privacy curtains.

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6. Place reusable resident care equipment in plastic bag for cleaning.
7. Clean low- and high-touch surfaces, including those not accessible when the room/area.
   a. resident mattress
   b. bedframe
   c. tops of shelves
   d. vents
   e. windowsills
8. Clean (scrub) and disinfect handwashing sinks and faucets.
9. Clean (scrub) and disinfect commodes, toilet seats, flush handles, and showers.
10. Clean prior to disinfection as recommended by the manufacturer of the product(s) being used for transmission precautions.
11. Clean and disinfect high touch areas to include, but not limited to:
    a. Bed rails
    b. Tray tables
    c. Bedside stands
    d. Call buttons, cords, and panels.
    e. TV remote
    f. Telephones
    g. Resident chairs
    h. IV poles
    i. Blood pressure cuffs
    j. Light switches
    k. Doorknobs and levers
12. Clean and mop floor from back to front of room.
13. Ensure wet floor signs are posted.
14. Remove mop heads and place in bag and send for cleaning.
15. Place non-disposable cleaning towels/rags in plastic bags to send to laundry.
16. Remove PPE and perform handwashing.
17. Empty mop water and buckets.
18. Remake the bed.

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Contact Tracing Protocols - Pandemic

Core Principles of Contact Tracing

- In contact tracing, the infected employee or resident is interviewed to help them recall everyone with whom they have had close contact* during the timeframe while they may have been infectious.
- The exposed individuals (contacts) are notified of their potential exposure as rapidly and sensitively as possible.
- To protect resident or employee privacy, contacts are only informed that they may have been exposed to a resident or employee with the infection. They are not told the identity of the resident or employee who may have exposed them.
- Contacts are provided with education, information, and support to understand their risk, what they should do to separate themselves from others who have not been exposed, monitor themselves for illness, and the possibility that they could spread the infection to others even if they themselves do not feel ill.
- Self-monitoring should include temperature checks twice daily and observing for cough or shortness of breath. If symptoms occur, they should be promptly evaluated for infection and for the need for medical care.

** **Close Contact** is defined as someone who was within 6 feet of an infected person for at least 15 minutes starting from 48 hours (about 2 days) before illness onset until the time the infected person is isolated. In healthcare settings, it is reasonable to define a prolonged exposure as any exposure greater than 10 minutes because the contact is someone who is ill. Brief interactions are less likely to result in transmission; however, symptoms and the type of interaction (e.g., did the person cough directly into the face of the individual) remain important.*

Completing the Review of Potential Exposures for Staff and Residents When an *EMPLOYEE* is Ill

1. Enter the employee's name, department, title, shift and level of care the employee worked (IL, AL or SNF).
2. Document the date that the employee's symptoms first started.
3. Describe the employee's symptoms.
4. Document the date that the employee last worked.
5. Determine if the infected staff member had any close resident contact, for example someone who washes dishes may not have any contact with residents, a housekeeper who cleans common areas only may not have close resident contact.
6. Determine if the employee was wearing a facemask at all times during close resident contact. If they were not, create a list of residents who had close contact with the employee who was not wearing a facemask for the 48-hour period before their symptoms started until they were restricted from work.

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7. For each resident listed in #6, determine the resident's risk of exposure. (See Determining Risk Exposure)
8. Determine if the employee who tested positive was wearing a facemask at all times during his or her shift and that he or she was social distancing from other employees during their breaks.

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RISK MANAGEMENT SERVICES

Telemedicine - Pandemic
Policy and Procedure

Policy:

To improve access to medical care and increase the efficiency of medical evaluation and management, it is the policy of this facility to enable the use of telecommunication technology. Virtual care may be an option while protecting beneficiaries and assisting with infection control protocols. Residents who provide appropriate consent will be connected to a health care professional at a different location via telemedicine/electronic devices. *

Procedure

1. Telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located.
2. Providers must have an existing physician-patient relationship.
3. Consent must directly or indirectly be obtained by a health care professional utilizing telemedicine.
4. The provider must confirm the identity of the resident.
5. The resident must be provided with a private space to complete their telemedicine consultation.
6. The provider will use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the resident.
7. Video conferencing platforms used for telemedicine services must have the appropriate tools to authenticate individual users and secure transmission (such as end to end encryption). The platforms must meet the privacy and security requirements of, and be compliant with, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
8. It is the policy of this facility to require use of the_____ as its telehealth platform. Use of a non-HIPAA compliant telehealth platform as detailed in the Addendum below will only be allowed with written permission from the _____ (Administrator / Executive Director) and the written consent of the resident.
9. Only in an official state of emergency/disaster and a Public Health Emergency has been declared where HIPAA requirements have been waived and with prior

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approval of the resident may the use of non-HIPAA compliant video conferencing platforms be used.

10. These platforms must be authorized and documented by the Compliance Officer, and only under certain conditions which have been defined and permitted by the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR), which enforces the HIPAA privacy and security regulations.
11. The use of public-facing video communication applications is NEVER allowed, such as Facebook Live, Twitch, TikTok, and other similar applications.

Modified Procedure

1. Any use of non-HIPAA compliant video conferencing technology platforms must be approved by the Compliance Officer and the resident for telemedicine consultations only.
2. The use of non-HIPAA compliant video conferencing platforms should only be used if there are no other HIPAA-compliant options available for the telemedicine consultations during an official state of emergency/disaster and a declared Public Health Emergency where HIPAA requirements have been waived.
3. Providers who wish to use non-HIPAA compliant video conferencing platforms under this exception must get prior authorization for such use and must document that they have made a good faith effort to use HIPAA-compliant solutions before using an alternative platform.
4. The responsible workforce members are still required to get a signed "Resident Consent to Telemedicine Consultations" form prior to initiating a telemedicine consultation with any provider.
5. If approved by the Compliance Officer, providers may use any non-public facing remote communication product that is available to communicate with patients. These may include popular applications that allow for video chats, such as:
    a. Apple FaceTime
    b. Facebook Messenger video chat
    c. Google Hangouts video
    d. Skype
6. Telemedicine consultations must be documented by the provider in the same manner as a normal telemedicine consultation.
7. The use of public-facing video communication applications is NEVER allowed, such as Facebook Live, Twitch, TikTok, and other similar applications.

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RISK MANAGEMENT SERVICES

Definitions

Telemedicine: Means the use of electronic information and telecommunication technologies to support or promote long-distance clinical health care, patient and professional health-related education, public health, or health administration. To be considered telemedicine, the health care professional must be able to examine the resident via a real-time, interactive audio or video, or both, telecommunication system, and the resident and/or nurse must be able to interact with the off-site health care professional at the time the services are provided.

*Medicaid reimburses for live video telemedicine for certain healthcare professionals and for residents at certain originating sites. Live video telemedicine is reimbursed and should primarily be used when travel is prohibitive for the beneficiary or there is an imminent health risk justifying immediate medical need for services.

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